Provider Operations Manual
Delegated Participating Providers
2019

Alignment Healthcare
Alignment Health Plan
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Welcome to Alignment Healthcare! Alignment Healthcare’s (Alignment) Provider Operations Manual contains information on Alignment’s operational policy and procedures that support many of our programs and services. It also contains key contacts, addresses, phone numbers and websites.

Alignment is an industry leader in managed care and operates different business models and networks across the country. In California, Alignment owns and operates Alignment Health Plan, a Medicare Advantage Health Maintenance Organization (HMO) health plan and qualified Special Needs Plan (SNP). Alignment is based in Orange, California, and works in diverse communities to promote health and wellness and delivers high-quality care and services to its Medicare Advantage Members. Alignment offers its network providers a variety of contracts that enable them to better serve their Medicare and Medicare/Medi-Cal (Medi-Medi) population in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Joaquin, Santa Clara and Stanislaus counties.

Outside of California, Alignment Healthcare operates as a health care delivery system. Alignment contracts with professionals, institutional and ancillary health care providers to make services of such Participating Providers available to individuals enrolled as Members in certain Medicare Advantage plans offered by managed care organizations, including HMOs and other prepaid health plans that are contracted with Alignment Healthcare.

This Provider Operations Manual applies to IPAs, Medical Groups, and other Participating Providers who Alignment has delegated to perform certain managed care functions, such as utilization management, claims payment and credentialing, as outlined in the agreement with Alignment.

A Participating Provider is an IPA, Medical Group, Primary Care Physician, Specialist, Ancillary Provider, Hospital, supplemental vendor or other health care provider or practitioner who is contracted with Alignment to provide services to our Members.

**Our Purpose**
To serve others. This is our calling.

**Our Vision**
Lead a movement to fundamentally change health care.

**Our Mission**
Use our compassion, technology and experience to provide a new, higher level of care.

**Purpose of the Provider Operations Manual**
The Provider Operations Manual describes Alignment’s policies and operating procedures. It serves as a general reference and guide to Participating Providers and their staff to comply with these policies and procedures and is an extension of the IPA/Medical Group Participating Provider Services Agreement. The contents of Alignment’s Provider Operations Manual supplements the IPA/Medical Group Participating Provider Services Agreement and its addendums. When the
contents of Alignment's Provider Operations Manual conflict with the IPA/Medical Group Participating Provider Services Agreement, the IPA/Medical Group Participating Provider Services Agreement takes precedence.

In addition to the Provider Operations Manual, Alignment’s Network Management Department is responsible for educating the IPA/Medical Group about Alignment and providing access to written provider educational materials, bulletins, newsletters and reports.

Alignment Department Descriptions

Claims
Processes claims for payment to Participating Providers and assists providers with claims status inquiries. Maintains Participating Provider files and information to ensure proper reimbursement according to contracted rates.

Credentialing
Conducts credentialing and services for Participating Providers and Health Delivery Organizations that are contracted with Alignment.

Eligibility
Eligibility Department is responsible for processing all Member enrollments and disenrollment, verifies Member eligibility for services for Participating Provider’s offices, pharmacies and vendors.

Finance
Processes capitation payments for the IPA/Medical Groups and payments for other Alignment Participating Providers, as appropriate.

Marketing
Promotes Alignment within the Health Plan’s service area communities through community events, new Member orientations, distribution of educational and marketing materials and participation in community activities geared toward marketing benefits and services.

Member Services
Answers all Member calls regarding benefit inquiries, complaints, replacement ID cards, and appeals and grievances. Representatives also assist with scheduling interpreter services, transportation and assist Members with Primary Care Physician transfers. Member Services maintains a Member retention unit to assist Members to resolve customer service issues. Inquiries or appeals about Prescription Drug Coverage are delegated to Alignment’s Pharmacy Benefits Manager (PBM).

Network Management
Negotiates and maintains all contracts for medical services provided to our Members. Works with Providers on contract inquires.

Pharmacy
Administers the Part D prescription drug benefit and offers a comprehensive pharmacy services program, including formulary management, utilization management and pharmacy network management.
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Provider Data Management (PDM)
Inputs and maintains all Provider data, practice information (such as demographics) and applicable contract information.

Sales
The Sales staff schedules and conducts presentations in the community and private homes to ensure potential Members understand Alignment benefits and the enrollment process. The Sales Representatives interact with Primary Care Physicians offices and their staff specifically related to enrollment and retention. Also, the Sales Department coordinates all sales events and develops collaterals and other printed materials.

STARS Performance Improvement/Risk Adjustment
The Stars Process Improvement Program establishes guidelines to achieve the common goal of a 5 Star status. The STARS Performance Improvement Department monitors and assists Physicians to help improve their individual Star ratings. Members with chronic diseases are monitored to assure best outcomes and best practices in treating their diseases. In order to serve the greatest good for health care and cost containment, the Risk Adjustment department assures that complete data is gathered through coding and other documentation of services provided to each Member at every visit. The Centers for Medicare and Medicaid Services (CMS) has given ratings to Health Plans based on how well Health Plans provide clinical quality, customer services and satisfaction to its Membership.

Quality Management (QM)
Quality Management is responsible for all quality activities, conducting Quality Improvement Projects, audits that are compliant with the Centers for Medicare and Medicaid Services (CMS) guidelines, and may perform credentialing for all Participating Providers and/or Health Delivery Organizations (HDO) that are contracted with Alignment.

Utilization Management (UM)
Ensures all medical services are provided appropriately in the correct settings, and referred to Participating Providers, unless as otherwise directed by Alignment. The Utilization Management department reviews medical records to determine approvals of medical care. Reviews may be required for medical services referrals, level of care determinations, length of stays, and approval decisions based on medical necessity.

Alignment Department, Participating Provider and Vendor List:
To contact the above departments, IPA/Medical Groups and Participating Providers can access the Alignment Department and Vendor List located on the Alignment Provider Portal at https://providers.ahcusa.com.

The roster also includes Alignment’s Participating Providers and designated Ancillary and Supplemental Vendors (including but not limited to Vision, Dental, Transportation, fitness, hearing aids, etc.) for Member referrals. IPA/Medical Groups can access Alignment’s full provider network on Access Express at the link listed above.
Section 2: Member Rights and Responsibilities

Member Rights
Members have the right to:

- Receive information in a way that works for them (in languages other than English, in Braille, in large print, or other alternate formats, etc.).
- Be treated with fairness, respect, and be free from discrimination based on race, ethnicity, national origin, religion, gender, sexual orientation, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.
- Timely access to covered services which includes: the right to choose a Primary Care Physician (PCP) in the Health Plan's network to provide and arrange for covered services, the right to go to a women's health specialist (such as a gynecologist) without a referral, the right to get appointments and covered services from the Health Plan's network of providers within a reasonable amount of time, the right to get timely services from specialists when Members need that care.
- Privacy of their medical records and personal health information.
- Confidentiality of personal and health information regardless of the format of that information (i.e., spoken communications, written materials, electronic records, facsimiles). This includes the release of medical records.
- Access to personal medical records only in accordance with law.
- Participation of decisions about their personal healthcare and education of all available treatment options and associated risks (including the option of no treatment) or alternative courses of care that is available. Members must be told in advance if any proposed medical care or treatment that is part of a research experiment, and they always have the choice to refuse any experimental treatments.
- Utilize an advance directive, such as a living will or a durable healthcare power of attorney.
- Appoint a representative to make health care decisions including the decision to withhold resuscitative services or withdraw life-sustaining treatment if requested by the Member.
- File complaints and obtain a prompt resolution of issues, including complaints, grievances or appeals relating to the authorization, coverage, or payment of services. When Members exercise this right, they must be treated fairly.
- Obtain information regarding health care coverage and costs, and rules that Members must follow when using coverage.
- Obtain information about affiliated IPA/Medical Group and any Participating Providers, including their qualifications and how they are paid by the Health Plan.

Members Responsibilities
Members have certain responsibilities. These include the responsibility to:

- Have a general understanding of their health care coverage, and the rules that must be followed to receive care as a Member and inform the Health Plan of any other health insurance coverage or prescription drug coverage in addition to our Health Plan, so benefits can be appropriately coordinated.
• Members will provide their Physicians and other health care Providers complete and accurate information necessary to provide appropriate health care.
• Payment of any applicable co-payment, deductible, co-insurance or charge for non-covered services when requested by their Alignment Participating Providers.
• Appropriate behavior in and around health care Participating Providers’ place of business to promote a healthy environment to receive health care.
• Members must tell us if they move outside of the Health Plan service area.
• Inform the Health Plan of any questions, concerns, or suggestions.
Section 3: Eligibility and Enrollment

Overview
This section describes the eligibility requirements and enrollment process for Medicare entitled beneficiaries. Member eligibility requirements are determined by the Health Plan in conjunction with The Centers for Medicare and Medicaid Services (CMS).

1. Eligibility Requirements
   To be eligible to enroll, a beneficiary must be enrolled with Medicare Part A and Part B coverage, reside within the Health Plan’s approved service area, must be a United States citizen or lawfully present in the United States, not have End-Stage Renal Disease (ESRD) at the time of enrollment (with limited exceptions, such as if the individual developed ESRD when he/she was already a Member of a Health Plan).

2. Limitations on Enrollment
   - The beneficiary cannot enroll with a Health Plan if at the time of enrollment, the beneficiary has ESRD.
   - Medicare beneficiaries who have elected Medicare hospice coverage prior to enrollment are eligible to enroll in the Plan. Original Medicare is responsible for hospice services and Part A and Part B services related to the Member’s terminal prognosis. The Health Plan is only responsible for Covered Services that are not related to the Member’s terminal condition.
   - Health Plans follow the CMS enrollment periods as indicated in the Medicare Managed Care Manual, [Chapter 2 – Medicare Advantage Enrollment and Disenrollment, Section 30] Medicare Managed Care Manual MA Enrollment and Disenrollment

3. Hospitalized at Time of Enrollment
   A Member, who is an (acute) hospital inpatient on the effective date of enrollment, will be covered by the Health Plan, following discharge from an inpatient hospital stay or when the Member is transferred to a lower level of care. The Health Plan assumes responsibility for all other Part A and Part B coverage (except inpatient hospital care) on the effective enrollment date.

4. PCP Selection
   The Member will be required to select a Primary Care Physician at the time of enrollment to provide services described in the Member’s Evidence of Coverage (EOC) booklet. If the Member does not select a Primary Care Physician, or selects a Primary Care Physician, and the panel is closed, the Health Plan will assist the Member with their Primary Care Physician selection or assign a default Primary Care Physician near the Member’s residence.

5. Lock-In Feature
   Prior to enrolling with a Health Plan, the Member is educated about the “lock-in” provision, which requires the Member to obtain all medical care through the Health Plan. This provision applies from the effective date of coverage forward.
The Health Plan offers its benefits through a contract with CMS, the federal government agency that administers the Medicare program. Under this contract, the government has an agreement to pay the Health Plan a fixed monthly amount to provide health care to the Member. This means that Medicare will only pay the Health Plan for the Member’s health care while the Member is enrolled in the Health Plan. If the Member chooses to go outside of the Health Plan for services and the situation is not an emergency or Out-of-Area urgently needed service, neither the Health Plan nor Medicare will pay for the services rendered.

All medical services (except emergency or Out-of-Area urgently needed services) must be provided or authorized by the Primary Care Physician, Participating Provider or the Health Plan as defined your contract with the Health Plan. Services rendered without the authorization of the Primary Care Physician, Participating Provider or the Health Plan, as the case may be, will not be covered.

6. Member Ineligibility
A Medicare-entitled Member becomes ineligible for coverage under the Health Plan on the date when any of the following situations occur:

- The Member is no longer entitled to Medicare Part A and Part B (termination is effective the first day of the month following the month this occurs).
- The Member establishes primary residency outside of the United States.
- The Member permanently moves out of the service area. The Member is required to notify the Health Plan if moving out of the service area. The Health Plan is required to provide emergency, Out-of-Area urgently needed services, or Out-of-Area dialysis services only until the Member’s termination is effective with CMS. Members are allowed to be out of the service area for a maximum period of 6 months.
- The Member commits fraud or allows another person to use his/her Alignment ID card to obtain services.
- The Member is disruptive, abusive, unruly, or uncooperative to the extent that this behavior jeopardizes the well-being of any Participating Provider, Member, or employee, and the information is documented by the Health Plan. Such terminations must be approved by CMS.
- The Member knowingly omits or misrepresents a material fact on the application for Membership.
- The Health Plan’s contract with CMS is not renewed.
- The Member is deceased.

**NOTE:** The Member has the right to have their termination reviewed. Such termination, if not appealed or overruled, is effective on the date set forth in the notice.

7. Voluntary Disenrollment
A Member may not always be able to make a change until the appropriate election periods apply. If a specific election period applies to the Member, and the Member wishes to make a change, he/she must submit a written request to the Health Plan’s Member Services Department. The Member may also request to have a disenrollment form mailed to them. In addition, the Member may contact Medicare at 1-800-MEDICARE (1-800-633-4227). The written request must be signed before the effective date of disenrollment. Telephone requests for disenrollment will not disenrollment form will be mailed to the Member at their request. When a written disenrollment request is submitted without a signature, the Health Plan shall
verify the request to disenroll with the Member by phone, document the contact and process the disenrollment request rather than return the written request as incomplete.

If a Member enrolls in another Medicare Advantage Plan, the Member will automatically be disenrolled from their current Health Plan when the Member becomes effective with the new Medicare Advantage Plan. The effective date of the disenrollment is the first day of the month following the month in which CMS receives the Member’s request.

8. Member Transfers between Primary Care Physicians
CMS guidelines allow transfers between Primary Care Physicians without any type of annual limitation. These unlimited transfer requests may be made at any time by the Member. The effective date of transfer shall be the first day of the month following the transfer request.

The Member Services Department is responsible for all Member transfer requests. Members requesting a transfer should contact the Health Plan’s Member Services Department. Transfer request procedure is as follows:

- The affected Primary Care Physician and or the IPA/Medical Group is notified of the transfer via the eligibility report
- Once the request is completed, the Member is sent an updated Health Plan Member ID card

9. Member Notification of Voluntary and Involuntary Participating Provider Terminations
IPA/Medical Group will notify all Members who are patients seen on a regular basis of the termination of Specialists, ancillary providers or hospitals, regardless of the reason for termination. The Health Plan will notify all Members impacted by the termination of a Primary Care Physician. The Health Plan will ensure minimum disruption of the Member’s health care when the transition of care from one Participating Provider to another occurs. The Health Plan and IPA/Medical Group will make a good faith effort to provide written notification to its affected Members of termination of a contracted IPA/Medical Group, Primary Care Physician, Specialist, ancillary provider or hospital within thirty (30) calendar days of receipt or issuance of a notice of termination, as indicated in the Medicare Managed Care Manual Chapter 11 section (42 CFR 422.111(e)).

10. Member Notification of Terming Provider due to Participating Providers being on Preclusion List
IPA/Medical Group will notify all Members who have received care in the last 12 months from a Specialist, ancillary provider, hospital or other practitioner who is included on the CMS Preclusion List. Alignment will provide the Preclusion List to IPA/Medical Group. Alignment will notify all Members who are assigned to a Primary Care Physician who is included on the CMS Preclusion List. Members will be notified within 30 days of the Health Plan receiving the Preclusion List.

11. Provider Initiated Disenrollment
The IPA/Medical Group and Participating Provider can request that a Member be involuntarily disenrolled from the Participating Provider’s practice if a Member does not respond to recommended patterns of treatment or repeated abusive behavior. Examples include the following:
• Repeated abusive behavior by the patient
• Assault
• Serious threats
• Disruption to IPA/Medical Group operations or to Participating Provider’s office
• Inappropriate use of Out of Network Services
• Inappropriate use of medical services
• Non-Compliance with prescribed treatment plan

12. In all such instances of the above non-compliance, the IPA/Medical Group and Participating Provider recognizes its responsibility to make reasonable efforts to counsel, educate, and advise Members of the potential harm that may result from their actions prior to submitting a Provider Initiated Disenrollment. Participating Provider offices must document all occurrences in the Member’s medical record. The IPA/Medical Group acting on behalf of the Participating Provider must send a certified letter to the Health Plan’s Member Services Department stating the reasons for the request for disenrollment to the following address:

<table>
<thead>
<tr>
<th>California Alignment</th>
<th>1100 W. Town and Country Road, Suite 1600 Orange CA. 92868 Phone: (866) 634-2247 Fax: (323) 728-1460</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida Blue</td>
<td>1100 W. Town and Country Road, Suite 1600 Orange CA. 92868 Phone: (800) 926 – 6565 Fax: (323) 728 -1460</td>
</tr>
<tr>
<td>North Carolina FirstMedicareDirect</td>
<td>1100 W. Town and Country Road, Suite 1600 Orange CA. 92868 Phone: (844) 499-5630 Fax: (323) 728 -1460</td>
</tr>
<tr>
<td>North Carolina Humana</td>
<td>PO Box 14605 Lexington, KY 40512 Phone: 1-800-457-4708 Fax: 1-888-556-2128</td>
</tr>
</tbody>
</table>

The Health Plan’s Member Services Department must evaluate the request and determine the conditions that would warrant the request. Until the effective date of an approved disenrollment, the IPA/Medical Group Participating Provider shall continue to be responsible for the health care of the Member. Based on the outcome of the review, the Member may be transferred and notified according to policy or shall be given a corrective action plan to follow. If the Member does not respond to the corrective action plan, an immediate transfer shall be made to another physician within the network. If the matter was due to non-compliant or disruptive behavior, a request for an involuntary disenrollment may be made to CMS.

The Health Plan recognizes that if a Member’s disruptive behavior is of such a serious nature, that one (1) or two (2) occurrences are sufficient to warrant an involuntary Participating Provider to Participating Provider transfer or involuntary disenrollment. Examples of this behavior include threatened or actual bodily harm to the Participating Provider or the Participating Provider’s medical staff. These situations are reviewed on a case-by-case basis by the Health Plan’s
administrative staff and a determination is made as to whether a Member corrective action plan, Participating Provider transfer or involuntary disenrollment is justified.

Exhibits:
Exhibit 3.1 – California Eligibility Verification and Sample Member ID Cards
Exhibit 3.2 – Florida Eligibility Verification and Sample Member ID Cards
Exhibit 3.3 – North Carolina Eligibility Verification and Sample Member ID Cards
Exhibit 3.1
California
Eligibility Verification and Sample Member ID Cards

A beneficiary must complete and sign an individual election form to enroll in Alignment prior to the effective date of coverage. Alignment must verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen). Therefore, the Member is not required to provide evidence with the enrollment request. The Member’s current Medicare coverage will continue until the Member’s coverage with Alignment begins. Once enrolled with Alignment, the Member agrees to obtain all Medicare benefits through Alignment Participating Providers, except for emergency or Out-of-Area urgently needed services.

The Member’s enrollment generally becomes effective the first day of the following calendar month after an election is made. The Member’s enrollment under any other Medicare Advantage Plan or stand-alone Part D plan (when applicable) will terminate on the effective date of enrollment with Alignment.

Alignment operates on “prospective enrollment”, which means that Alignment includes the names of their prospective Members and the name of the Member’s Primary Care Physician on the eligibility report, but until confirmation and payment is received from CMS, Alignment does not include the Member’s name on the capitation reports. All confirmed retroactive capitation shall be paid accordingly to each capitated Participating Provider IPA/Medical Group. All Members that appear on the Alignment eligibility report are to be rendered care when they present to their assigned Primary Care Physician’s office; they are not to be denied service due to the fact that their name may not appear on the capitation report.

Member Identification Card
New Members are mailed their Member ID card and their Welcome Packet upon enrollment with Alignment. If a Member requires services prior to receiving a Member ID card, the Member’s confirmation/acknowledgment letter or enrollment form may be used in place of the ID card. A Member ID card or enrollment form does not constitute coverage under Alignment. Participating Providers should always verify eligibility prior to rendering services to any Member. To verify eligibility, contact the Eligibility Department at (888) 517-2247 or use the Alignment website to verify eligibility on-line: https://www.alignmentthealthplan.com.

Website and IVR Eligibility Verification
Participating Providers are responsible for verifying eligibility each time a Member receives care. To obtain eligibility, Participating Providers must have the Member ID# example: (00012345601), Medicare HIC# or Medicare Beneficiary Identifier (MBI) number and date of birth. You may verify Member’s eligibility as far back as 01/01/2017 and for dates of service in the current calendar month (up to actual calendar date); for dates of service prior to 01/01/2017 please contact Eligibility Dept. Members with future effective dates will only able to be checked on or after their effective date. Please follow the steps below to verify eligibility:

1. Go to https://www.alignmentthealthplan.com
2. Click on “Providers” tab
3. Click on “Member Eligibility"
4. Log in to secure website
5. Enter Member information

For any issues please contact Network Management at the following phone number: (844) 361-4712.

Participating Providers can also verify Member eligibility via the Interactive Voice Response (IVR) at (888) 517-2247. Participating Providers will need to provide their NPI and Tax ID Number to verify Member eligibility and benefits.

Eligibility Reports
Alignment has a Secure File Transfer Protocol (SFTP) site for obtaining eligibility reports, Qualified Medicare Beneficiary (QMB) reports, capitation reports, and anything that contains Protected Health Information (PHI). Primary Care Physician’s monthly reports are available on our SFTP site for downloading. These secured servers allow the users to upload/download multiple files at once. For information on how to access reports on the SFTP site, please view Accessing Monthly Outbound Reports.

The IPAs/Medical Groups and capitated Participating Provider Groups will receive a monthly eligibility report that contains a list of all Members that are eligible. IPAs/Medical Groups and Participating Providers should check the Member’s effective and termination dates to ensure eligibility prior to rendering services. This report can be used to reconcile with the capitation report to verify that the correct capitation has been received, and that the capitation includes retroactive activity. Alignment strives to ensure that our IPA/Medical Groups and Participating Providers and staff receive the most current information as soon as possible, to facilitate patient care and referrals.

The IPA/Medical Group will also receive the Qualified Medicare Beneficiary (QMB) report each month. This report can be used to identify Dual status beneficiaries. QMB file is distributed in fixed length file format.

Alignment distributes the eligibility report in two file formats: excel and fixed length file. Below are the explanations of the fields and a description of the layout.

The eligibility report contains all of your eligible Members for the current calendar month. The file consists of:

- Member ID# (which is the ID# that is assigned to the Member by Alignment)
- Last Name
- First Name
- Middle Initial
- Sex
- Birthdate
- SSN # (Due to PHI Alignment will no longer provide the Social Security#)
- MBI#
- Address1
- Address 2 (applicable for apartment numbers only)
- City
- State
- Zip
- Phone #
- HP Eff Date (which is the date the Member enrolled with Alignment)
- Medicaid (this field is populated with either “Y” or “N” (if “Y” is populated then the Member does have Medicaid, if “N” is populated then the Member DOES NOT have Medicaid)
- PCP ID
- PCP Name
- PCP Eff Date (date Member is eligible with their assigned PCP)
- Prospective (This field will identify the Members who are PROSPECTIVE, meaning that the Member is in the process of enrollment and pending CMS confirmation)
- Tran Status
- Term Date
- Prior PCP Name
- Prior IPA/Medical Group Name
- New Mbr History
- Mailing Address
- Mailing Address 2
- Mailing City
- Mailing State
- Mailing Zip
- RAF Score
- RAF Type
- LIS Level
- LIS Date
- Working Aged/COB
- Resident County
- IPA/Medical Group POD
- Primary Language
- Benefit Option
- Member Email
- Contact Name
- Contact Phone#
- Contact Email
- Contact Relationship
- PCP Street
- PCP Street 2
- PCP City
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| • PCP State       |
| • PCP Zip         |
| • PCP Phone#      |
| • PBP (Plan Benefit Package) |

**ADDITIONAL INFORMATION:**

- **Mailing Address:** The columns “Z-AD” if populated will indicate the Member alternative address which is NOT the Member permanent address. The mailing address will only populate if the Member designates an alternative address to Alignment.

- **Prior Primary Care Physician + IPA/Medical Group Name:** These columns “W” and “X” if populated, will indicate that an existing Alignment Member has transferred into your office. This column will assist you as the current Primary Care Physician to contact the Member's prior Primary Care Physician/ IPA/Medical Group to obtain their medical chart.

- **Mbr History:** This column “Y” shall identify those Members that are new to your office with an *. Each asterisk accounts for one calendar month of enrollment. This indicator will remain on file for 4 months. For each Member transferred to your office, a “+” sign shall be included followed by “**”. Our goal is to assist you in identifying those new Members to complete an initial health assessment or physical and Jump Start Assessment.

- **Working Aged/COB:** This column “AI” shall identify if the Member has other coverage for coordination of benefits. This field will be populated with a “Y” or “N”. If column is flagged with a “Y”, this indicates the Member has other coverage and additional information can be provided upon request to the Eligibility Department.

- **RAF Score:** Column “AE” will include the Risk Adjustment Factor (RAF) score. Managing your Member's RAF scores will enable you to deliver the appropriate and quality health care to our Members.

- **LIS Level:** Column “AG” will indicate the LIS level (Low Income Subsidy) co-pay with a (0, 1, 2, 3, 4) to indicate the different levels of co-pays. Column “AH” will identify the effective date with the level of LIS.
Your QMB report contains beneficiaries with Dual status for the current calendar month. The file consists of:

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Format</th>
<th>Max Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBER_ID</td>
<td>Member ID.</td>
<td>Text</td>
<td>25</td>
</tr>
<tr>
<td>LAST_NAME</td>
<td>Member last name.</td>
<td>Text</td>
<td>30</td>
</tr>
<tr>
<td>FIRST_NAME</td>
<td>Member first name.</td>
<td>Text</td>
<td>30</td>
</tr>
<tr>
<td>MI</td>
<td>Member middle initial.</td>
<td>Text</td>
<td>3</td>
</tr>
<tr>
<td>SEX</td>
<td>Member gender code where “M” is for Male, and “F” is for Female.</td>
<td>Text</td>
<td>1</td>
</tr>
<tr>
<td>DOB</td>
<td>Member date of birth.</td>
<td>Date (YYYYMMDD)</td>
<td>8</td>
</tr>
<tr>
<td>MEDICARE_ID</td>
<td>Member Medicare ID (HI/C/MBI).</td>
<td>Text</td>
<td>12</td>
</tr>
<tr>
<td>REPORTING_CATEGORY</td>
<td>Name of the reporting category. See section 4.0 for the definition.</td>
<td>Text</td>
<td>60</td>
</tr>
<tr>
<td>REPORTING_CODE</td>
<td>Name of the reporting code. See section 5.0 for the definition.</td>
<td>Text</td>
<td>50</td>
</tr>
<tr>
<td>START_DATE</td>
<td>Effective start date of the reporting code.</td>
<td>Date (YYYYMMDD)</td>
<td>8</td>
</tr>
<tr>
<td>END_DATE</td>
<td>Effective end date of the reporting code.</td>
<td>Date (YYYYMMDD)</td>
<td>8</td>
</tr>
</tbody>
</table>

**No Balance Billing**
Payments made by Alignment to IPA/Medical Groups and Participating Providers, less copayments, coinsurance, or deductibles, which are the financial responsibility of the Member, are considered payment in full. IPA/Medical Groups and Participating Providers may not seek additional payments from Members for the difference between the billed charges and the rate paid by Alignment, nor for any unpaid balance remaining after coordination of benefits.

**Qualified Medicare Beneficiary**
Federal law prohibits all Medicare Providers from billing dual eligible Qualified Medicare Beneficiary (QMB) Members for Medicare deductibles, copayments and coinsurance. The QMB program assists low-income Medicare beneficiaries with their Medicare Part A and B premiums and cost sharing. All Medicare and Medicaid payments received by the IPA/Medical Group and Participating Providers for furnishing services to a QMB are considered payment in full. IPA/Medical Groups or Participating Providers may request payment for these premiums and cost sharing amounts from the state. IPA/Medical Groups and Participating Providers are responsible for educating their staff on the importance of checking patient’s QMB status before billing for any deductibles, copayments and coinsurance. To verify status, please call the Alignment Eligibility
Hotline at (888) 517-2247. As an additional resource, the IPA/Medical Groups will receive the above Qualified Medicare Beneficiary (QMB) report each month from Alignment. This report can be used to identify QMB Members. For information on Medicare billing restrictions see Medicare Learning Network:

MLN Dual Eligible Beneficiaries Under Medicare and Medicaid
Exhibit 3.1
California
Sample Member ID Cards

Member: FIRSTNAME LASTNAME
Member ID: 00000000000
PCP Name: DOCTOR NAME
PCP Phone: (000) 000-0000
Med Grp: MEDICAL GROUP NAME
Med Grp #: (000) 000-0000
Member Services: 1-866-634-2247 / TTY 711
Liberty Dental Provider Help: 888-703-6999
Transportation: 1-866-327-2247

Eff Date: 01/01/2019
Rx Grp: H3815
RxBin: 610455
RxPCN: AHPPARTD
RxID: 00000000000
Plan Code: XXXX

Alignment Health Plan

All claims must be mailed to:
Alignment Health Plan
PO. Box 14010, Orange, CA 92863

Pharmacy Technical Help Desk: 1-844-227-7616
Member Pharmacy Help: 1-844-227-7616
Eligibility Verification: 1-888-617-2247
Mem 24/7 Nurse Advice Line: 1-844-323-2247

For information regarding Vision Care and Hearing Services contact Member Services. Pre-authorization is required for all non-emergent hospital admissions, please call (323) 728-7232.

alignmenthealthplan.com
Exhibit 3.2
Florida
Eligibility Verification and Sample Member ID Cards

Member Eligibility
Participating Providers may obtain Member eligibility status through the Health Plan’s website or by calling Alignment. Participating Providers should always verify eligibility prior to rendering services to any Member. To obtain eligibility the Participating Provider must have the Member Health Plan ID# (as it reflects on the Member Health Plan ID card), date of birth and provide their NPI or Tax ID#. You may only verify Member’s eligibility for date of service in the current calendar month (up to actual calendar date), or the previous calendar month. Members with future effective dates will only be able to be checked on, or after their effective date.

Access Express Provider Authorization System
Participating Providers may also use Alignment Healthcare’s Access Express Provider Authorization System to view Member eligibility information. Participating Providers may access this portal at: https://providers.ahcusa.com. Verifying eligibility directly with the Health Plan, either using the website or Member Services is the ideal method.

Member Identification Card
Possession of a Member identification card is not a guarantee of eligibility. New Members are mailed their Member ID card and their Welcome Packet upon enrollment. Providers should always verify eligibility prior to rendering services to any Member.

Website Verification
Providers have access to obtain Member eligibility status through the Health Plan’s website or by calling the Health Plan’s Member Services department.

Florida Blue Medicare Preferred HMO
Call Eligibility Department at: 1 (888) 517-2247

Or visit website: https://providers.ahcusa.com

No Balance Billing
Payments made by the Health Plan to Participating Providers, less copayments, coinsurance, or deductibles which the financial responsibility of the Member are, are considered payment in full. Participating Providers may not seek additional payments from Members for the difference between the billed charges and the rate paid by Alignment nor for any unpaid balance remaining after coordination of benefits.

Qualified Medicare Beneficiary
Federal law prohibits all Medicare Providers from billing dual eligible Qualified Medicare Beneficiary (QMB) Members for Medicare deductibles, copayments and coinsurance. The QMB program assists low-income Medicare beneficiaries with their Medicare Part A and B premiums and cost sharing. All Medicare and Medicaid payments received by Participating Providers for furnishing services to a QMB are considered payment in full. Participating Providers may request payment for these premiums and cost sharing amounts from the state. Participating Providers are responsible for educating their staff on the importance of checking patient’s QMB status before rendering services.
billing for any deductibles, copayments and coinsurance. To verify status, Participating Providers need to call the Health Plan at (800) 926-6565. For information on Medicare billing restrictions see Medicare Learning Network:

**MLN Dual Eligible Beneficiaries Under Medicare and Medicaid**

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**Florida Sample Member ID Cards**
Exhibit 3.3
North Carolina
Eligibility Verification and Sample Member ID Cards

Member Eligibility
Participating Providers may obtain Member eligibility status through the Health Plan’s website or by calling the Member’s Health Plan Eligibility Department. Participating Providers should always verify eligibility prior to rendering services to any Member. To obtain eligibility the Participating Provider must have the Member Health Plan ID# (as it reflects on the Member Health Plan ID card), date of birth and provide their NPI or Tax ID#. You may only verify Member’s eligibility for date of service in the current calendar month (up to actual calendar date), or the previous calendar month. Members with future effective dates will only be able to be checked on, or after their effective date

Access Express Provider Authorization System
Participating Providers may also use Alignment Healthcare’s Access Express Provider Authorization System to view Member eligibility information. Participating Providers may access this portal at: https://providers.ahcusa.com. Verifying eligibility directly with the Health Plan, either using the website or Member Services is the ideal method.

Member Identification Card
Possession of a Member identification card is not a guarantee of eligibility. New Members are mailed their Member ID card and their Welcome Packet upon enrollment. Providers should always verify eligibility prior to rendering services to any Member.

Website Verification
Providers have access to obtain Member eligibility status through the Health Plan’s website or by calling the Health Plan’s Eligibility department.

FirstMedicareDirect
Call Eligibility Department at 1 (844) 499-5630
Or visit website: https://providers.ahcusa.com

Humana
Call Eligibility Department at 1 (800) 448-6262
Or visit website: https://apps.availity.com/availity/web/public.elegant.login

No Balance Billing
Payments made by the Health Plan to Participating Providers, less copayments, coinsurance, or deductibles which the financial responsibility of the Member are, are considered payment in full. Participating Providers may not seek additional payments from Members for the difference between the billed charges and the rate paid by Alignment nor for any unpaid balance remaining after coordination of benefits.
Qualified Medicare Beneficiary
Federal law prohibits all Medicare Providers from billing dual eligible Qualified Medicare Beneficiary (QMB) Members for Medicare deductibles, copayments and coinsurance. The QMB program assists low-income Medicare beneficiaries with their Medicare Part A and B premiums and cost sharing. All Medicare and Medicaid payments received by Participating Providers for furnishing services to a QMB are considered payment in full. Participating Providers may request payment for these premiums and cost sharing amounts from the state. Participating Providers are responsible for educating their staff on the importance of checking patient’s QMB status before billing for any deductibles, copayments and coinsurance. To verify status, Participating Providers need to call the Health Plan at (844) 499-5630 for First Medicare Direct (HMO) and (800) 448-6262 for Humana. For information on Medicare billing restrictions see Medicare Learning Network:

MLN Dual Eligible Beneficiaries Under Medicare and Medicaid

North Carolina
Sample Member ID Cards

FirstMedicareDirect

- First Medicare Direct – Preferred Plus (HMO)
- Direct Smart HMO (HMO)
North Carolina
Sample Member ID Cards

Humana

2019 H1036-233

Humana
HUMANA GOLD PLUS (HMO)
A Medicare Health Plan with Prescription Drug Coverage

Dental Included CARD ISSUED: 11/09/2018

Member Name
Member ID:
Plan (80840) 9140461101
RxBIN: 015581
RxPCN: 03200000
RxGRP: W7131

Copayments:
Office Visit: $0
Specialist: $35
Hospital Emergency: $120

Medicare
Prescription Drug Coverage
CMS H1036 233

Member/Provider Service: 1-800-457-4708
If you use a TTY, call 711

Pharmacist/Physician Rx Inquiries: 1-800-865-8715
IPA/Center Name: ALIGNMENT PAYER ID CCHPC
Primary Physician: (919) I MD
Telephone: (919)

Claims, PO BOX 14010 ORANGE CA 92863
Please visit us at Humana.com (For Dentists - Humana.com/sb)

EyeMed Vision: 1-888-299-0595

2019 H1036-276 D-SNP

Humana
HUMANA GOLD PLUS (HMO SNP)
A Medicare Health Plan with Prescription Drug Coverage

Dental Included CARD ISSUED: 11/01/2018

Member Name
Member ID:
Plan (80840) 9140541101
RxBIN: 015581
RxPCN: 03200000
RxGRP: Y0268

Medicare
Prescription Drug Coverage
CMS H1036 276

Member/Provider Service: 1-800-457-4708
If you use a TTY, call 711

Pharmacist/Physician Rx Inquiries: 1-800-865-8715
IPA/Center Name: ALIGNMENT PAYER ID CCHPC
Primary Physician: (919) I MD
Telephone: (919)

Claims, PO BOX 14010 ORANGE CA 92863
Please visit us at Humana.com (For Dentists - Humana.com/sb)

Additional Benefits: DEN113 VIS739 HER950
EyeMed Vision: 1-888-289-0595
Section 4: Regulatory Compliance

Overview
IPA/Medical Groups and Participating Providers are always required to comply with federal law, including the Centers for Medicare and Medicaid Services (CMS) regulatory requirements, and applicable state law, except where such state law is preempted by federal law. These requirements, including the Medicare Advantage Regulatory requirements, are included in your agreement with Alignment. Alignment’s Compliance department will monitor and provide oversight to ensure that our IPAs/Medical Groups and Participating Providers are complying with all applicable laws and regulatory requirements and will require IPAs/Medical Groups and Participating Providers to implement corrective action plans when these requirements are not being met.

Although your agreement with Alignment includes the regulatory requirements, a few compliance reminders are listed below, and others are included throughout this Provider Operations Manual.

Obligation for Reporting Suspected Non-Compliance or FWA
IPA/Medical Groups and Participating Providers play a vital role in protecting the integrity of Alignment and the Medicare Program. Alignment maintains an “open door” policy to support and encourage IPA/Medical Groups and Participating Providers to report compliance-related issues or concerns, to ensure that reports of questionable practices are handled as confidentially as possible, and to take issues that cannot be resolved to a higher level of management within their own organization.

The methods available for reporting compliance or Fraud, Waste and Abuse (FWA) concerns and a non-retaliation policy must be publicized throughout the IPA/Medical Groups and Participating Providers facilities. IPA/Medical Groups and Participating Providers should train their employees on their own reporting processes including emphasis that reports may be made directly to Alignment when applicable. Alignment has adopted and enforces a no-tolerance policy for retaliation or retribution against any IPA/Medical Group or Participating Provider, or their employees, who in good faith report suspected non-compliance or FWA. To this end, IPA/Medical Groups and Participating Providers must ensure their employees understand that they:

- Have an obligation to raise compliance concerns and issues to the appropriate parties;
- May seek clarification and guidance on compliance related issues from the IPA/Medical Group or Participating Provider, Alignment management or the Alignment Compliance and Regulatory Affairs Department; and
- May report compliance related issues anonymously and without fear of retaliation.

IPA/Medical Groups and Participating Providers should ensure their employees know how to report suspected non-compliance and FWA either through the appropriate IPA/Medical Group or Participating Provider management or directly to Alignment using any of the following methods:

- Call Alignment Medicare Compliance Officer: 657-218-7713
• Email Alignment Compliance and Regulatory Affairs Department: compliance@ahcusa.com
• Report Online via Anonymous Compliance Hotline: www.alignmentthehealth.ethicspoint.com
• Call Anonymous Compliance Hotline: 844-297-5948 (24 hours a day, 7 days a week)

Additionally, there is a Compliance Hotline quick reference document posted on the Alignment website:

1. Go to https://www.alignmentthehealthplan.com
2. Click on “Providers” tab
3. Log in to secure website
4. Click on “Compliance Information” and then on “Compliance Hotline” to view the quick reference document.

Alignment Code of Conduct and Medicare Compliance and FWA Plan
CMS guidelines require Alignment to distribute our Code of Conduct and the Compliance Policies and Procedures contained within the Medicare Compliance and Fraud, Waste and Abuse Plan (Compliance Plan) to our employees and first-tier, downstream, and related (“FDR”) entities. Alignment’s Code of Conduct and Compliance Plan are accessible to FDRs on the Alignment website:

1. Go to https://www.alignmentthehealthplan.com
2. Click on “Providers” tab
3. Log in to secure website
4. Click on “Compliance Information” to view the Code of Conduct and the Compliance Plan.

FDR’s employees (temporary and permanent), board members, volunteers/interns, consultants, contractors and downstream entities, subcontractors must receive a copy of Alignment’s Code of Conduct and Compliance Plan, or the FDR’s own materially comparable Code of Conduct and written Compliance Policies and Procedures, during orientation (or upon contracting in the case of subcontractors), upon revision and annually thereafter. Evidence of distribution and receipt of this information must be retained for ten years to meet CMS’s ten-year retention requirement, and it may be requested by Alignment upon audit.
Section 5: Delegation and Delegation Oversight

Overview:
Alignment delegates certain functions to the IPA/Medical Groups and Participating Provider Groups and is responsible for the overall performance of all delegated activities. Alignment evaluates the IPA's/Medical Group’s and Participating Provider Group’s ability to perform delegated services in accordance to State and Federal requirements and regulations. The IPA/Medical Group’s and the Participating Provider Group's agreement with Alignment includes the delegation criteria and requirements, and other reporting requirements for the IPA/Medical Group and Participating Provider Group. Alignment performs systematic monitoring and oversight of all IPA/Medical Groups and Participating Provider Groups that are delegated, and the oversight of their respective provider networks to assure compliance with contractual and regulatory requirements. Oversight is conducted through Alignment’s Compliance Delegation Oversight Department, and the staff conducts routine audits and monthly monitoring of delegated activities that include Credentialing, Claims and Utilization Management activities.

Alignment will communicate its expectations to the IPA/Medical Group and Participating Provider Group and enforces the requirements of various regulatory and accreditation bodies, including DMHC, CMS, NCQA and others. The IPA/Medical Group and Participating Provider Group must continuously comply with Alignment’s standards to retain delegation status. Alignment can revoke any or all delegated activities if the IPA/Medical Group or Participating Provider Group is continuously non-compliant with the delegated activity.

To ensure IPA/Medical Group and Participating Provider Group compliance with delegated functions, Alignment’s Delegation Oversight Team conducts the following activities:

1. Monitoring of IPA/Medical Group Utilization Management Timeliness and Claims Timeliness
2. Routine Audits
3. Education
4. Quarterly Universe Integrity Testing
5. Issuance of Corrective Action Plan as needed

Monitoring:
The Alignment Delegation Monitoring and Audit program incorporates the following requirements, at minimum:

Claims:
- Monthly, Claims Delegation Oversight receives Monthly Timeliness Reports (MTR) from the MSO/IPA to monitor the CMS Claims Timeliness Compliance Standard. Alignment must pay 95 percent (95%) of clean claims from non-contracted providers within 30 (thirty) calendar days of the request. If not, interest must be paid. All other claims must be paid or denied within 60 (sixty) calendar days from the date of the request. Compliance threshold is 95%.
The reports contain the following information:
✓ Number of fully favorable clean claims paid
✓ Number of partially favorable clean claims paid
✓ Total of clean claims paid within 30-calendar days
✓ Total number of fully favorable unclean claims paid
✓ Number of fully favorable non-contracted unclean claims paid
✓ Total number of partially favorable unclean claims paid
✓ Total number of Member liability fully unfavorable unclean claims denied
✓ Number of non-contracted Member liability fully unfavorable unclean claims denied
✓ Total number of provider denials (fully unfavorable) - unclean
✓ Total number of non-contracted provider denials (fully unfavorable) – unclean.
✓ Total number of unclean claims paid or denied within 60-calendar days or less

• If the thirty (30) or sixty (60) calendar days Compliance Standard falls below the 95% threshold, the IPA/Medical Group or Participating Provider Group is required to submit a Corrective Action Plan (CAP) to Alignment.

• Quarterly, the IPA/Medical Group or Participating Provider Group submits the required CMS reporting (Part C) to Alignment. The information is reviewed for completeness. If discrepancies are noted, the IPA/Medical Group or Participating Provider Group is contacted to correct the data and resubmit to Alignment.

• Quarterly, the IPA/Medical Group or Participating Provider Group submits the Provider Dispute Resolution (PDR) reports for review to Alignment. The reports are due on the 15th of the month following quarter end.

**Utilization Management (UM):**

• Monthly, UM Delegation Oversight prepares Monthly Pre-Service Timeliness metrics from pre-service IPA/Medical Group or Participating Provider Group reports to monitor the CMS Organization Determinations Timeliness Compliance Standard. When an enrollee makes a request for a service, Alignment must notify the enrollee of its determination within 14 calendar days for Standard Pre-service Organization Determinations (SOD) and 72 hours for Expedited Pre-service organization determination (EOD). If an extension is used for either the SOD or EOD, an additional 14 calendar days is granted. The Compliance threshold is 95%. The reports contain the following information:
   ✓ Number of SODs within 14 calendar days
   ✓ Number of SODs past 14 calendar days
   ✓ Number of EODs within 72 hours
   ✓ Number of EODs passed 72 hours
   ✓ Total Standard Authorizations processed
   ✓ Total Expedited Authorizations processed

• If the SOD and/or the EOD Compliance Standard falls below the 95% threshold, the IPA/Medical Group or Participating Provider Group is required to submit a Corrective Action Plan (CAP) to Alignment.

• Quarterly, the IPA/Medical Group or Participating Provider Group submits the required CMS
reporting (Part C/Table 1 & 2) to Alignment. The information is reviewed for completeness. If discrepancies are noted, the IPA/Medical Group or Participating Provider Group is contacted to correct the data and resubmit to Alignment.

- Weekly and daily authorization and denial reporting (pre-service, retro, inpatient, case management) is required by Alignment’s Utilization Management and Case Management teams that is separate from the requirements outlined above. These requirements are listed in Exhibit 13. (Utilization Management Reporting and Contacts).

**Credentialing:**

- Monthly, the provider names of each delegated IPA/Medical Group and Participating Provider Group are submitted through Verify Comply to identify any potential sanctions. The results are reviewed, and any identified sanctions are presented to Compliance and Network Management.

- To help ease the burden on Provider Organizations, Accredited Health Plans joined together to create a collaboration to share their annual credentialing audits results. The credentialing audit results are on posted on the Industry Collaborative Effort (ICE) website. As a Health Plan, Alignment can request a copy of the audit results and measure audit outcomes against its own established performance thresholds. If acceptable, Alignment can rely on the audit results for its annual credentialing audit.

- Credentialing Delegation Oversight obtains the Health Plan shared credentialing results from the ICE website.

- The results of the shared credentialing audit are reviewed and measured against Alignment’s performance standards by performing the following steps:
  
  ✓ Review the Audit Results Summary Page and File Results
  ✓ Review each credentialing standard and element and assess the noted audit results and comments
  ✓ If the score is between 90%-100%, Alignment will review the noted issues and determine whether a CAP is needed.
  ✓ If the score is less than 90%, Alignment will require a CAP
  ✓ The CAP will be reviewed by Alignment to ensure the actions noted will remediate the issues in the audit report
  ✓ Alignment will request supporting documentation for the action plan milestones

**Corrective Action (CAP) Procedure**

The CAP procedure is applicable for all functions. The purpose of this procedure is to ensure Alignment works with the delegated entity to implement timely and effective actions when indicators reveal a need for improved performance. This procedure outlines how Alignment may initiate a corrective action if a delegated entity does not comply with Alignment’s delegation standards and/or CMS regulations.

**CAP Process**

- During the monitoring and audit process, if the line of business (ie claims, utilization
management, credentialing) and/or Delegation Oversight Team identifies a need for improved performance, noncompliance, deficiencies, etc., the line of business and/or Delegation Oversight Team shall communicate with the applicable delegated entity to discuss the issue and gain an understanding of the root cause and action plans. A CAP will be imposed and will include timeframes for specific achievements to comply with regulatory and performance standards.

- The elements of the CAP will be detailed in writing and include ramifications if a delegated entity fails to implement the corrective action satisfactorily and/or continued performance of one or more delegated activities poses a threat to the health, safety or welfare of Members/patients.

- The delegated entity will be notified with a CAP issue form by the line of business and/or Delegation Oversight Team no later than thirty (30) calendar days of a desk/site audit which documents non-compliance or monthly monitoring noncompliance.

- The delegated entity will have fifteen (15) business days to provide a written response describing how they will meet the requirements found to be noncompliant within the specified timeframes.

- Fifteen (15) calendar days after the CAP is received, the line of business issue owner will advise the delegated entity if actions and/or remediation dates are acceptable. If rejected, the line of business and/or Delegation Oversight Team issue owner will work with the delegated entity to ensure remediation steps are put in place to correct the issue timely. Once the CAP is acceptable, the line of business and/or Delegation Oversight Team will communicate such to the delegated entity.

- Communication between the line of business and/or Delegation Oversight Team issue owner and the delegated entity will occur as frequently as needed but no less then monthly to ensure movement on the action plan milestones.

- When a delegate’s CAP trend has demonstrated improvement, a delegate has met all the CAP activities, and submitted the required documentation within the specified timeframes to validate remediation, the delegate’s CAP will be documented as completed and closed by the line of business and/or Delegation Oversight Team issue owner. The closure communication will be sent to the delegate.

- When the delegates demonstrate non-compliance within 90 days after the issue had been corrected and CAP had been closed, Alignment will not issue a new CAP but will re-open the existing CAP.

Noncompliance with the performance of the delegated responsibilities and requirements may result in the de-delegation of such functions from IPA/Medical Group or Participating Provider Group. In the event of de-delegation, IPA/Medical Group and Participating Provider Group will be financially responsible for the administrative costs incurred by Alignment to perform the functions previously delegated to IPA/Medical Group and Participating Provider Group.

**Summary:**
- **Alignment CAP Initiation** = 30 calendar days of a desk/site audit noncompliance or monthly
monitoring non-compliance

- **Delegate** = Respond to CAP within 15 business days of receiving the CAP
- **Alignment** = Accept or reject CAP in 15 calendar days of receiving the action plan
- **CAP Resolution** = Issue needs to be resolved within 90 calendar days of CAP acceptance. Note, there may be cases where immediate action is required. The maximum time an issue may be open will be determined based on the criticality of the issue.

IPA/Medical Group is required to submit to Alignment the required reports, data and other information as indicated in Exhibit 5.1 (IPA/Medical Group and Delegated Participating Provider Group Reporting Responsibilities). Alignment may also delegate certain utilization management, claims, credentialing or other functions to other types of Participating Provider Groups, as defined in those Participating Provider Group Services Agreement with Alignment. All of the requirements in Exhibit 5.1 shall also apply to those delegated Participating Provider Groups, where applicable.

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Policy Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC-03</td>
<td>Delegation Oversight Program</td>
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</table>

**Exhibits:**

**Exhibit 5.1 - IPA/Medical Group and Delegated Participating Provider Group Reporting Responsibilities**
Exhibit 5.1
IPA/ Medical Group and Delegated Participating Provider Group
Reporting Responsibilities

<table>
<thead>
<tr>
<th>Required Information</th>
<th>Submit as follows:</th>
<th>Submission Timeframes</th>
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<tr>
<td><strong>Delegation Oversight</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Utilization Management</strong></td>
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<td></td>
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<tr>
<td>Contact: <a href="mailto:DelegatedReports@AHCUSA.com">DelegatedReports@AHCUSA.com</a></td>
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<td></td>
</tr>
<tr>
<td><strong>UM Program</strong></td>
<td>Submit via Alignment Web Portal: Reports Submission Delegation Reporting</td>
<td>Annually, by 2/15</td>
</tr>
<tr>
<td><strong>ICE Template</strong></td>
<td>Submit via Alignment Web Portal: Reports Submission Delegation Reporting</td>
<td></td>
</tr>
<tr>
<td><strong>Part C Reporting:</strong></td>
<td>Submit via Alignment Web Portal: Reports Submission Delegation Reporting</td>
<td>Quarterly, by April 15, July 15, October 15 and January 15</td>
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<tr>
<td>Pre-Service Standard and Expedited Organization Determinations- Summary Log “Approved” “Modified” &amp; “Denied”</td>
<td></td>
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</tr>
<tr>
<td><strong>UM ODA</strong></td>
<td>Submit via Alignment Web Portal: Reports Submission Delegation Reporting</td>
<td>Monthly, by the 10th</td>
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<td><strong>Universes (2 Separate Files):</strong></td>
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<tr>
<td>Table 1- Standard Organization Determinations</td>
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</tr>
<tr>
<td>Table 2- Expedited Organization (template provided using CMS field criteria)</td>
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</tr>
<tr>
<td>Required Information</td>
<td>Submit as follows:</td>
<td>Submission Timeframes</td>
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<tr>
<td><strong>Credentialing</strong></td>
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<tr>
<td>Contact: <a href="mailto:DelegatedReports@AHCUSA.com">DelegatedReports@AHCUSA.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credentialing Program</td>
<td>Submit via Alignment Web Portal: Reports Submission Delegation Reporting</td>
<td>Annually, by 2/15</td>
</tr>
<tr>
<td>ICE Template</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Claims</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact: <a href="mailto:DelegationOversight_Claims@ahcusa.com">DelegationOversight_Claims@ahcusa.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Include detailed report of “Approved” “Modified” &amp; “Denied” claims decisions</td>
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<td></td>
</tr>
<tr>
<td>Table 3 (template provided using CMS field criteria)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Information Systems (I.S.)

| Encounter Data | Submit questions to: EDI Support at [AHCEDI_Support@ahcusa.com](mailto:AHCEDI_Support@ahcusa.com) | Weekly |

### Finance

| Externally Audited Financial Statements | [financialplanning@ahcusa.com](mailto:financialplanning@ahcusa.com) (323) 728-7232, ext 2210 | Annually within 120-days of year-end |
| Quarterly Financial Statements | [financialplanning@ahcusa.com](mailto:financialplanning@ahcusa.com) (323) 728-7232, ext 2210 | Quarterly within 45-days of quarter-end |

**PLEASE NOTE:**
- Please submit reports through Alignment Web Portal address noted above. Reference the Web Portal Instructions document for submission questions or issues at: [Delegation Reporting](#) |
- Reporting due dates that fall on a weekend or holiday will be due the prior business day.
Section 6: Provider Network

Overview
Alignment’s Network Management department negotiates and maintains all contracts in support of Alignment’s provider network. Network Management works with IPA/Medical Groups and Participating Providers on contract inquiries and compliance issues to ensure Alignment is compliant with CMS regulations such as maintaining adequate provider networks, accurate and current provider directories, ensuring Members are not balance billed on services beyond their cost-share, and providers are trained on Alignment benefit plans and policies.

1. Provider Network Changes
IPA/Medical Groups and Participating Provider Groups are required to notify Alignment of requests for provider additions, terminations, changes and panel closures. If the change is an addition of a new Participating Provider, the profile sheet must accompany the notification, and should be emailed to your local Network Management/Relations Representative. Contact information, email and telephone numbers are listed at the end of this Section.

Terminations:
IPA/Medical Groups and Participating Provider Groups are to provide Alignment with at least ninety (90) calendar days prior written notice of the termination of any of its Participating Providers. In the event a Participating Provider is terminated with less than ninety (90) days’ notice, the IPA/Medical Group or Participating Provider Group is to provide Alignment with written notice within five (5) business days of becoming aware of the termination. All Primary Care Physician termination notices, however, must be provided with no less than sixty (60) days’ advance notice, with the exception of death or Office of Inspector General/General Services Administration exclusion notification. In addition, for Primary Care Physician terminations, the IPA/Medical Group must also provide Alignment with a default Primary Care Physician to whom to transfer the Members and who is accepting new Members. The notification from the IPA/Medical Group and Participating Provider Group must include the reason for the termination (i.e., left service area, expired DEA or License, Medicare Optout, deceased).

Adverse Actions:
IPA/Medical Groups and Participating Providers are to immediately notify Alignment of all adverse actions, which include, but are not limited to Participating Providers who are listed on the Office of Inspector General/General Services Administration, have inactive or expired licenses, etc. Alignment must also be notified of Participating Providers that are opting out of Medicare. Such Participating Providers will not be permitted to provide or arrange for services to Alignment Members and must be terminated from the Alignment network.

Additions:
IPA/Medical Groups and Participating Provider Groups are to provide Alignment with at least thirty (30) days prior written notice of the addition of any new Participating Providers. IPA/Medical Group is required to send a complete profile that includes a copy of the W9,
and the data face sheet with the first and signature pages of the IPA/Medical Group Participating Provider’s contract with the IPA/Medical Group. Alignment will not process additions if the required information is not included. Incomplete requests will be returned to the IPA/Medical Group.

Panel Closures:
IPA/Medical Group shall keep their patient panels open to new Alignment Members and shall not close their respective panels to any new Alignment Members if those patient panels remain open for any other patient or Member of any other health plan. IPA/Medical Group shall provide at least ninety (90) calendar days’ prior written notice to Alignment upon IPA’s/Medical Group’s knowledge of any significant changes in the capacity of IPA/Medical Group or IPA/Medical Group Participating Providers to provide and arrange Covered Services to Members.

Demographic and Administrative changes:
IPA/Medical Group must notify Alignment of demographic or administrative changes at least thirty (30) days prior to the date the change takes effect. Examples of these types of demographic or administrative changes include office location, office hours, office email, telephone numbers, fax numbers, billing address, tax identification number, key contact person, etc. Alignment will update its provider database and directories accordingly.

2. Provider Directory Accuracy
CMS requires Alignment to maintain, at all times, accurate provider directories. IPA/Medical Groups and Participating Providers must maintain accurate provider roster information and must promptly notify Alignment, or Alignment’s designee, of any changes to IPA/Medical Group’s or to Participating Provider’s provider roster, including but not limited to the addition of new providers, the termination of any providers, changes to any provider’s address, telephone number, office hours or panel status (i.e. accepting new patients). IPA/Medical Group and Participating Providers are required to respond timely to Alignment’s or Alignment’s designee for all provider directory validation requests to ensure accurate and current IPA/Medical Group and Participating Provider information. Alignment will audit and validate on a quarterly basis the Participating Providers that are included in its provider directories (printed and online version). Any Participating Provider that Alignment or Alignment’s designee is unable to validate may result in such provider being suppressed from Alignment’s provider directories. In addition, failure of IPA/Medical Group or Participating Provider to submit accurate and current provider roster information, timely notification of provider changes, or respond to provider directory validation requests from Alignment or Alignment’s designee may result in Alignment closing such Participating Provider’s panel, Alignment terminating such Participating Providers from the Alignment network, Alignment discontinuing to accept new IPA/Medical Group Participating Providers or new Participating Providers, may result in reductions to compensation, and/or may jeopardize IPA’s/Medical Group’s or Participating Provider’s credentialing delegation status. CMS considers inaccurate provider data and directories a potential violation of its access and availability requirement. 42 CFR 422.111(b) (3) and (h) (2) (i), 422.112, 423.128(d) (2).

To ensure Alignment is complying with CMS’s requirement on maintaining accurate and current directories, IPA/Medical Groups and Participating Providers will have five (5) business days to respond to Alignment’s directory validation request, or such other timeframe as requested by Alignment.
3. **Use of Contracted Providers When Alignment is Financially Responsible for Services and Prior Authorization**

When Alignment is financially responsible for a service as per the IPA/Medical Group’s Division of Financial Responsibility (DOFR) or as per the delegated Participating Provider Group’s Agreement with Alignment (when delegated for Utilization Management), IPA/Medical Group and delegated Participating Provider Group will be required to direct such services to providers who are contracted with Alignment. Referrals to non-contracted providers require prior authorization from Alignment. Failure to comply with Alignment’s prior authorization policy or failure to obtain prior authorization from Alignment may result in IPA/Medical Group and delegated Participating Provider Groups being financially responsible for such services, up to and including offsets from future payments to IPA/Medical Group or delegated Participating Provider Group.

4. **Physician Incentive Plans**

Physician Incentive Plan regulations are governed by CMS and prohibit any payment arrangements, whether directly or indirectly made to a physician or physician group, that might create an inducement to reduce or limit medically necessary services furnished to Alignment Members. If a physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, then such physician or physician group, or IPA/Medical Group as the case may be, shall be required to obtain stop-loss coverage in accordance with the requirements under the Physician Incentive Plan regulations. 42 CFR § 422.208.

5. **IPA/Medical Group and Participating Provider Based Activities**

Alignment is responsible for any comparative/descriptive material developed and distributed on our behalf by our IPAs/Medical Groups and Participating Providers, and as such, we must ensure that any IPAs/Medical Groups and Participating Providers (and their subcontractors) comply with CMS marketing rules. See 42 CRF 422.2260 & 422.2262. IPAs/Medical Groups and Participating Providers may not:

- Offer sales/appointment forms or accept enrollment applications;
- Direct, urge or attempt to persuade beneficiaries to enroll in a specific Health Plan based on financial or any other interests;
- Mail marketing materials on behalf of Health Plan sponsors;
- Offer anything of value to induce enrollees to select them as their IPA/Medical Group or Participating Provider;
- Offer inducements to persuade beneficiaries to enroll in a particular Health Plan;
- Health screen when distributing information to patients;
- Accept compensation directly or indirectly from the Health Plan for enrollment activities; or
- Use Alignment’s logo, or engage in co-branding, without Alignment’s prior written consent.

IPAs/Medical Groups and Participating Providers should remain neutral in assisting Health Plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. IPAs/Medical Groups and Participating Providers may provide the names of Health Plans with which they contract and objective information on all benefits based on a particular patient’s medications and health care needs. IPAs/Medical Groups and Participating...
Providers may also make available or distribute Health Plan marketing materials, display posters for all Health Plan sponsors being offered, and refer their patients to other sources of information such as CMS’s website or phone number.

6. **Provider Training**
Alignment’s Network Management department is responsible for educating IPA/Medical Groups and Participating Provider Groups on Alignment and providing access to Provider educational materials, provider operations manuals, newsletters, and reports. If you have any training needs or have questions, please contact your local Network Management/Provider Relations Representative. Contact information is listed at end of this Section.

7. **Provider Portal and Online Provider Tools**
Alignment is committed to providing resources to support IPA/Medical Group and the Participating Providers serving our Members. The following resources are available to IPA/Medical Groups and the Participating Providers on Alignment’s Provider Portal at: [https://www.ahcusaweb.com/ProviderWeb/Default.aspx](https://www.ahcusaweb.com/ProviderWeb/Default.aspx).

<table>
<thead>
<tr>
<th>Provider Manual</th>
<th>Provider Newsletter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Educational Tool</td>
<td>Schedule Transportation</td>
</tr>
<tr>
<td>Part D Information</td>
<td>Special Needs Plan (SNP)</td>
</tr>
<tr>
<td>Compliance Information</td>
<td>Report Submission</td>
</tr>
<tr>
<td>Disease Treatment Guidelines</td>
<td>Claim/Encounter Management</td>
</tr>
<tr>
<td>Fraud, Waste and Abuse Training</td>
<td>Member Eligibility</td>
</tr>
</tbody>
</table>

For access to the Alignment Provider Portal, contact your local Network Management/Provider Relations Representative.

<table>
<thead>
<tr>
<th>Alignment Network Management/Provider Relations Contact List</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Market/State</strong></td>
</tr>
<tr>
<td>California</td>
</tr>
<tr>
<td>Florida</td>
</tr>
<tr>
<td>North Carolina</td>
</tr>
</tbody>
</table>
Section 7: Capitation Payments and Reporting

1. **Capitation Payments:**
   Alignment pays fixed monthly payments (i.e., capitation or other payment methodologies) to IPA/Medical Groups and to certain other Participating Provider Groups for the provision of health care services provided or arranged by IPA/Medical Group, or arranged by Participating Provider Groups, to its assigned Members that are IPA’s/Medical Group’s or Participating Provider Group’s responsibility, according to the terms of their Agreements with Alignment. The payment schedule, unless as otherwise stated in the Alignment Agreement, is as listed below by Market/State:

<table>
<thead>
<tr>
<th>Market/State</th>
<th>Payment and Capitation Remittance Report Due Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>15th calendar day of month</td>
</tr>
<tr>
<td>Florida</td>
<td>20th day of the month</td>
</tr>
<tr>
<td>North Carolina</td>
<td>27th day of the month</td>
</tr>
</tbody>
</table>

*If payment date falls on a weekend or national holiday, payment will occur on the first subsequent business day, unless as otherwise stated in the Agreement.*

2. **Capitation Adjustments**
   Alignment may apply adjustments to the capitation payments, which include but are not limited to the examples below:
   - Retroactive adjustments either upward or downward due to retroactive changes in the number of IPA/Medical Group or Participating Provider Group assigned Members.
   - Recoupment of claims that are the financial responsibility of IPA/Medical Group or Participating Provider Group
   - Deductions to fund the Shared Risk Withhold Pool as stated in the IPA/Medical Group Participating Provider Services Agreement
   - Withholds for failure to submit encounter data
   - Withholds for failure to provide accurate and timely provider roster information
   - CMS revenue recoveries less vendor fees associated with such recoveries
   - Deductions for services IPA/Medical Group or Participating Provider Group refer to providers who are not contracted with Alignment without Alignment’s prior authorization, where such services are Alignment’s financial responsibility
   - Upon prior written notice from Alignment, deductions for services IPA/Medical Group or Participating Provider Group refer to non-designated vendors without Alignment’s prior authorization, where such services are Alignment’s financial responsibility

3. **Capitation Remittance Report**
   The Capitation Detail Report provides a summary of the payments, and any adjustments, for each Member assigned to the IPA/Medical Group and Participating Provider Group. The Capitation Remittance Report will be placed in IPA/Medical Group’s and Participating Provider Group’s SFTP site each month for downloading on or before the due dates listed in the above table. For information on how to access the capitation reports, please view...
Accessing Monthly Outbound Reports.

If you have any questions, please contact your local Network Management/Provider Relations Representative at the email or telephone listed below.

<table>
<thead>
<tr>
<th>Market/State</th>
<th>Telephone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>(844) 361-4712</td>
<td><a href="mailto:CAProviders@ahcusa.com">CAProviders@ahcusa.com</a></td>
</tr>
<tr>
<td>Florida</td>
<td>(844) 783-5191</td>
<td><a href="mailto:FLProviders@ahcusa.com">FLProviders@ahcusa.com</a></td>
</tr>
<tr>
<td>North Carolina</td>
<td>(844) 215-8442</td>
<td><a href="mailto:NCProviderRelations@ahcusa.com">NCProviderRelations@ahcusa.com</a></td>
</tr>
</tbody>
</table>
Section 8: Claims

Overview
Alignment will delegate claims processing and payment to IPA/Medical Groups and certain Participating Providers that have shown, through a pre-delegation assessment, that they are capable of processing claims while adhering to CMS regulations and Alignment’s standards.

The delegate is required to meet specific reporting and compliance requirements as outlined in the Delegation Oversight section.

1. Encounter Data and Claims Submission
   Refer to the Encounter Data section for details on submission of encounter data to Alignment.

2. Misdirected Claims
   Delegates must have a process for forwarding misdirected claims. Triage and sorting processes must be established so that misdirected claims can be identified and forwarded per the timeline outlined in the contract in order to ensure the payer has the necessary time required to adjudicate and pay the claim.

3. Collection of Copayments
   IPAs/Medical Groups and Participating Providers shall be responsible for the collection of Copayments upon rendering Covered Services to Members. IPAs/Medical Groups and Participating Providers shall not refuse to provide Covered Services in the event a Member is unable to pay the Member’s Copayment, except as may otherwise be specifically approved in advance by Alignment.

4. No Balance Billing
   Under CMS regulations, Members (including Qualified Medicare Beneficiaries) cannot be billed for Covered Services beyond their normal cost sharing amounts (copayment, deductible, or coinsurance).

   IPAs/Medical Groups and Participating Providers cannot bill, charge, collect a deposit, or seek compensation from any Medicare Member who is eligible for both Medicare and Medicaid. IPAs/Medical Groups and Participating Providers must either:
   • Accept payment made by or on behalf of the Medicare Health Plan as payment in full; or
   • Bill the appropriate State source for such cost-sharing amount

5. Maximum Out of Pocket (MOOP) Limit
   Delegates must have processes that ensure accurate data, including Encounter Data, used to accumulate the Maximum Out-of-Pocket (MOOP). Medical Groups/IPAs and Participating Providers are expected to have systems and processes in place to track MOOP amounts and to apply benefit limitations. Medical Groups/IPAs and Participating Providers are also required to submit claims history upon request.
   For any DOFR related issues or questions, please contact your Alignment Network Management representative.

7. **Recoupment**
   Alignment may recoup amounts owed by IPA/Medical Group and Participating Providers, which include but are not limited to the examples below:
   - Due to overpayments or payments made in error by Alignment
   - Outcome of the Member appeals and grievance procedure
   - Retroactive deletions of IPA/Medical Group and Participating Provider Members based on determinations of Members’ eligibility
   - Capitated Services that are the financial responsibility of IPA/Medical Group or Participating Provider
   - Deductions for services IPA/Medical Group or Participating Provider Group refer to providers who are not contracted with Alignment without Alignment’s prior authorization, where such services are Alignment’s financial responsibility
   - Upon prior written notice from Alignment, deductions for services IPA/Medical Group or Participating Provider Group refer to non-designated vendors without Alignment’s prior authorization, where such services are Alignment’s financial responsibility
   - Vendor audit recoveries less associated with such recoveries

   Alignment will provide prior written notice to IPAs/Medical Groups and Participating Providers of the amount of the recoupment and the reason(s). IPAs/Medical Groups and Participating Providers agree that all recoupments and any offset rights pursuant to their Alignment Agreement constitute rights of recoupment authorized under law. Alignment may apply the overpayment against future claim payments unless IPA’s/Medical Group or Participating Provider’s agreement states otherwise, or as required by law.

8. **Payment Reconsideration and Disputes**
   Payment reconsideration and dispute processes for IPA/Medical Group and Participating Providers are governed by the terms of the contract between the IPA/Medical Group/Participating Provider and Alignment.

   **Special Rules for Non-contracted Providers**
   Alignment has established a Payment Dispute Resolution (PDR) process by which non-contracted providers may dispute the amount paid for a Covered Service, i.e. the amount is less than or greater than the amount that would have been paid under original Medicare. The PDR process for non-contracted providers cannot be used to challenge payment denials that result in zero payment being made to the non-contracted provider; these matters must be processed as reconsiderations.

   The Reconsideration and PDR processes for non-contracted providers are summarized below:

<table>
<thead>
<tr>
<th>Type</th>
<th>Provider Actions</th>
<th>Alignment Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Reconsideration</td>
<td>Non-contracted provider must</td>
<td>Alignment has 60-calendar</td>
</tr>
<tr>
<td>(Denied Claims Only)</td>
<td>submit a reconsideration request to Alignment in writing</td>
<td>days from receipt of the complete appeal request to</td>
</tr>
<tr>
<td>Type</td>
<td>Provider Actions</td>
<td>Alignment Actions</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Payment Dispute Resolution</td>
<td>within 60-calendar days of the date on the remittance advice. The request must include, at a minimum, the following information and/or documentation:</td>
<td>make a reconsideration determination.</td>
</tr>
<tr>
<td></td>
<td>• Completed Waiver of Liability (WOL) statement</td>
<td>Upheld denials will be forwarded to CMS’s Independent Review Entity (IRE) for second-level review.</td>
</tr>
<tr>
<td></td>
<td>• Member first and last name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Member ID number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Date of service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Billed amount</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Copy of claim/EOP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Detailed reason for the reconsideration request and any supporting information and/or documentation</td>
<td></td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; Level PDR</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; level PDR is delegated to IPA/Medical Group/Participating Provider where the IPA/Medical Group/Participating Provider is delegated for claims processing.</td>
<td>Delegate has 30-calendar days to make a payment review determination.</td>
</tr>
<tr>
<td></td>
<td>Non-contracted provider must submit a dispute in writing to the delegate within 180-calendar days of the date on the remittance advice.</td>
<td></td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; Level PDR</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; level PDR is not delegated to IPA/Medical Group/Participating Provider.</td>
<td>Alignment has 30-calendar days to make a payment review determination.</td>
</tr>
<tr>
<td></td>
<td>Non-contracted provider must submit a dispute in writing to Alignment within 180-calendar days of the date of upheld 1&lt;sup&gt;st&lt;/sup&gt; level PDR.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The request must include, at a minimum, the following information and/or documentation:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Member first and last name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Member ID number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Date of service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Billed amount</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Copy of claim/EOP</td>
<td></td>
</tr>
<tr>
<td>Type</td>
<td>Provider Actions</td>
<td>Alignment Actions</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>• Copy of upheld letter from 1st level dispute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Detailed reason for the dispute and any supporting information and/or documentation</td>
<td></td>
</tr>
</tbody>
</table>

9. **CMS and State Regulations**
Delegates are expected to adhere to all applicable CMS and State regulations governing claims processing and payment.
Section 9: Encounter Data

**Encounter Data Submission Requirements**
Encounter information must be submitted electronically, for all services, to Alignment’s clearinghouse directly. At the discretion of Alignment, all encounters submitted must be compliant with the electronic transactions and standard CMS code sets and protected health information (PHI) policies based on ASC X12 8371 current version 5010. Additional information regarding electronic billing & EDI transactions can be found at:

**UB Institutional** - CMS.gov Centers for Medicare & Medicaid Services Institutional Paper Claim Form

**CMS 1500** - CMS.gov Centers for Medicare & Medicaid Services Professional Paper Claim Form

**Alignment’s Clearinghouse - Office Ally Contact Information**
IPA/Medical Groups and Participating Providers can file all professional and institutional claims electronically through Office Ally which is free of charge to the provider. IPA/Medical Groups and Participating Providers can also use a clearinghouse approved by Alignment. Please note that some vendors and/or Clearinghouses may charge a service fee.

Enroll at [https://www.officeally.com](https://www.officeally.com)
Customer Service: (360) 975-7000 Option 1
Business Hours: Monday thru Friday 6:00 AM PT to 5:00 PM PST
After Hours Support is also available 24/7.

When submitting encounters through a clearinghouse, Providers must supply the following:
Electronic Payer ID: CCHP2

When submitting claims through a clearinghouse, IPA/Medical Groups and Participating Providers must supply the following: Electronic Payer ID: CCHPC

**Claims Attachments:** In addition to submitting claims electronically, Office Ally can also accept claims attachments. For instructions on submitting attachments visit: Submitting Claim Attachments

**Helpful Hints Encounter Submissions**
1. Ensure that you are an authorized representative of the designated IPA/Medical Group or Participating Provider.
2. Have your contact, organization, and financial account information available.
3. Supply your NPI in the Provider ID field.

For general questions regarding account setup, test transaction scheduling and production support, please use the following contact information. Please note that your inquiry will be handled during normal business hours.
**Alignment EDI Contact Information**

E-Mail Contact: AHCEDI_support@AHCusa.com
Support Contact: Toll Free (844) 286-2855

The EDI Support team will return your inquiry within two (2) business days. If your request is urgent, please make sure your request is identified as “URGENT” on e-mail or voicemail correspondence.

**Encounter Data**

Alignment requires IPA/Medical Groups and delegated Participating Providers to collect and submit timely, accurate and complete encounter data in accordance to CMS requirements. All claim submissions, both electronic and paper, must meet the CMS billing guidelines for required information. The billing guidelines can be found at CMS.gov and by accessing the following link:


This includes encounter data for IPA’s/Medical Group’s affiliated Primary Care Physicians, Specialists, laboratories and, imaging providers and encounter data for all of Participating Providers affiliated providers.

IPA/Medical Group and Participating Provider responsibilities include:

- Submit all claim detail for adjudicated claims only, including all applicable billed, paid, adjusted and denied information.
- Encounter claims should be submitted electronically directly to Alignment’s, designated clearinghouse.
- Encounter data should reflect all procedures that were performed by the Participating Provider during the course of single health care encounter, and as documented in the Member’s medical record.
- All fee-for-service Encounters must include the total billed amount, the total allowed amount (e.g. the total contracted amount), the Member’s cost share, and Alignment’s / the Health Plan’s share. ¹
- All capitated Encounters must include the total billed amount, the Medicare Allowable amount, the Member’s cost share, and Alignment’s / the Health Plan’s share. ¹
- Encounter Data should use standard CMS code sets, including Claims Adjustment Reason Codes (CARC).
- Encounter claims should be submitted on at least a weekly basis following the date of service
- Lab Encounter Data should be submitted and include all laboratory results data on a weekly basis in a standard HL7 format.

¹ Requirements in accordance to CMS guidelines: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketingModelsStandardDocumentsandEducationalMaterial.html
The expected encounter data thresholds Per Member Per Year (PMPY) that IPA/Medical Group; and Participating Providers are expected to submit is as follows:

<table>
<thead>
<tr>
<th>Encounter Category</th>
<th>PMPY Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Encounters – Total</td>
<td>2.30</td>
</tr>
<tr>
<td>Professional Encounter – Total</td>
<td>12.00</td>
</tr>
<tr>
<td>Provider Visit</td>
<td>6.00</td>
</tr>
<tr>
<td>Lab and Radiology</td>
<td>4.00</td>
</tr>
<tr>
<td>Other Professional</td>
<td>2.00</td>
</tr>
</tbody>
</table>

Alignment will measure IPA/Medical Group’s and Participating Provider’s compliance in submitting encounter data as follows:
- Encounter Data acceptance rate shall not be less than 95% of all data submitted.
- Encounter Data shall meet the benchmarks, standards and timeframes as outlined in this Section.
Section 10: Appeals and Grievances

Appeal Overview
Reconsiderations and Redeterminations are appeal procedures that apply when a Member disagrees with a decision about payment or provision of services (either pre-authorization denial, claim denial, or a prescription drug denial, in whole or in part). Federal regulations require special appeals process procedures for Medicare Members that are enrolled in a Medicare program offered through an HMO. The Evidence of Coverage details the appeals and grievance process and procedures. Please visit Alignment’s or the Health Plans’ Evidence of Coverage located at the following websites:

<table>
<thead>
<tr>
<th>Health Plans</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment Health Plan</td>
<td>866-634-2247</td>
<td>323-201-5690</td>
<td><a href="#">www.alignmenthealthplan.com</a></td>
</tr>
<tr>
<td>Blue Medicare Preferred/Florida Blue</td>
<td>844-783-5189</td>
<td>323-201-5690</td>
<td><a href="#">www.floridablue.com/medicare</a></td>
</tr>
<tr>
<td>First Medicare Direct</td>
<td>844-499-5630</td>
<td>816-313-3061</td>
<td><a href="#">www.firstmedicare.com</a></td>
</tr>
<tr>
<td>Humana Gold Plus</td>
<td>800-457-4708</td>
<td>800-949-2961</td>
<td><a href="#">www.humana.com</a></td>
</tr>
</tbody>
</table>

Initial Organization Determination
An initial determination is made when either Alignment, the Health Plan, IPA/Medical Group or a delegated Participating Provider Group approves or denies payment on a service rendered or have failed to authorize or provide a service. For Alignment’s process on Initial Organization Determinations, refer to policy UM-01 (Standard Initial Organization Determination), noted in Exhibit 13.1.

Redetermination - Part D Appeals
A Member who is dissatisfied with the initial determination of their Part D drug request may request a redetermination within sixty (60) days of the initial determination. A request for redetermination may be initiated orally or in writing. Requests should be directed to the Pharmacy Benefits Manager (PBM) delegated by Alignment or the Health Plan.

Reconsideration - Part C Appeals
A Member who is dissatisfied with the initial determination of their request for service (pre-service) or claim payment of services (post-service) may request a reconsideration within sixty (60) days of the initial determination. A request for reconsideration may be initiated orally or in writing.

If Alignment, the Health Plan, IPA/Medical Group or a delegated Participating Provider Group denies a request for service, and the Member appeals the decision, the Health Plan must reconsider its decision as quickly as the Member’s health permits but no longer than thirty (30) days (standard request), or seventy-two (72) hours (expedited request) after receipt of the Member’s written appeal.
The Health Plan is required to take the following actions:

- Reviews the initial determination
- Assures that the reconsideration/redetermination decision is not made by the same person or persons who were involved in making the initial determination
- Sends written notification of the appeal decision. For reconsiderations (medical services or claim payment appeals), if the decision has been made to uphold the initial determination, the interested party will be informed that the case has been forwarded to an Independent Review Entity (IRE) MAXIMUS Federal Services, for third party review
- Standard and expedited appeals received by Alignment for denials due to “lack of medical necessity” will be reconsidered by a physician with expertise in the medical field appropriate to the services under appeal
- If Alignment overturns the original decision to deny a service, Alignment will authorize or provide the service in question as quickly as the Member’s health requires, but no later than thirty (30) calendar days from the date Alignment reverses its determination.

MAXIMUS Federal Services

If the original determination is upheld in whole or partially, Alignment is required to send a new notification to the Member stating this information. At that point, the case file is forwarded to CMS contractor, MAXIMUS Federal Services for processing. Alignment will prepare the files for MAXIMUS by identifying each one with the Member’s name and Health Insurance Number. Alignment will communicate to the Member that the final determination will be made by CMS. If the decision is overturned by MAXIMUS, Alignment must authorize or provide the service in question as quickly as the Member’s health requires but no later than thirty (30) days from the date of the MAXIMUS letter informing Alignment of the decision. Alignment Healthcare reserves the right to request a re-opening of the MAXIMUS decision.

Administrative Law Judge (ALJ)

A Member who is dissatisfied with the CMS reconsideration may request a hearing before an Administrative Law Judge. The Member may file this request with Alignment, the Social Security office, the Railroad Retirement Board office, or MAXIMUS Federal Services. In order to qualify, the dispute must involve an amount pre-determined by CMS. The request for this type of hearing must be filed in writing and it must be filed within sixty (60) calendar days from the date of the reconsideration notice. Although Alignment may not appeal a MAXIMUS reconsideration decision, it is party to any ALJ hearing.

The request for review must be within sixty (60) days from the date Alignment receives the hearing decision. The request for appeal may be submitted to any Social Security Office, hearing office or directly to the address listed below:

Medicare Appeals Council Office of Hearings and Appeals
P.O. Box 3200 Arlington, VA 22203

Either Alignment or the Member may request judicial review of the ALJ decision in Federal District Court if the amount in controversy is an amount pre-determined by CMS. Any decision may be reopened, by any entity that rendered a decision, within twelve (12) months of the notice of initial or reconsidered determination, after such twelve (12) month period, but within four (4) years for “just cause”, or at any time for a clerical correction, suspected fraud, or to consider new evidence that was not available earlier.
Expedit ed Appeal Process (72-Hour)
Members are notified of the appeal processes, including the right to an expedited review, at initial enrollment, upon notification of an adverse determination. A Member, or physician on behalf of the Member, can file an expedited appeal if they do not agree with the health care decisions made by Alignment. Health Plans routinely have thirty (30) days to process a standard appeal seventy-two (72) hours for an appeal regarding medication). However, in certain cases, the Member has a right to an expedited, seventy-two (72) hour appeal twenty (24) hours for an appeal regarding medication. The Member can receive a faster expedited appeal if the Member’s health or ability to regain maximum function could seriously be harmed by waiting for a standard service appeal, which might take up to thirty (30) days. If an expedited appeal is requested by the Member, the Health Plan will evaluate the request and determine if it qualifies for an expedited appeal. If it does not meet the requirements, the thirty (30) day processing time will be invoked.

The Member may file an oral or written request for a seventy-two (72) hour appeal if the Member has missed the deadline for requesting a Quality Improvement Organization (HSAG) review of a termination of services from a SNF, Home Health or Comprehensive Outpatient Rehabilitation Facility services. The Member must specifically state that an expedited appeal is being requested and that the Member believes that his/her health could be harmed by waiting the standard appeal time period. If any doctor asks the Health Plan, on behalf of the Member to conduct an expedited appeal or supports the Member’s request for a quicker appeal, the Health Plan must expedite the appeal. CMS routinely publishes regulations for the expedited determination of preauthorization and appeals. These regulations apply to Medicare contracted Participating Providers.

Fourteen (14) Day Extension
If an extension will benefit the Member, an extension of up to fourteen (14) calendar days is permitted for both a standard thirty (30) days and an expedited appeal (seventy-two (72) hours). If the Member needs time to provide additional information to the Health Plan, or additional diagnostic tests need to be completed, an extension will be granted. The Health Plan will make a decision on an expedited appeal and notify the Member within seventy-two (72) hours of receiving the request. If the decision does not fully favor the Member, the Health Plan will automatically forward the appeal request (medical service and claim payment only) to CMS contractor, MAXIMUS Federal Services for an independent review. MAXIMUS will send the Member a letter with their decision within ten (10) working days of receipt of the Member’s case from Alignment.

Oral Requests for Expedited Appeals
Oral requests for expedited appeals should be directed to the Health Plan’s Member Services Department. The Health Plan will document the oral request in writing. The Centers for Medicare and Medicaid Services (CMS) requires that Medicare Advantage (MA) Health Plans, and delegated IPA/Medical Groups/delegated Participating Provider Groups have a process in place to record and respond to all verbal requests for an appeal. Requests for appeals may be received in writing by the Medicare Advantage Health Plan, the Social Security office or the Railroad Retirement Board (RRB) office. All requests received orally must be documented. When an appeal is received, the Medicare Advantage Health Plan, or delegated IPA/Medical Group/Participating Provider Group must:

- Document Member information, Participating Provider information, appeal issue, date and time request was received
• Obtain all pertinent information, including medical records
• Ensure that the review of denied service or claim is conducted by an individual that is not involved in the original review and denial
• Notify the Member of the appeal decision in writing within thirty (30) calendar days for service appeals and within sixty (60) calendar days for standard appeals

Fax Request for Standard or Expedited Appeals
Written requests transmitted via fax machine should be directed to the Member Services Appeals and Grievance Department. If a Member is in a hospital or skilled nursing facility, he/she can request assistance in having a written appeal transmitted to Alignment or the Health Plan by use of a fax machine. It is important to note that the time limit for the review of the appeal will not begin until the request for the appeal has been received.

IPA/Medical Groups and Participating Providers should direct Members to call Alignment’s or the Health Plan’s Member Services Department at the numbers below, which include for initial determinations, review or appeals.

<table>
<thead>
<tr>
<th>Health Plans</th>
<th>Phone</th>
<th>Fax</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment Health Plan</td>
<td>866-634-2247</td>
<td>323-201-5690</td>
<td>1100 W. Town and Country Rd. Suite 300 Orange, CA 92868</td>
</tr>
<tr>
<td>Blue Medicare Preferred/Florida Blue</td>
<td>844-783-5189</td>
<td>323-201-5690</td>
<td>P.O Box 14010 Orange, CA 92863-9936</td>
</tr>
<tr>
<td>First Medicare Direct</td>
<td>844-499-5630</td>
<td>816-313-3061</td>
<td>42 Memorial Dr. Pinehurst, NC 28374</td>
</tr>
<tr>
<td>Humana Gold Plus</td>
<td>800-457-4708</td>
<td>800-949-2961</td>
<td>P.O Box 14165 Lexington, KY 40512-4165</td>
</tr>
</tbody>
</table>

Grievance Overview
A grievance is any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare Advantage Plan, or delegated entity provides health care services, regardless of whether any remedial action can be taken. A Member may make a complaint or dispute either orally or in writing, to Alignment, the Health Plan, IPA/Medical Group, Participating Provider or facility. A grievance may also include a complaint that Alignment (or its delegated entity) refused to expedite, an organization determination or reconsideration. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet acceptable standards for delivery of health care (quality of care complaint). Potential Quality of Medical Care complaints is an event or sequence of events that has negatively impacted a Member’s medical outcome. All complaints of this nature require submission at the time it is identified but no later than within twenty-four (24) hours.
**How to File a Grievance**

A Member who is dissatisfied or has a grievance that falls into the above-mentioned categories, may call the Member Services department at the phone numbers listed below. Members may also write to Alignment or the Health Plan at the following address:

<table>
<thead>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Lexington, KY 40512-4165</td>
</tr>
</tbody>
</table>

When submitting a written compliant or dispute, the Member must include all pertinent information from the Member ID card, and the details of his/her concern. Alignment will acknowledge receipt of the request within seven (7) days and will review the grievance and respond to the Member in writing with thirty (30) days (plus fourteen (14) days if an extension is taken).

The written response will state whether additional time is necessary to complete the review or provide a determination regarding the case. A written notice will be sent once the determination has been made.

Members may also contact Alignment or the Health Plan; see the table above for contact options. For Online Complaints to Medicare go to: [https://www.medicare.gov/MedicareComplaintForm/home.aspx](https://www.medicare.gov/MedicareComplaintForm/home.aspx)

**Notice of Denial of Medical Coverage (NDMC)**

IPA/Medical Groups/delegated Participating Provider Groups are responsible for sending Notice of Denial of Medical Coverage determination/service denial letters to Members for initial determination. The Industry Collaboration Effort (ICE) received approval from CMS to standardize the service denial templates. In accordance with standards established by CMS, Alignment, and its IPA/Medical Groups / delegated Participating Provider Groups are required to issue service denial letters.

As per the CMS guidelines, an Acute Care Hospital must furnish each Medicare Member with an Important Medicare Notice (IMN) upon admission (explains appeal rights should they disagree with discharge), and re-issue that important notice by at least the day of discharge. If the Member appeals the discharge, Alignment, the IPA/Medical Group/delegated Participating Provider Group, or Hospital is financially responsible for the inpatient stay until a decision has been made by Health Services Advisory Group (HSAG) as to whether or not the discharge is appropriate. Prior to the issuance of the written IMN, Alignment, IPA/Medical Group/delegated Participating Provider Group or the Hospital must obtain the approval of the physician responsible for the inpatient care. The IMN must include the Member’s appeal rights. Failure to
follow the above protocol will result in the IPA/Medical Group/delegated Participating Provider Group being responsible for the charges of the continued hospital stay until a valid IMN is presented to the Member. If the Member appeals to either HSAG or the Health Plan, the IPA/Medical Group/delegated Participating Provider Group must provide a copy of the signed IMN (or certified letter with proof of delivery) and issue the detailed notification of discharge. To determine whether further inpatient hospital stay is medically necessary, the level of care required by the Member and the availability and appropriateness of other facilities and services, must be considered. Copies of NOMNC are appended to this section as exhibits listed below.

Copies of the IMN, DMD, NOMNC and Detailed Explanation of Non-Coverage (DENC) letters should be forwarded to Alignment’s or the Health Plan’s fax numbers above. For CMS approved versions of these letters and for complete information regarding Grievances, Organizational Determinations, and Appeals, refer to:

Medicare Managed Care Manual: Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs)

For detailed information, refer to Alignment policy UM-41 (Communication for Denial of Service), noted in Exhibit 13.1.

Grijalva Final Rule Member Appeal Rights

"Grijalva" refers to Grijalva v. Shalala – a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services was denied or terminated. The Grijalva Rule regarding appeal rights became effective 4/23/2003. The requirements under this rule are as follows:

- The Member has the right to an immediate review of a “termination of skilled services” being provided in a SNF, HHA, or CORF decision by an independent review body if the Member believes services should continue. CMS has designated Quality Improvement Organizations (QIO) to conduct these fast-track reviews. (In California that is the Health Services Advisory Group (HSAG).
- SNF/HHA/CORF are contractually required to issue the advanced written notice (NOMNC) to all MA Members at least two days (of visits, in the case of home health) before the termination of skilled nursing facility, home health and comprehensive outpatient rehabilitation facility (CORF) services, with instructions on how to obtain a detailed notice and file an appeal.
- Upon request, a specific and detailed explanation of why services are either no longer medically necessary or are no longer covered by Alignment or the Health Plan must be provided by the delegated IPA/Medical Group/Participating Provider Group. Alignment can assist the Member to describe any applicable Medicare coverage rule, policy, contract provision or rationale upon which the termination decision was based in conjunction with the mandatory reporting requirements from CMS. Alignment has a billing requirement for all IPA/Medical Groups and delegated Participating Provider Groups and providers to include a copy of the regulatory Notice of Medicare Non-Coverage, including the Member’s (or legal representative’s) signed acknowledgment of receipt of the notice (or documentation of refusal to sign). Claims received without a copy of the notice and signed acknowledgment (or without documentation of an individual’s refusal to sign the acknowledgment) will be considered incomplete.
IPA/Medical Groups and Participating Providers also are prohibited from balance billing the Member for any Covered Services.

Exhibit:
Exhibit 10.1 - Grijalva FAQs from CMS
Exhibit 10.1
Released by Centers for Medicare and Medicaid Services (CMS)

FREQUENTLY ASKED QUESTIONS on the GRIJALVA FAST-TRACK APPEALS PROCESS
(updated April 28, 2004)

The purpose of this document is to provide additional guidance on frequently asked questions (FAQs) received by CMS on the Medicare Advantage (MA) fast-track review process for terminations of Medicare-covered services in skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs). We recognize that implementing these new procedures has been a challenge, and there is likely to be a need for further guidance as all parties continue to gain experience with the process. Thus, we intend to update the FAQs as frequently as experience and the volume of questions dictate. Previous FAQs have been updated as appropriate and are incorporated into this document; thus, these FAQs replace in their entirety the FAQs that were posted on 12/16/03.

Q1. Please verify if the advance notice, the Notice of Medicare Non-Coverage (NOMNC), must be issued if the enrollee no longer requires skilled services in a SNF, but the Medicare Advantage (MA) organization authorized the enrollee to receive home health services subsequent to the discharge. Does this qualify as an end to the episode of care?

A1. The enrollee must receive an NOMNC preceding the conclusion of the SNF stay. The enrollee has the right to appeal being discharged from the SNF to home. At the end of the home health visits, the enrollee must receive an NOMNC for this separate episode of care ending.

Q2. Would you please clarify if the issuance of an NOMNC would be required for a single visit, and if so, can the notice be given during this first (and last) visit? I understand that the notice is not required if home care is not initiated, following an evaluation visit.

A2. In cases where the duration of services is for only 1 visit, the NOMNC should be given during that visit. However, if that visit is strictly for evaluation purposes, and no services are initiated, then the NOMNC is not required.

Q3. Are notices required in situations involving the exhaustion of Medicare benefits?

A3. The NOMNC is not required in this situation. Instead, as in the past, enrollees who disagree that they have exhausted their benefits should contact their MA organizations. MA organizations should treat such disagreements as requests for organization determinations and issue the Notice of Denial of Medical Coverage (NDMC), which provides information regarding appeal rights through the MA organization. Thus, QIOs will not conduct expedited reviews in exhaustion of benefit situations.

Q4. If a patient agrees that services should end on the service termination date, is the provider still required to deliver the NOMNC on behalf of the MA organization, have the patient sign the NOMNC and submit the form to the MA organization?

A4. An MA enrollee must receive the NOMNC in all applicable situations, regardless of whether the enrollee agrees that services should end. Thus, the provider must still deliver the notice and obtain the patient’s signature. CMS does not require that the provider submit the signed form to
the MA organization. However, providers should work with their respective MA organizations to determine where to maintain records that may be needed for review purposes.

**Q5. Who is responsible for providing the quality improvement organization (QIO) with the patient’s medical records if a patient appeals to the QIO -- the provider or the MA organization?**

A5. Although the MA organization is ultimately responsible for providing records to the QIO, we recognize that the provider may be in a better position to promptly submit the needed records to the QIO. Thus, providers and MA organizations must work cooperatively to ensure that the QIOs receive information needed to make a timely decision on the appeal.

**Q6. CMS form # 10095A states that an enrollee has the right to an immediate, independent medical review, while services continue, of the decision to end Medicare coverage. If a patient decides to appeal the discharge decision and requests that services continue pending the outcome of the appeal, who is financially responsible for the additional days of service -- the patient, provider, or the MA organization?**

A6. The QIO’s decision will determine whether the MA organization or the enrollee is financially responsible for the disputed days. To the extent that the termination date is upheld, the enrollee is responsible for services received after the effective date indicated on the termination notice. Disputes involving whether a provider or an MA organization bear financial responsibility for services that the QIO determines should be covered are not within the purview of the QIO.

**Q7. Please confirm whether the NOMNC and the Detailed Explanation of Non-Coverage (DENC) can be issued at the same time. By issuing the notices simultaneously, enrollees can fully be aware of the reasons why they are being discharged.**

A7. The fast-track process only requires delivery of the NOMNC, unless the enrollee chooses to appeal the service termination. However, an MA organization may choose to issue the NOMNC and the DENC simultaneously, provided that the NOMNC advance delivery requirements are met. Note that the final version of the NOMNC includes additional space that can be used, at the discretion of the provider or the plan, to include additional patient-specific information, including information about the reason for the discharge.

**Q8. If an enrollee has been approved to receive services and meets his or her goals, e.g., for the specific purpose of rehabilitation, does the provider need to deliver the NOMNC?**

A8. In this instance, the MA organization is simply discontinuing coverage/payment to the SNF as of the discharge date.

**A9. If the enrollee requires in-home services, does the situation change? If a provider delivers an NOMNC to the enrollee, but the MA organization subsequently determines that services should continue beyond the original effective date, does the provider have to deliver a new NOMNC?**

A9. The provider must inform the enrollee of the new effective date that coverage will end, either through delivery of a new NOMNC, delivery of an amended NOMNC, or through a mail or telephone contact. If the provider contacts the enrollee other than in person to deliver this information, the provider should annotate the original NOMNC to reflect the revised effective date that coverage will end, the date and time that the provider contacted the enrollee, and the name of the person who initiated the contact. The annotated NOMNC should be placed in the enrollee’s medical file.
Q10. If an enrollee refuses continuation of services, does the enrollee have to fill out any type of form to indicate that s/he waives the right to the fast track process?

A10. No form is required in this situation; although, the MA organization may wish to document this refusal.

Q11. Who can act on behalf of an incompetent enrollee? What is the process for delivering an NOMNC if the enrollee is in a SNF but is not capable of receiving a notice?

A11. Where an appointment of representative form (CMS-1696-U4) has not been executed, an individual authorized under State law may be the authorized representative of the enrollee. State laws differ from one jurisdiction to another with respect to what is required to legally represent an incompetent enrollee. For example, some States have health care consent statutes providing for health care decision-making by surrogates on behalf of patients who lack advance directives and guardians. Other States have laws that grant authority to individuals with durable powers of attorney. In an emergency, a disinterested third party, such as a public guardianship agency, may be an authorized representative, e.g., where the beneficiary’s inability to act has arisen suddenly (e.g., a medical emergency, a traumatic accident, an emotionally traumatic incident, disabling drug interaction, stroke, etc.), and there is no one who genuinely can be considered as the beneficiary’s choice as his or her authorized representative. Thus, the SNF should deliver the NOMNC to the individual authorized under State law to make health care decisions on behalf of the enrollee.

Q12. Can a family Member who has been involved in the enrollee’s care act as the authorized representative without having signed the appointment of representative form (CMS-1696-U4)?

A12. Family Members that do not fill out an authorized representative form, CMS-1696-U4, must act under arrangements provided under State law. Individuals appointed or designated under State statutes may act as authorized representatives.

Q13. Our durable medical equipment (DME) authorization letter to the patient and provider has start and end dates. Will this satisfy the 2-day notification?

A13. The fast-track appeals process does not apply to DME suppliers. However, in any situation where the expedited review process is available, the NOMNC is the only appropriate notice.

Q14. Please clarify how to calculate the delivery of the NOMNC. We have had mixed messages regarding the date that should be inserted on the NOMNC. CMS’ education material sometimes uses the terms “discharge date” and “last covered day” interchangeably.

A14. We recognize that the terminology can be confusing, particularly in the SNF setting where the day of discharge often is not a “billed” day. However, regardless of how days are billed, “Medicare-covered services” continue until the moment of discharge. Thus, the day of discharge constitutes the “effective date” of the service termination. The following scenarios illustrate the calculation of the 2-day advance notice: standardized notices.
Section 11: Clinical Programs and Member Resources

Overview
Alignment provides a range of clinical programs and Member resources to supplement the care Members receive through their network providers. Alignment providers work alongside the Member’s Primary Care Physician to develop a care plan that puts the Member’s needs first. To refer a Member to an Alignment clinical program, a referral is required which are attached as Exhibit 11.2 - 11.4 (for each state).

For a complete listing of Alignment’s Member resources (i.e., Hearing, Fitness, Teledoc, Transportation, etc.) visit:

<table>
<thead>
<tr>
<th>Market</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Provider Resource Guide</td>
</tr>
<tr>
<td>Florida</td>
<td>Alignment Healthcare Florida Contact Information</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Alignment Healthcare North Carolina Quick Reference Guide</td>
</tr>
</tbody>
</table>

Comprehensive Annual Health Assessment
The Comprehensive Annual Assessment is an in-depth review of a Member’s health conditions to assist in identifying chronic diseases, modifiable risk factors, and urgent health needs. Complementing a Member’s routine visit to the Primary Care Physician (PCP), the Comprehensive Annual Assessment provides a holistic approach to caring for our Members to ensure that all acute, chronic, and preventative care needs are addressed. As new Members enroll, this also enables Alignment to collect comprehensive psychosocial and health status information for medical record integration into the Command Center, our advanced analytics platform for real-time health alerts. This is done through Alignment’s Jump Start Assessment (JSA). Alignment encourages Members to complete an initial health risk assessment within the first ninety (90) days of enrollment and annually thereafter. Depending on the specific contractual agreement, Alignment may conduct this assessment in patient’s home, in an Alignment Care Center, in the PCP offices or delegate the function to the IPA/Medical Group to complete as an Annual Wellness Visit. This service only applies to Primary Care Physicians and does not include services provided in any other settings.

Care Anywhere
The Care Anywhere program is a physician led, Advance Practice Clinician (APP) driven model of care designed to support patients that have been identified to benefit from a comprehensive in-home assessment to address immediate, chronic, and social health care needs. The Care Anywhere program targets the top five percent (5%) of frail or sickest Members that account for a disproportionate amount of health expense, primarily through the utilization of hospital ER and inpatient services. The program delivers an extra layer of care services for targeted Members to not only reduce the unnecessary utilization of ER and inpatient services, but also to improve health outcomes and restore humanity in advanced care planning. During the initial visit, the APP assesses the comprehensive health and psychosocial needs of a Member and builds an
appropriate care plan including frequency of follow-up visits. The program works alongside the Member's PCP and existing care team to ensure the Member's care is coordinated and is receiving his/her treatments as prescribed. Once enrolled, Members have access to an interdisciplinary care team, which includes an Alignment physician, social worker, and RN to address any care needs the Member may have including any potential acute health needs, provider referrals, open care gaps, or medication compliance. For those Members in the advanced stages of their care journey, the program provides Members and their families high quality, compassionate care when a cure may not be possible. This includes palliative care services and hospice care referrals as determined in conjunction with the Member and their Alignment provider.

**Case Management**
Alignment offers the following telephonic case management programs for Members at risk of poor health outcomes:
- General Case Management/ Post Discharge Case Management
- Telephonic Disease Management
- Complex Case Management

**General Case Management** is a collaborative, person-centered process that serves as a means to advocate for Member/patient well-being and autonomy through health education, decision support, care coordination, and the facilitation to engage resources and services identified in the Individualized Care Plan; working with the Member/patient and their representatives directly for the purpose of coordinating benefits and services with other agencies and providers, monitoring to assess ongoing progress and ensuring interventions are delivered within a supportive relationship that promotes the Individualized Care Plan.

**Post Discharge Case Management** is a subset of the General Case Management Program that focuses on those Members discharged from a facility. It provides timely education and assistance with access to care and services with the goal of preventing unnecessary readmissions. The Case Manager will complete a post discharge assessment which includes but is not limited to the following:
- Access to Care - Facilitating post discharge visit with Provider or Specialist
- Medication Review and Medication Reconciliation
- Verify ordered services are in place (HHC, DME, RX)
- Readmission Prevention
  - Reinforce understanding of Discharge Instructions
  - Member educations on symptom management
  - Education regarding PCP visit
  - Ensure Family/Caregiver Support is in place
- Identify any ongoing coordination of care needs for referral to Telephonic Disease Management, General or Complex Case Management.

**Non-Delegated Complex Case Management (CCM)** is provided to Members that have experienced a critical event or diagnosis that requires extensive use of resources and requires oversight to navigate the needed delivery of care and services. Case Management becomes complex when the illness and/or conditions, and complexity are severe and require an intense level of management beyond that of General Case Management. Referral criteria can be found in exhibit 11.1.
**Telephonic Disease Management (TDM)** is a system of coordinated health care interventions and communications for defined patient populations with conditions where self-care efforts can be implemented to manage their disease and prevent complications. Alignment’s TDM program is designed to help Members and practitioners manage chronic conditions including Diabetes, Chronic Kidney Disease (CKD), Coronary Artery Disease (CAD), Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD) and Hypertension (HTN). Referral criteria can be found in exhibit 11.1.

Alignment’s Case Management programs incorporate the dynamic processes of assessment, problem identification, care planning, intervention, monitoring and evaluation. The programs use an interdisciplinary team approach to meet the Member’s health care needs.

Members who are identified for case management and agree to participate will be assessed for needs when the case is initially opened. Upon completion of the initial assessment, the case will be assigned to the appropriate level of case management based on Member need. Communication and collaboration will occur with the PCP and the IPA/Medical Group, as needed, as well as any Specialty Care Participating Providers that may be involved in the Member’s care. The Member and family, as appropriate, will be actively involved in the care plan which will be documented and updated on a periodic basis or when there is a change in health status. Both short and long-term goals will be formulated, and the Member’s progress toward those goals will be monitored. Outcomes are documented when the case is closed, and Member satisfaction with the case management process will be assessed periodically. All pertinent information is relayed in a timely manner to both the PCP and the IPA/Medical Group, as necessary, throughout the case management process.

IPA/Medical Groups or Participating Provider Groups that are delegated for the inpatient process will also be delegated for the General and Post Discharge Case Management programs and will be monitored for their compliance to the above criteria. Alignment does not delegate Complex Case Management or Telephonic Disease Management. Referrals to Alignment’s Non-Delegated Complex Case Management or Telephonic Disease Management programs can be made using the referral form in exhibit 11.2.

**Remote Monitoring**

Alignment has developed and designed a home monitoring program, in partnership with Vivify, that is targeted towards the high risk, high acuity Membership. Depending on a Member’s unique disease state and other comorbidities, a Member may be offered a home monitoring device through a variety of channels. This program allows Members to submit key biometric data on a daily basis along with answering a health status questionnaire. Any responses that fall outside of that Member’s pre-set range may trigger alerts to Alignment for follow up. There is a team dedicated to addressing the alerts and following up with the Members as needed on a daily basis. This team may consist of a physician, advanced practitioner, registered nurse, coordinator and/or medical assistant. The program also allows Members to request video appointment with an Alignment provider in cases where the Member has any question related to their health.

Alignment’s home monitoring program is intended to support multiple clinical outcomes. The program not only enables Alignment to engage with Members on a more real-time basis, but it also minimizes admissions and readmissions for Members who can be better managed in an outpatient setting.
Exhibits:
Exhibit 11.1 – Non-Delegated Complex Case Management and Telephonic Disease Management Criteria
Exhibit 11.2 - Clinical Programs Referral Form-California
Exhibit 11.3 - Clinical Programs Referral Form-Florida
Exhibit 11.4 - Clinical Programs Referral Form-North Carolina
Exhibit. 11.1

Non-Delegated Complex Case Management and Telephonic Disease Management Criteria

Any Member identified with a listed diagnosis below should be referred to Alignment for review and consideration to be included in the Complex Case Management or Telephonic Disease Management Program.

**Complex Case Management Criteria:**
- Members followed in General CM > 60 days
- SNP Members
- Traumatic Brain Injury
- Major Organ Transplant
- Spinal Injuries
- 4 or more Chronic Conditions
- Cancer- Active Treatment
- Complex Behavioral Health Issues
- Complex Social Issues
- Neurologic Impairments (ALS, Parkinson’s etc.)
- Other

**Telephonic Disease Management Criteria:**
- Diabetes (DM)
- Chronic Kidney Disease (CKD/ESRD)
- Coronary Artery Disease (CAD)
- Hypertension (HTN)
- Heart Failure (HF)
- Chronic Obstructive Pulmonary Disease (COPD)
## Exhibit 11.2
Clinical Programs Referral Form-California

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>Patient First Name</th>
<th>Patient Middle Name</th>
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<tbody>
<tr>
<td>Patient DOB</td>
<td>Health Plan ID</td>
<td>Patient Home or Cell Phone</td>
</tr>
<tr>
<td>Referring Provider Name</td>
<td>Provider Type</td>
<td>Provider Phone</td>
</tr>
<tr>
<td>Provider Email</td>
<td>Provider Fax</td>
<td></td>
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</tbody>
</table>

Please check all that apply to this member*:

- □ COPD (Gold stage III, IV)
- □ Advanced wound care assessment / planning needed
- □ Paraplegia /quadruplegia
- □ Advanced Care Planning discussion needed
- □ Complex psychosocial or symptom management needed

- □ CHF (NYHA stage III and IV)
- □ High Risk for Readmission
- □ Feeding tubes
- □ Evaluation for referral to hospice needed
- □ Progression of cancer or metastasis

- □ CKD stage IV or greater
- □ Frequent ER utilization (2 or more visits in last 6 months)
- □ Dialysis
- □ Dementia with functional decline, Parkinson’s, CVA with inability to maintain caloric intake or hydration, ALS, or MS
- □ Hoyer lift

- □ Hypertension (uncontrolled, >160 systolic)
- □ Two falls in the last 6 months
- □ 15 prescription medications identified in HAV visit
- □ Liver disease with ascites
- □ SNP member

- □ DM2 (HbA1c >9.0, hypoglycemic episodes, or new to insulin) resulting in an admission
- □ Active Cancer /chemotherap y
- □ Member is home bound /bed bound or institutionalize d, or at risk of either
- □ CKD>4 and not interested in pursuing dialysis

*The Alignment Healthcare Clinical team will review all referrals and route to the appropriate care intervention team based on referral criteria and internal risk score. Intervention teams include:
- Care Anywhere Home Based High Risk Program
- Telephonic Case Management (CCM/TDM)

You may refer members by phone (657) 218-7500 or send this form via secure email to: CareAnywhereCoordination@AHCUSA.com.


### Exhibit 11.3
Clinical Programs Referral Form-Florida

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>Patient First Name</th>
<th>Patient Middle Name</th>
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<tbody>
<tr>
<td>Patient DOB</td>
<td>Health Plan ID</td>
<td>Patient Home or Cell Phone</td>
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<tr>
<th>Referring Provider Name</th>
<th>Provider Type</th>
<th>Provider Phone</th>
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<th>Provider Email</th>
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</table>

**Please check all that apply to this member**:  

- □ COPD (Gold stage III, IV)  
- □ Advanced wound care assessment / planning needed  
- □ Paraplegia /quadriplegia  
- □ Advanced Care Planning discussion needed  
- □ Complex psychosocial or symptom management needed

- □ CHF (NYHA stage III and IV)  
- □ High Risk for Readmission  
- □ Feeding tubes  
- □ Evaluation for referral to hospice needed  
- □ Progression of cancer or metastasis

- □ CKD stage IV or greater  
- □ Frequent ER utilization (2 or more visits in last 6 months)  
- □ Dialysis  
- □ Dementia with functional decline, Parkinson’s, CVA with inability to maintain caloric intake or hydration, ALS, or MS  
- □ Hoyer lift

- □ Hypertension (uncontrolled, >160 systolic)  
- □ Two falls in the last 6 months  
- □ 15 prescription medications identified in HAV visit  
- □ Liver disease with ascites

- □ DM2 (HbA1c >9.0, hypoglycemic episodes, or new to insulin) resulting in an admission  
- □ Active Cancer/chemotherapy  
- □ Member is home bound/bed bound or institutionalized, or at risk of either  
- □ CKD>4 and not interested in pursuing dialysis

*The Alignment Healthcare Clinical team will review all referrals and route to the appropriate care intervention team based on referral criteria and internal risk score. Intervention teams include:*

- Care Anywhere Home Based High Risk Program
- Telephonic Case Management (CCM/TDM)

You may refer members by faxing this form to 855-903-5152.
Exhibit 11.4  
Clinical Programs Referral Form-North Carolina

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>Patient First Name</th>
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<th>Referring Provider Name</th>
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Please check all that apply to this member*:

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- ☐ Advanced wound care assessment / planning needed
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- ☐ Feeding tubes
- ☐ Evaluation for referral to hospice needed
- ☐ Progression of cancer or metastasis

- ☐ CKD stage IV or greater
- ☐ Frequent ER utilization (2 or more visits in last 6 months)
- ☐ Dialysis
- ☐ Dementia with functional decline, Parkinson’s, CVA with inability to maintain caloric intake or hydration, ALS, or MS
- ☐ Hoyer lift

- ☐ Hypertension (uncontrolled, >160 systolic)
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- ☐ Liver disease with ascites

- ☐ DM2 (HbA1c >9.0, hypoglycemic episodes, or new to insulin) resulting in an admission
- ☐ Active Cancer /chemotherapy
- ☐ Member is home bound /bed bound or institutionalized , or at risk of either
- ☐ CKD>4 and not interested in pursuing dialysis

*The Alignment Healthcare Clinical team will review all referrals and route to the appropriate care intervention team based on referral criteria and internal risk score. Intervention teams include:

- Care Anywhere Home Based High Risk Program
- Telephonic Case Management (CCM/TDM)

You may refer members by sending this form via secure email to: CareAnywhereCoordinationNC@AHCUSA.com.
Section 12: Special Needs Plan

Special Needs Plan Overview
Alignment offers a chronic condition Special Needs Plan (SNP) to its eligible Members. Members with confirmed Chronic Heart failure, Cardiovascular diagnosis of Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, and/or Chronic Venous Thromboembolic Disorder living in Los Angeles and Orange Counties, CA may enroll in this benefit plan. Oversight of this Model of Care program is retained by Alignment and is not a delegated function.

Network providers are expected to participate in program requirements to help manage and improve health outcomes. Ways in which our providers can help our Members include:

- Complete the credentialing and re-credentialing process
- Participate in Alignment’s annual SNP Model of Care Training
- Assess/re-assess the Member to identify health status changes and update their Individualized Care Plan (ICP) as needed
- Review and discuss the Individualized Care Plan (ICP) with our Members
- Communicate with the Alignment Interdisciplinary Care Team (ICT) to ensure coordination of care and transition of care for our Members
- Refer Members to Alignment Case Management

Care Transitions
When a Member has a Care transition, respond to request for information from Alignment, ensure that Alignment receives admission and discharge notification in the EMR and work with the Alignment Case Manager to facilitate needed services. In addition, please evaluate the Member as soon as possible after an inpatient discharge and review, update and discuss the care plan with the Member.

SNP Quality Improvement Projects (QIPs)
As required by regulation, each Medicare Advantage Organization must develop and implement a QIP as part of its required Quality and SNP Program. A QIP is a clinically focused initiative designed to improve the health and focuses on Promoting Effective Management of Chronic Disease. Effective management of chronic conditions is expected to result in slowing of the disease progression, prevention of complications and development of comorbidities, preventable emergency room (ER) encounters and inpatient stays, improved quality of life for the Member, and cost savings to the plan and the Member.

Alignment’s SNP QIP is focused on women 67-85 years of age who suffered a fracture and had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. The goal is to improve the NCQA HEDIS® OMW measure to meet or exceed the 75th percentile or 65% by the end of the QIP cycle.
Section 13: Medical Management/Utilization Management

Overview
The purpose of the Utilization Management Program is to ensure consistent delivery of quality inpatient and outpatient health services with optimal Member outcomes, as well as to provide and manage coordinated, comprehensive, quality health care within the service area, without discrimination toward any individual and in a culturally competent manner. The Utilization Review Program will be in accordance with CMS, state and accreditation agency requirements.

Separation of Medical Decisions and Financial Concerns
Under existing law (Health and Safety Code Section 1367(g)), medical decisions regarding the nature and level of care to be provided to a Member, including the decision of who will render the service (Primary Care Physician, Specialist, in-network provider, out of network provider, etc.), must be made by qualified medical Participating Providers, without regard to fiscal or administrative concerns. Utilization Management decisions must be made by medical staff and based solely on medical necessity and medical appropriateness in coordination with CMS guidelines and the IPA/Medical Group or Participating Provider's contract language with Alignment.

The Utilization Management Program for IPAs/Medical Groups and delegated Participating Provider Groups must include provisions to ensure that financial and administrative concerns do not impact Utilization Management decisions. Alignment monitors compliance with this requirement. Failure to comply may result in the withdrawal of delegated utilization management from an IPA/Medical Group/delegated Participating Provider Group and ultimately, termination of their Alignment Agreements.

For detailed information, refer to Alignment’s UM Program Description, noted in Exhibit 13.1 below.

Utilization Management Goal
The goal of the Alignment Utilization Management Program is to provide Members access to the health services delivery system in order to receive, timely, appropriate, and quality medical care in the most appropriate setting. The objectives of the Alignment Utilization Management Program include, but are not limited to, the following areas:

- Providing oversight of delegated functions to IPA/Medical Groups and delegated Participating Provider Groups.
- Monitoring the health services delivery system for appropriateness, effectiveness and timeliness.
- Arranging for the provision of medical care to Members at the appropriate level of care.
- Monitoring Member’s utilization of medical services, including those which may be unnecessary, and monitoring and evaluating Member health status and medical care outcomes for patterns of under and over-utilization.
- Ensuring that services rendered are medically necessary for the Member’s condition.
- Confirming that the service being ordered or referred is covered under the Member’s...
Alignment benefit plan.

- Identifying and conveying relevant information to Quality Improvement for tracking and trending.
- Analyzing patterns of health care utilization to identify opportunities to improve effectiveness and efficiency.

**Clinical Criteria for Utilization and Case Management Decisions**

Evidence based clinical criteria for Utilization and Case Management is used to determine medical appropriateness. In addition to utilizing CMS National and Local Coverage Determinations, other examples of criteria that should be used include InterQual®, MCG and/or Apollo Guidelines. IPA/Medical Groups and Participating Provider Groups with delegated responsibilities are required to use these types of standardized Utilization Management criteria for decision making. For detailed information, refer to Alignment’s UM Program Description and Alignment policies UM-26 (Clinical Criteria and Treatment Guidelines) and UM-35 (UM Referral and Authorization Process), noted in Exhibit 13.1 below.

**Required Information for Authorizations / Authorization Forms**

The IPA/Medical Group/delegated Participating Provider Group should have a designated authorization form and/or process for its Participating Providers, which should contain all relevant information, including but not limited to the following:

- IPA/Medical Group Name
- Member name and Member Identification Number
- IPA/Medical Group/delegated Participating Provider Group authorization number, if appropriate
- Referring Participating Provider’s Name
- Requested Facility or Participating Provider Name
- Description of service (inpatient admission, outpatient surgery, SNF, DME, Hospice, etc.) If home health service, treatment plan should be included
- Admit Date (if scheduled) or service start date (if applicable), with estimated length of stay or service end date.
- Number of visits (if applicable)
- Admitting diagnosis or primary diagnosis (description and ICD-10 code(s))
- Admitting and/or Attending Physician
- Procedure (description and CPT code(s))
- Clinical rationale for service
- Description of treatment related to diagnosis and requested service and services to date (to include but not limited to: diagnostics (labs, scans, etc.), consults, treatment to date (such as Physical Therapy, procedures) and recommendations, elective referrals, inpatient services, and outpatient procedures requested by physicians.

When Utilization Management functions are not delegated, or when IPA/Medical Group or Participating Provider is required to obtain prior authorization from Alignment, the above required information should be submitted directly to Alignment in writing at fax number (562) 207-4628, or by utilizing Alignment’s Access Express.
Delegation of Utilization Management
Alignment maintains accountability for the delivery of care and services to its Members when services are delegated to the IPA/Medical Group or delegated to a Participating Provider Group. Alignment’s Utilization Management Program requires that delegated IPA/Medical Groups and delegated Participating Providers have a Utilization Management program in place to monitor and evaluate the care and services provided to its Members. IPA’s/Medical Group’s and delegated Participating Provider Group’s Utilization Management program must meet Alignment, state and federal requirements. Alignment will perform systematic monitoring and oversight of all IPA/Medical Groups, delegated Participating Provider Groups, and the oversight of their respective provider networks to assure compliance with contractual and regulatory requirements. Oversight of utilization practices is conducted through Alignment’s Compliance Delegation Oversight Department. Alignment conducts annual and ongoing assessments of delegated activities that include Quality Management and Utilization Management activities.

For detailed information, refer to Alignment’s UM Program Description, noted in Exhibit 13.1 below.

Utilization Management Components:
IPA/Medical Groups and delegated Participating Provider Groups must have the following committees and processes in place:

- **Utilization Management Committee**
  Each IPA/Medical Group and delegated Participating Provider Group is required to have a Utilization Management Committee which meets no less than quarterly, and more frequently if necessary. The Utilization Management Committee’s purpose and responsibilities should be written and on file. The Committee minutes should be on file and made available to Alignment upon request.

- **Prospective Review Process**
  Prospective review is performed to determine the medical necessity of elective referrals to specialty or ancillary care, inpatient admissions, and/or outpatient procedures. Requests for preauthorization of elective referrals, admissions, or procedures are received by the IPA/Medical Group/ delegated Participating Provider Group from either the Primary Care Physician or specialist and will be approved or denied based on medical necessity. The IPA/Medical Group/ delegated Participating Provider Group determines medical necessity through the use of standardized criteria.

- **Concurrent Review Process**
  IPA/Medical Group/ delegated Participating Provider Group utilization review staff should perform concurrent review on a daily basis, or as appropriate based on clinical presentation. The objective of the concurrent review is to assess clinical information during a Member’s hospital stay, coordination of the discharge plan, assist in determining medical necessity at an appropriate level of care, and perform quality management screening. For detailed information, refer to Alignment policy UM-40 (Inpatient Acute Concurrent Review), noted in Exhibit 13.1 below.

- **Retrospective Review Process**
  IPA/Medical Group/ delegated Participating Provider Group shall conduct retrospective review on individual cases and on aggregate decision data. Individual case review helps to identify
specific issues arising from an episode of care; for example, emergency room claims are reviewed for medical necessity and covered benefits. For detailed information, refer to Alignment policy UM-39 (Retrospective Review), noted in Exhibit 13.1 below.

- **Initial Organization Determination**
  An initial determination is made when either Alignment, the IPA/Medical Group or a delegated Participating Provider Group approves or denies payment on a service rendered or have failed to authorize or provide a service. Alignment must make an initial decision on a request for a service as quickly as the Member’s health permits, but no later than fourteen (14) calendar days from the date of receipt of the request, or seventy-two (72) hours from the date and time of receipt of the request when an urgent situation exists and the need for an expedited determination is deemed medically necessary as defined by CMS. For detailed information, refer to Alignment policy UM-01 (Standard Initial Organization Determination), noted in Exhibit 13.1 below.

- **Case Management**
  IPA/Medical Group/ delegated Participating Provider Group shall proactively assess, plan, implement, and coordinate care across the continuum of care needs, as well as monitor, evaluate options and refer Members to programs to meet Members’ needs to promote quality cost-effective outcomes.

For detailed information, refer to Alignment’s UM Program Description, noted in Exhibit 13.1 below.

**IPA’s/Medical Group’s/Delegated Participating Provider Group’s Utilization Management Program**
In addition to the key components listed above, IPA/Medical Groups and Participating Provider Groups with delegated responsibilities for Utilization Management are required to have a written Utilization Management Program which documents all facets of delegated authority. All decisions regarding the approval or denial of health care services under delegation are made in accordance with the IPA/Medical Group/ delegated Participating Provider Group Utilization Management Program, which includes a Utilization Management Committee review process. The Utilization Management Program should specify the medical criteria and process used to determine medical necessity.

The IPA/Medical Group/ delegated Participating Provider Group Utilization Management Program and workplan will be evaluated annually by Alignment to determine compliance with Alignment standards. The IPA/Medical Group/ delegated Participating Provider Group Utilization Management Program and workplan must also be approved by the governing body of the IPA/Medical Group/ delegated Participating Provider Group on an annual basis, with such approval documented and signed in the minutes. An IPA’s/Medical Group’s/ delegated Participating Provider Group’s Utilization Management Program should provide evidence that internal procedures for Utilization Management are operational, and include, but are not limited to the following:

- A specific person/position designated to ensure necessary authorization procedures are performed; minimum requirements by experienced RNs/LVNs
- Authorization for elective and urgent health care services meet established timeliness
standards

- Physician involvement and collaboration for medical necessity determinations occurs daily.
- A summary of utilization activities is reviewed by the IPA/Medical Group / delegated Participating Provider Group Utilization Management Committee
- Documentation of Utilization Management includes the decision and Member notification. In the case of a denial, an alternative treatment plan and Member appeal rights must be included
- Timely, documented Member notification of approval or denial determinations is on record
- Daily logs of hospital admissions and denials/appeals are maintained and available upon request to Alignment staff for review purposes
- Cooperation with Alignment’s Utilization Management for all Out-of-Area admissions
- In accordance to CMS requirements, IPA/Medical Group/ delegated Participating Provider Group shall provide valid and reliable encounter data in a timely manner and complies with the Alignment Utilization Management Program. The encounter data system assists in tracking and trending utilization patterns across the Alignment provider network.
- Reporting and analysis including, at a minimum, the following information:
  - Pre-service determinations (including denials)
  - Bed days/1,000, admits, length of stay, level of care (monthly, quarterly, annually)
  - Behavioral health statistics/1,000, admits, length of stay, level of care (Monthly, quarterly, and annually)
  - All outliers will require a corrective action plan for the Utilization Management indicator
- Specific written procedures for pre-certification, concurrent and retrospective review, and case management that is supervised by qualified medical professionals and physician consultants representing the appropriate specialty of medicine and surgery
- A Utilization Management Committee, comprised of Participating Providers that make determinations regarding the approval or denial of health care services to Members
- Utilization Management Program and policies and procedures, specifically outline Member/Participating Provider notifications of medically necessary determinations, including approval and denials. The denial process is clearly outlined and includes an appeal process
- Denial and/or appeal policy and procedure and Member letters include specific regulatory language that clearly indicates the reason for the denial, alternative treatment suggestions as appropriate, and how the Member can appeal directly to Alignment. (Alignment does not delegate the appeal process; therefore, IPA/Medical Groups/ delegated Participating
Provider Group need to define their role in appropriate and timely notification to Alignment of appeal requests. Only a licensed physician can deny services.

- Utilizes evidence based clinical criteria for Utilization Management medical review criteria (e.g., CMS National and Local Coverage Determinations, MCG, Apollo Medical Management Guidelines) to ensure reliable and consistent medical necessity determinations for all individuals involved in the utilization process. All criteria and guidelines are clearly documented.

- Case management cases are reported to Alignment staff at the point of identification.

- Assists in the identification of coordination of benefits and third party payer information.

- Participates with Alignment in Joint Operations Meetings annually, or more frequently as indicated.

- Administers Member benefits based on the Alignment Member’s individual benefit schedule.

- Failure of the IPA/Medical Group/delegated Participating Provider Group to meet under-utilization and over-utilization standards will result in the development of a corrective action plan that is submitted to Alignment for review and approval.

- IPA/Medical Group/delegated Participating Provider Group representatives participate in Alignment medical management committees, as requested.

- IPA/Medical Group/delegated Participating Provider Group is responsible for timely submission of monthly, quarterly and annual reporting as listed in Section 5, Exhibit 5.1 - IPA/Medical Group and Delegated Participating Provider Group Reporting Responsibilities.

For detailed information, refer to Alignment’s UM Program Description and Alignment policy and UM-35 (UM Referral and Authorization Process), noted in Exhibit 13.1 below.

**Timeliness Requirements for Utilization Review Decisions**

Alignment and its IPA/Medical Groups and Participating Provider Groups, to which Utilization Management functions have been delegated, are required to comply with the following Utilization Management decisions. For detailed information, refer to Alignment policy UM-28 (UM Timeliness Standards), noted in Exhibit 13.1 below.

**Oversight and Monitoring of IPA/Medical Group and Participating Provider Group Delegated Utilization Management**

Alignment’s oversight of the IPA/Medical Group/delegated Participating Provider Group operations includes annual review and approval of the written description of the Utilization Management Program, monitoring of denial activity, compliance with Alignment criteria, compliance with approval and denial decision timeliness standards which are based on regulatory requirements, and compliance with appeal decision standards. For detailed information, refer to Alignment policy UM-07 (Over and Under Utilization), noted in Exhibit 13.1 below.
Revoke of Delegated Medical Management
Alignment reserves the right to revoke delegated status when the IPA/Medical Group/ delegated Participating Provider Group has failed to meet and maintain established standards.

Referrals and Prior Authorizations
IPAs/Medical Groups/ delegated Participating Provider Groups are responsible for the following:
- Monitor referrals that have been authorized for medically appropriate care to ensure Members' access and follow up with the Primary Care Physician. In turn, the Primary Care Physician is responsible for maintaining continuity of care for Alignment Members during the referral process. This may entail monitoring the referrals made for their Alignment Members to ensure that appropriate services are accessed, and pertinent specialty service reports are received for inclusion in the primary care medical record. IPA/Medical Groups/ delegated Participating Provider Group also have a responsibility for tracking those services.
- Monitor the quality of care and the cost associated with outside referrals.
- Assure timely payment to referral Participating Providers for covered services
- Authorization may not be withdrawn once it has been given (except when notified by the Member or the Participating Provider that this service is no longer required and is being withdrawn by the Participating Provider or the Member themselves). In these cases, there needs to be complete documentation about who is making this decision to withdraw
- Notify Alignment upon Member’s permanent relocation outside of the Alignment service area, when identified by IPA/Medical.
- Notify Alignment’s Utilization Management when a Member resides outside of the Alignment service area for more than six (6) months. Notification should be faxed to Alignment at (562) 207-4632.

All referrals where Alignment is or may be at risk, except for Emergency Services, Direct Access services, and services specifically excluded from prior authorization in accordance with CMS and other regulatory agencies, require prior authorization from the IPA/Medical Group/delegated Participating Provider Group or Alignment, as set forth in this Section. IPA/Medical Group/ delegated Participating Provider Group shall refer Members to its contracted providers, and to Alignment contracted Participating Providers when such referral services are Alignment’s financial responsibility. In the event the use of a non-Participating Provider is necessary, IPA/Medical Group shall obtain prior authorization from Alignment. If IPA/Medical Group or Participating Providers refer Members to a non-Participating Provider without obtaining Alignment’s prior approval, IPA/Medical Group and/or Participating Provider may be responsible for the cost of services resulting from such failure to use Participating Providers.

For detailed information, refer to Alignment’s UM Program Description and Alignment policies UM-18 (Emergency and Urgently Needed Services) and UM-35 (UM Referral and Authorization Process), noted in Exhibit 13.1 below.

Referrals and Authorizations for Specialty Care
The Primary Care Physician is responsible for management and coordination of a Member’s complete medical care, including initial and primary care, maintaining continuity of care and initiating specialist referrals. The Primary Care Physician refers for specialty care when additional knowledge or skills are required. IPA/Medical Groups and delegated Participating Providers are required to monitor referrals that have been authorized for medically appropriate care to ensure Members’ access and follow up with the Primary Care Physician. In turn, the Primary Care
Physician is responsible for maintaining continuity of care for Alignment Members during the referral process. This may entail monitoring the referrals made for their Alignment Members to ensure that appropriate services are accessed, and pertinent specialty service reports are received for inclusion in the Primary Care Physician medical record.

IPA/Medical Groups and delegated Participating Providers are required to monitor referrals that have been authorized for medically appropriate care to ensure Members’ access and follow up with the Primary Care Physician. In turn, the Primary Care Physician is responsible for maintaining continuity of care for Alignment Members during the referral process. This may entail monitoring the referrals made for their Alignment Members to ensure that appropriate services are accessed, and pertinent specialty service reports are received for inclusion in the Primary Care Physician medical record. For detailed information, refer to Alignment policy UM-35 (UM Referral and Authorization Process), noted in Exhibit 13.1 below.

### Designated Ancillary/Supplemental Vendors
All IPA/Medical Groups regardless of contractual risk arrangements, and all delegated Participating Provider Groups are required to use Alignment’s designated ancillary and supplemental vendors for services, such as transportation, supplemental vision, dental, fitness, hearing aids, etc. For a complete listing of Alignment’s designated ancillary and supplemental vendors, access the list below:

<table>
<thead>
<tr>
<th>Market</th>
<th>Resource</th>
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<tbody>
<tr>
<td>California</td>
<td>Provider Resource Guide</td>
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<tr>
<td>Florida</td>
<td>Alignment Healthcare Florida Contact Information</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Alignment Healthcare North Carolina Quick Reference Guide</td>
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Referring Members to a non-designated ancillary or supplemental vendor could result in a deduction in payment for services incurred to such non-designated provider.

### Authorization and Denial Log Submissions
All IPA/Medical Groups regardless of contractual risk arrangements, and all delegated Participating Provider Groups, are required to submit authorization and denial logs for all services where an authorization is required for such services by either the IPA/Medical Group/delegated Participating Provider Group or Alignment, as set forth in Exhibit 13.2. For detailed information, refer to Alignment policy UM-07 (Over and Under Utilization), noted in Exhibit 13.1 below.

### Concurrent Notification of Inpatient and Hospital Observation Services
- **Hospital Admission Notification**
  Alignment requires notification of elective, urgent and emergency Member admissions, regardless of whether the services are in or out of the service area, within twenty-four (24) hours of an admission, when Alignment is or may be at risk for the hospital services. IPA/Medical Groups and Hospitals are directed to call the Alignment Utilization Management department at (844) 361-4715 or fax to (562) 207-4628. Participating hospitals are notified of this requirement with contract implementation. These phone numbers are also included on the back of the Member’s ID card. Unless otherwise authorized by Alignment, elective hospital
stays, and hospital services are required to be provided by Participating Hospitals that are contracted with Alignment when such services are Alignment's financial responsibility. For detailed information, refer to Alignment policy UM-40 (Inpatient Acute Concurrent Review), noted in Exhibit 13.1 below.

- **Emergency Admission Notification**
  Hospital admissions due to an emergent condition do not require authorization prior to the service(s) being rendered. Alignment should be notified of emergent admissions within twenty-four (24) hours of the admission when Alignment is or may be at risk for the hospital services. For detailed information, refer to Alignment policy UM-18 (Emergency and Urgently Needed Services), noted in Exhibit 13.1 below.

- **Outpatient Hospital Observation**
  Outpatient hospital observation status is designed to evaluate a Member’s medical condition to determine the need for an inpatient admission, to stabilize a Member’s condition, or to rule out a diagnosis or medical condition that responds quickly to care. Alignment applies CMS and nationally recognized evidenced based guidelines to determine when services meet criteria for outpatient hospital observation. A Member’s outpatient hospital observation status may later change to an inpatient admission if criteria is met. Hospitals are expected to issue the appropriate claims for outpatient hospital observation services when i) outpatient hospital observation services are authorized by either IPA/Medical Group or Alignment or ii) such services meet the CMS or nationally recognized evidenced based guidelines for observation.

**Medicare Outpatient Observation Notice (“MOON”)**
CMS requires hospitals and critical access hospitals (CAH) to deliver the Medicare Outpatient Observation Notice (“MOON”) to Members who receive observation services as an outpatient for more than twenty-four (24) hours. The purpose of the MOON is to inform Medicare beneficiaries when they are an outpatient receiving observation services for more than twenty-four (24) hours and are not an inpatient of the hospital or CAH. The MOON must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as the Member’s cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than thirty-six (36) hours after observation services begin.

**Authorization for Skilled Nursing Facility**
IPA/Medical Group shall follow the procedures set forth in this section for referral to and authorization of skilled nursing facility services. In addition, IPA/Medical Group shall authorize the level of care and the number of therapies that are required for the Member. Unless otherwise authorized by Alignment, skilled nursing facility admissions are required to be directed to skilled nursing facilities that are contracted with Alignment when such services are Alignment’s financial responsibility. For detailed information, refer to Alignment policy UM-40 (Inpatient Acute Concurrent Review), noted in Exhibit 13.1 below.

**Authorization of Other Ancillary Services**
IPA/Medical Group/ delegated Participating Provider Group shall follow the procedures set forth in this section for referral to and authorization of ancillary services, such as home health, DME, mental health, outpatient surgery, etc. Unless otherwise authorized by Alignment, such ancillary services are required to be directed to Participating Providers that are contracted with Alignment when such services are Alignment’s financial responsibility. For detailed information, refer to
Alignment policy UM-35 (UM Referral and Authorization Process), noted in Exhibit 13.1 below.

**Out-of-Area Medical Services**
Out-of-Area medical services are those emergent or urgently needed services to treat an unforeseen illness or injury that arises while a Member is outside of the IPA's/Medical Group’s contracted service area. Alignment is responsible for the management of Out-of-Area services, unless otherwise specified in IPA’s/Medical Group’s Participating Provider Services Agreement. Medical services provided outside of the IPA/Medical Group defined service area that are arranged, referred directly or indirectly, and/or authorized by IPA/Medical Group may be IPA/Medical Group’s financial responsibility, and are not considered Out-of-Area services.

IPA/Medical Group shall notify Alignment of all known Out-of-Area cases no later than the first (1st) business day after receiving Member notification of an Out-of-Area admission, procedure and/or treatment, when Alignment is or may be at risk for Out-of-Area services. Failure to notify Alignment within this timeframe may result in Alignment holding the IPA/Medical Group financially responsible for the Out-of-Area care and service. Once deemed stable for transfer to an in-area facility, the IPA/Medical Group must work actively and collaboratively with Alignment to return the Member to a contracted Participating Provider in a timely fashion. If the IPA/Medical Group does not cooperate with Alignment or delays the transfer of a Member considered medically stable for transfer, Alignment may hold the IPA/Medical Group financially responsible for any additional Out-of-Area charges incurred as a result of the delay.

**Out-of-Area Dialysis**
Travel dialysis services are dialysis services required by a Member who is temporarily outside of the IPA’s/Medical Group’s service area. Travel dialysis is not considered an Out-of-Area medical service. The financial responsibility for travel dialysis will be the same as dialysis services or travel dialysis services included in the IPA’s/Medical Group’s DOFR. Travel dialysis services do not require prior authorization, but delegated IPA/Medical Groups are responsible for the medical management of Members who require travel dialysis services. In addition, IPA/Medical Group shall notify Alignment within one (1) business day upon becoming aware of a Member utilizing travel dialysis services.

**Out-of-Network Services**
Out-of-Network Services are those services provided or arranged by providers who are not contracted with Alignment. With some exceptions as set forth in the Member’s Evidence of Coverage (EOC), Alignment only covers services provided by providers that are in the Alignment contracted network. IPA/Medical Groups and delegated Participating Provider Groups are responsible for obtaining prior authorization from Alignment for services that are Alignment’s financial responsibility as per the IPA’s/Medical Group’s DOFR, and delegated Participating Provider Group’s Agreement with Alignment, and are Out-of-Network. IPA/Medical Group/delegated Participating Provider Group may be financially responsible for Out-of-Network services that IPA/Medical Group/delegated Participating Provider Group or IPA/Medical Group Participating Providers/delegated Participating Providers refer, authorize or direct without prior authorization from Alignment. For detailed information, refer to Alignment policy UM-19 (Non-Contracted Providers), noted in Exhibit 13.1 below.

**Transplants**
IPA/Medical Groups and Participating Providers must receive prior authorization from Alignment’s Utilization Management for all transplant services, regardless of contractual risk arrangement.
The Primary Care Physician or referred Specialist is responsible for the initial diagnostic work-up prior to a referral to a contracted and approved Transplant Center. The Alignment transplant case manager will work in conjunction with the Member's transplant team, Primary Care Physician, and other Specialists to complete an assessment of the Member's healthcare needs, develop, implement and monitor a care plan, coordinate services and re-evaluate the care plan for the Member.

**Hospice**
For hospice authorizations, the Member must sign the IPA/Medical Group designated authorization form indicating that the Member elected hospice. The physician is required to sign a certification of terminal illness.

**Second or Third Opinions**
For detailed information, refer to Alignment policy UM-22 (Second Opinions), noted in Exhibit 13.1 below.

**Direct Access Services**
For detailed information, refer to Alignment policy UM-25 (Direct Access OB GYN and Women's Preventative Services), noted in Exhibit 13.1 below.

**Non-Discrimination**
IPA/Medical Groups and Participating Providers shall not deny, limit, or condition the provision of Covered Services to Members on the basis of race, ethnicity, national origin, religion, gender, age, mental or physical disability or medical condition, sexual orientation, claims, experience, medical history, evidence of insurability, disability, genetic information, or source of payment. IPA/Medical Groups and Participating Providers must maintain policies and procedures to demonstrate that it does not discriminate in the delivery of health care services.

**Interpreter Services**
Delegated IPA/Medical Groups and Participating Providers are expected to have mechanisms to ensure the provision of interpreter services are available to Members to access health care services, and are expected to ensure that:

- Interpreter services shall be available at no cost to the Member. Alignment also provides interpreter services at no cost to the Member.
- Members are encouraged to use interpreter services instead of using family and friends as interpreter
- Trained and bilingual staff are used for medical interpreting
- The Member's primary spoken language and any request or refusal of interpreter services is recorded in their medical record

**For California, Florida and FirstMedicareDirect in North Carolina:**
To access Alignment’s interpreter services for Members, please contact Member Services at (866) 634-2247 at least 7 (seven) days prior to the service.

**For Humana in North Carolina:**
To access interpreter services for Members, please contact Humana's Member Services at (800) 457-4708.
Alignment’s Utilization Management Program, Policies and Procedures
Refer to Exhibit 13.1 to obtain detailed information pertaining to Alignment’s UM Program Description and UM policies. IPAs/Medical Groups and delegated Participating Provider Groups are required to comply with the program and policies.

IPA/Medical Group and Participating Provider Group reporting requirements and Alignment contact information can be obtained in Exhibit 13.2

Exhibits:
Exhibit 13.1 – Utilization Management Program, Policies and Procedures
Exhibit 13.2 – Utilization Management Reporting and Contacts
## EXHIBIT 13.1

### Utilization Management - Program, Policies and Procedures

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Policy Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td>UM Program Description</td>
</tr>
<tr>
<td>UM-01</td>
<td>Standard Initial Organization Determination</td>
</tr>
<tr>
<td>UM-02</td>
<td>Expedited Initial Organization Determination</td>
</tr>
<tr>
<td>UM-03</td>
<td>Adverse Determinations</td>
</tr>
<tr>
<td>UM-04</td>
<td>Coverage Termination SNF/HHA/CDRF</td>
</tr>
<tr>
<td>UM-06</td>
<td>Prior Authorization Inter-Rater Reliability Audit</td>
</tr>
<tr>
<td>UM-07</td>
<td>Over and Under Utilization</td>
</tr>
<tr>
<td>UM-09</td>
<td>Coordination and Continuity of Care</td>
</tr>
<tr>
<td>UM-12</td>
<td>Concurrent Hospital Residential and Intensive Outpatient Review</td>
</tr>
<tr>
<td>UM-13</td>
<td>Evaluation of New Technology</td>
</tr>
<tr>
<td>UM-14</td>
<td>Termination of Services-Inpatient Hospital</td>
</tr>
<tr>
<td>UM-15</td>
<td>Behavioral Health Management</td>
</tr>
<tr>
<td>UM-18</td>
<td>Emergency and Urgently Needed Services</td>
</tr>
<tr>
<td>UM-19</td>
<td>Non-Contracted Providers</td>
</tr>
<tr>
<td>UM-22</td>
<td>Second Opinions</td>
</tr>
<tr>
<td>UM-24</td>
<td>Standing-Extended Access to Specialty Care</td>
</tr>
<tr>
<td>UM-25</td>
<td>Direct Access OB GYN and Women’s Preventative Services</td>
</tr>
<tr>
<td>UM-26</td>
<td>Clinical Criteria and Treatment Guidelines</td>
</tr>
<tr>
<td>UM-27</td>
<td>Communication Policy for UM Process and Authorizations</td>
</tr>
<tr>
<td>UM-28</td>
<td>UM Timeliness Standards</td>
</tr>
<tr>
<td>UM-35</td>
<td>UM Referral and Authorization Process</td>
</tr>
<tr>
<td>UM-36</td>
<td>Transition of Care</td>
</tr>
<tr>
<td>UM-37</td>
<td>Archiving and Retrieving Medical Records</td>
</tr>
<tr>
<td>UM-39</td>
<td>Retrospective Review</td>
</tr>
<tr>
<td>UM-40</td>
<td>Inpatient Acute Concurrent Review</td>
</tr>
<tr>
<td>UM-41</td>
<td>Communication for Denial of Service</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>UM-42</td>
<td>Cancellation of UM Referrals</td>
</tr>
<tr>
<td>UM-43</td>
<td>Pend for Clinical Review (PCR) List</td>
</tr>
</tbody>
</table>
## Utilization Management Reporting and Contacts

<table>
<thead>
<tr>
<th>UM Reporting Template*</th>
<th>Submit via Alignment Web Portal: Reports Submission Delegation Reporting</th>
<th>Weekly**, by Wednesday or earlier (Reporting period Monday through Friday for week prior)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attestation of Completion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorizations (Pre-Service; Retros; all determinations including denials)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UM Reporting Template:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attestation of Completion</td>
<td></td>
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</tr>
<tr>
<td>Case Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Observations (bed days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOMNC Letters</td>
<td>Submit via Alignment Web Portal: Reports Submission Delegation Reporting</td>
<td>Concurrent</td>
</tr>
<tr>
<td>Complex Case Management &amp; Disease Management</td>
<td>Submit via fax: (562) 207-4632 (refer to Complex Case Management form)</td>
<td>Concurrent</td>
</tr>
</tbody>
</table>

* There is one reporting template with multiple tabs for authorizations, inpatient/observations, case management, etc which can be completed and loaded in the time frames indicated above.

**Alignment will accept if IPA/Medical Group or delegated Participating Provider Group is capable of providing on a more frequent basis (e.g. daily).
Section 14: Quality Management/ Quality Improvement

Quality Management/Improvement Overview
The Alignment Quality Management (QM) Program is a comprehensive program designed to promote high quality care and service excellence. The overall goal is to maximize and optimize the cost-effective delivery of care with the best possible health outcomes for our Members. The program helps with monitoring and evaluating current practices and implementing quality improvement initiatives.

The program provides the foundation for fulfilling regulatory and statutory requirements of the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) as well as other required accreditation requirements.

Alignment and IPA/Medical Groups and delegated Participating Providers are required to engage in specific reviews and tasks applicable to state and federal regulatory guidelines which are geared towards improving care for Members enrolled in an Alignment plan.

Quality Management and Quality Improvement activities are not delegated functions.

1. Participation in the QM/QI Program
IPA/Medical Groups and Participating Providers play an integral role in the implementation of the Quality Management Program and are expected to understand and acknowledge the policies and procedures described by Alignment. Providers are required to cooperate with our Quality Management Department; in doing so, Providers will be requested to cooperate with access to the medical records of current or previously enrolled Members, as permitted by state and federal law.

The Quality Management Program includes, but is not limited to:
- Medical records review
- Focus studies
- Member satisfaction surveys
- Peer review investigations
- Complaint inquiries
- Special Needs Plan (SNP) Model of Care Requirements

When documentation is presented and there is an opportunity to improve a Member’s care, Providers may be asked to participate in formulating the care plan.

The Quality Management Department will assess the guidelines of care and documentation required by regulatory agencies and accreditation organizations for medical record review, health-screening and high-risk diagnoses on an ongoing basis. A Quality Improvement Representative will review the items, and, upon completion of the review, IPA/Medical Groups and Participating Providers will be advised of any deficiencies found during the review. This review will assist Provider offices with making any necessary corrections. A “Corrective Action Plan” will be requested for all deficiencies.
Results of all reviews will be made part of the IPA/Medical Group and Participating Provider's file and may be presented upon re-credentialing of the Participating Provider.

2. Data Collection Process
Monitoring activities are designed for a broad range of health care issues with focus on identifying areas of needed improvement in clinical, administrative, and financial areas. The ongoing monitoring of these activities will include reviews of compliance with clinical and administrative standards, as well as with accrediting agencies. Data is collected on a routine basis (monthly, quarterly, and/or annually) and on an ad hoc basis from internal and external sources.

This data is obtained by:
- Reviewing documentation in medical records
- Conducting Provider site visits
- Evaluation of Member outcomes
- Trending of administrative data
- Review of target diagnoses and sentinel events
- Trending of Member and Participating Provider complaints, grievances and appeals
- Evaluation of Care and Disease Management outcomes

3. Quality Improvement Committee (QIC) (fka: Medical Services Committee/MSC)
The Quality Improvement Committee (QIC) formerly known as Medical Services Committee (MSC) and subcommittees provide oversight of the Quality Management Program, policies and procedures. The purpose of the QIC is to provides oversight of the Quality Management Program as it reviews, approves, and makes recommendations for the program on at least an annual basis. In addition, the QIC ensuring that the implementation of the Quality Management Program is responsive to, and supports improving health outcomes, Member satisfaction, collecting, analyzing, and reporting of quality data in compliance with regulatory mandates and with accreditation standards.

The QIC reviews the Annual Quality Management Program and Annual Quality Management Evaluations, requests additional information when indicated, and directs action on opportunities to improve care and services or to resolve problems when required.

4. Medicare Advantage Chronic Care Improvement Program (CCIP)
The Center for Medicare and Medicaid Services requires Medicare Advantage plans to have an ongoing quality assessment and performance improvement program. This program must include assessing performance using standard measures required by CMS and reporting its performance to CMS.

Alignment chose “Improving Condition Management in Members with COPD” as its Chronic Care Improvement Project. This COPD CCIP is designed around patient education regarding risk avoidance, symptom management as well as medication adherence to avoid/minimize exacerbation. Collaboration with the PCP/Specialist to ensure Members identified as having an acute exacerbation are placed on bronchodilators and steroids post exacerbation as indicated. The program follows the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines.
5. **Provider Satisfaction**
The monitoring, evaluation, and improvement of Provider Satisfaction are key components of Alignment’s Quality Management Program. Provider surveys are conducted annually to gain an understanding of the level of satisfaction with the quality of services provided by various Alignment departments. Feedback is provided to IPA/Medical Groups and Participating Providers via newsletters and reported annually to the QIC and included in the Annual Quality Management Program Evaluation.

6. **Member Satisfaction**
Alignment participates in regulatory Member Satisfaction Surveys, as well as monitors Member satisfaction with clinical programs such as Case and Disease Management as well as the Care Anywhere Program. Member satisfaction data and surveys are used to track and trend Member satisfaction and identify opportunities for improvement initiatives by using the continuous quality improvement process.

7. **Medical Record Documentation**
Participating Providers are required to maintain a complete medical record for every Alignment Member for whom they provide care. IPAs/Medical Groups and Participating Providers shall maintain standards set forth by, but not limited to, accrediting agencies, Alignment, and state and federal regulatory requirements and guidelines which apply to medical records documentation and standards. IPAs/Medical Groups and Participating Providers will ensure that their office personnel will maintain the following:

1. Confidentiality, security and physical safety of medical records
2. Timely retrieval and distribution of medical records upon request between Participating Provider and Alignment
3. Unique identification of each Member’s medical record
4. Supervision of the collection, processing, maintenance, and storage of medical records
5. Maintain a secured and organized medical record format
6. Conduct periodic training in HIPAA Standards and Member information confidentiality.

IPAs/Medical Groups and Participating Provider Groups must have medical records procedures which address all areas listed in the Alignment QM PolicyQM-04 Medical Record Requirements & Documentation Standards. The criteria utilized for medical records and quality-of-care standards is based upon regulatory requirements outlined by regulatory agencies, accreditation guidelines, accepted national organizations and are subject to change based upon nationally-recognized practice guidelines. IPAs/Medical Groups and Participating Provider Groups will be given the results of the audit review and, if warranted, a “Corrective Action Plan” addressing any deficiencies. Any area which is not compliant with regulatory standards will require a correction plan. The Corrective Action Plan will be given to the Participating Provider at the time of the exit review and must be executed by the Participating Provider, then faxed or mailed to Alignment QI@ahcusa.com within five (5) business days of the review. Should a Participating Provider not acknowledge by signing and returning the corrective action plan in the allotted time, a final request will be sent to the Participating Provider and any Member assignments may be deferred until the signed plan is received by Alignment. Re-credentialing may not occur if the Participating Provider has an outstanding plan-of-correction. A follow-up audit will be scheduled and conducted within a reasonable time frame to ensure all deficiencies are corrected and meet regulatory compliance.
8. **Access to Care**

All IPA/Medical Groups and Participating Providers are responsible for fulfilling the access standards outlined in this section. Alignment monitors the ability of its Members to access each service type (left column) according to the specified Care Access Standard (right column).

### PCP/Specialist Access to Care Standards

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Care</strong>&lt;br&gt;Services for a potentially life-threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health</td>
<td>Immediately, 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td><strong>Routine Primary Care, Non-urgent appointments</strong>&lt;br&gt;Services for a symptomatic patient who does not require immediate diagnosis and/or treatment</td>
<td>Must offer the appointment within 10 business days (14 calendar days) of request</td>
</tr>
<tr>
<td><strong>Adult physical exams and wellness checks</strong>&lt;br&gt;²</td>
<td>Must offer the appointment within 30 calendar days of request</td>
</tr>
<tr>
<td><strong>Urgent Care appointments that do not require prior authorization</strong>&lt;br&gt;(includes appointment with any physician, Nurse Practitioner, Physician’s Assistant in office)¹&lt;br&gt;Services for a non-life-threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner</td>
<td>Must offer the appointment within 48 hours of request</td>
</tr>
<tr>
<td><strong>Initial Health Assessment</strong>&lt;br&gt;(age 18 years and older)³</td>
<td>Must be completed within 120 calendar days of enrollment</td>
</tr>
</tbody>
</table>

### Specialty Care Provider Accessibility Standards

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Specialist Care, Non-urgent appointments</strong></td>
<td>Must offer the appointment within 15 business days (21 calendar days) of request</td>
</tr>
<tr>
<td><strong>Urgent Care require prior authorization</strong>&lt;br&gt;(SCP)¹&lt;br&gt;Services for a non-life-threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner</td>
<td>Must offer appointment within 96 hours of request</td>
</tr>
</tbody>
</table>

### Ancillary Care Provider Accessibility Standards

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Urgent Appointments</strong>&lt;br&gt;(Diagnosis or treatment of injury, illness, or other health condition)</td>
<td>Must offer the appointment within 15 business days (21 calendar days) of request</td>
</tr>
</tbody>
</table>
## Behavioral Health Accessibility Standards

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Appointment</td>
<td>≤ 15 business days of request (Physicians)≤ 10 business days of request (Non-Physicians)</td>
</tr>
<tr>
<td><strong>Urgent Care appointments</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Must offer the appointment within 48 hours of request</td>
</tr>
<tr>
<td><em>Services for a non-life-threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner</em></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td><em>Services for a potentially life-threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health</em></td>
<td></td>
</tr>
<tr>
<td><strong>Life-Threatening Emergency Care</strong></td>
<td>Immediately, 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td><strong>Non-Life-Threatening Emergency</strong>&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td>Immediately, 24 hours a day, 7 days a week</td>
</tr>
</tbody>
</table>

### After Hours Call Standards

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>After-Hours Care</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>- Automated systems must provide emergency 911 instructions- Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, Behavioral Health Provider, Specialist or covering practitioner, or offer a call-back from the PCP, Behavioral Health Provider, Specialist, covering practitioner or triage/screening clinician within 30 minutes</td>
</tr>
<tr>
<td>Physicians are required by contract to provide 24 hours, 7 days a week coverage to Members.</td>
<td></td>
</tr>
</tbody>
</table>

### Office Wait Time Standards

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In Office Wait Time</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Within 30 minutes</td>
</tr>
<tr>
<td><em>The time after a scheduled medical appointment a patient is waiting to be taken to an exam room to be seen by the practitioner</em></td>
<td></td>
</tr>
<tr>
<td><strong>Speed of Telephone Answer (Practitioner’s Office)</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Within 30 seconds</td>
</tr>
<tr>
<td><em>The maximum length of time for practitioner office staff to answer.</em></td>
<td></td>
</tr>
<tr>
<td><strong>Missed Appointments</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>The time after a missed appointment that a patient is contacted to reschedule their appointment</td>
<td></td>
</tr>
</tbody>
</table>

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<sup>1</sup>DMHC: Timely Access to Care Standards

<sup>2</sup>CMS: MMCM - Provider Network Standards

<sup>3</sup>CMS: MMCM – Telephone Standards

<sup>4</sup>NCQA: Net 2: Accessibility of Services
9. **Potential Quality of Care Events**
Alignment is committed to improving patient safety and promoting a supportive environment for IPA/Medical Groups and Participating Providers to improve patient safety in their practices. Many of the ongoing QM/QI Program measurement activities include safety components, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation. Potential Quality of Care Issues (PQoCs) should be reported securely to QI@ahcusa.com as soon as identified or no later than ninety (90) days from the time of incident to ensure all relevant documentation and/or records can be obtained and a thorough review can be conducted.

10. **Preventive Health Services**
Alignment has adopted age specific preventive health guidelines for the prevention and early detection of illness and disease. The guidelines are based on CMS, CDC, the applicable accreditation organizations, and other nationally recognized organizations. These guidelines are reviewed and revised, as needed, on an annual basis and presented and approved at the QIC. Preventive health guidelines are distributed to Members, IPA/Medical Groups and Participating Providers annually.

All Primary Care Physicians (PCPs) are provided with established current preventative guidelines and are required to adhere to those guidelines in administering health care services to Alignment Members. Alignment may monitor the extent to which PCPs are adhering to these set guidelines.

For your convenience, a copy of the Medicare Preventative Services Quick Reference Information is available at the following link: [MLN Medicare Preventative Services](#).

11. **Member Health Education and Wellness Promotion**
IPAs/Medical Groups and Participating Providers are responsible for meeting the health education needs of Alignment Members. Appropriate brochures and class offerings should be available for Participating Providers to distribute to their Members. IPAs/Medical Groups and Participating Providers are responsible for referring Members to Alignment’s health and wellness resources.

Alignment’s Education Programs are a combination of coordinated and systematic health education. Member outreach and distribution of materials are designed to target a specific health problem or population. Members are identified as eligible for these programs based on specific inclusion criteria for each Program. The Programs are available at no cost to Members.

- Silver and Fit
- Annual Health Assessment

Alignment periodically distributes disease specific educational material to identified individuals, such topics include COPD, CAD, diabetes, preventive care and behavioral health topics.

Alignment offers an Access On-Demand concierge service which includes a nurse advice line with 24/7 access including holidays. Members can call 1-833-242-2223 to receive coordinated concierge services including scheduling doctor appointments and vision, hearing or dental
appointments and to get answers to their common health care related questions. See Section 11, Clinical Programs and Member Resources, for Alignment’s program details and contact information.

12. Cultural and Linguistic Competency

Alignment is committed to Cultural Competency by improving health care through meeting the unique and diverse needs of all its Members. Our set of values, principles, policies, and structures formed will enable the Alignment staff, IPA/Medical Groups and Participating Providers to work effectively cross-culturally.

At Alignment, Cultural Competency will evolve and grow with the comprehensive needs of our network, ensuring that employees, IPA/Medical Groups and Participating Providers understand and value cultural diversity. The employees, IPA/Medical Groups and Participating Providers of Alignment must possess the method, aptitude, and behavior to work cross-culturally in the delivery of healthcare services. Employees, IPA/Medical Groups and Participating Providers must effectively provide services to Members:

- Respective of their cultures, ethnic backgrounds, race and religion;
- In a manner which recognizes, values, affirms and respects the worth of the individual and protects and preserves their dignity;
- Removing all cultural or language barriers by providing or obtaining alternative communication methods, as needed;
- Utilizing culturally sensitive and appropriate educational materials based upon the Member’s race, ethnicity, and primary language spoken;
- Increasing satisfaction with clinical care and services, while decreasing health care disparities in the minority populations we serve;
- Increasing the understanding of health issues, including diagnoses and treatment plans;
- Improving sensitivity to cultural diversity, understanding the Members we serve.
- Development of an IPA/Medical Group and Participating Provider network which mirrors the cultural and linguistic characteristics of Members and provides for culturally appropriate services to Members
- Evaluating Provider offices for oral and written educational material and notices in languages which reflect the Membership
- Emphasizing the importance of Cultural Competency as part of a Provider’s initial in-service;
- Inform Providers of “Cultural Competency” educational opportunities available
- Alternative communication methods which Alignment will arrange for Participating Provider with Members who have potential linguistic barriers

13. Patient Safety

Alignment promotes a comprehensive strategy to assure patient safety by partnering with Members, physicians, practitioners, hospitals, ancillary providers and pharmacies.

Members’ education and risk awareness are central to this ongoing program, along with assessment of Participating Providers patient safety initiatives.
There are ways Participating Providers can develop a culture of patient safety in their practice. Clear communication is key to safe care. Collaboration between Members of the interdisciplinary care team, hospitals, care facilities and the patient are critical. Safe practices can include writing legibly when documenting orders or prescribing and avoiding abbreviations that can be misinterpreted.

Alignment has established a process that allows our organization to respond in a timely manner to reports of immediate threats that may expose patients to health and safety risks, such as suicide threats, spousal abuse and elder abuse, etc. It is the Alignment policy that any employee who, during the normal course of performing assigned duties, observes, suspects, or has knowledge of a patient health and safety risk, shall immediately report the known or suspected instance to any manager or director and appropriate agency.

14. Behavioral Healthcare
The Alignment Quality Management Program scope incorporates both medical and behavioral health care services. Alignment includes a designated behavioral health provider in the QIC as needed to encourage appropriate input on behavioral health issues.

Coordination of care between general medical care and behavioral health care is important to the well-being of Members. Processes are designed to facilitate the exchange of information in an effective, timely and confidential manner. Alignment collaborates with its IPAs/Medical Groups and Participating Providers to assist them and the Member to access all care required.

15. Clinical Practice Guidelines Monitoring and Improvement
The Clinical Practice Guidelines are used to assist IPAs/Medical Groups, Participating Providers and Members in their decisions about appropriate care for specific clinical circumstances. Alignment uses national, state, or specialty recognized guidelines. Alignment systematically reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines disseminated from peer reviewed sources and from organizations like the National Guideline Clearinghouse and U.S. Preventive Services Task Force. Guidelines for diseases and health conditions identified as most noticeable to Alignment Members for the provision of preventive, acute or chronic medical and behavioral health services are regularly reviewed by the Alignment Quality Management Committee to help improve the delivery of health care services to Members. Some of the clinical practice guidelines resources used include:

- The American Diabetes Association
- The National Institute of Health
- The American College of Cardiology
- The Journal of the American Medical Association
- The American Psychiatric Association
- The Global Initiative for Chronic Obstructive Lung Disease
- National Institute of Mental Health
Section 15: Credentialing

Credentialing Overview
Alignment is responsible for validating and assessing the qualifications of network health care Participating Providers and confirming their eligibility to participate in state and federal programs.

Alignment requires its delegated IPAs/Medical Groups and Participating Provider Groups to credential their own providers. An IPA/Medical Group or Participating Provider Group that has been delegated the credentialing responsibility is accountable for credentialing and recredentialing its Providers/Practitioners, even if it delegates all or part of these activities.

1. Non-Discrimination Policy
IPA/Medical Groups and delegated Participating Provider Groups must have policies that state they do not make credentialing, and re-credentialing decisions based solely on the applicant’s race, ethnic/national identity, gender, age, sexual orientation, types of procedures, or types of patients in which the Provider or Participating Provider specializes.

Alignment does perform periodic review of Provider or Participating Provider complaints to determine if there are complaints alleging discrimination, if the IPA/Medical Group and delegated Participating Provider Group maintains a varied credentialing committee Membership and requires those responsible for credentialing decisions to sign an affirmative statement to make decisions in a non-discriminatory manner.

2. Excluded Providers
Alignment expects their IPA/Medical Groups and delegated Participating Provider Groups to ensure that they do not credential those providers/practitioners who are identified on the CMS Preclusion List, with active exclusions by the Office of the Inspector General (OIG) via the List of Excluded Individual/Entities (LEIE), the System for Award Management (SAM), or providers who have opted out of Medicare. Members are never to be held responsible for those services which are not covered due to this circumstance, and the Provider will not bill Members.

3. Notification of Discrepancy
IPA/Medical Groups and delegated Participating Provider Groups are required to have a process in place to notify Provider and Participating Providers in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the Provider’s or Participating Provider’s application and a process to address a provider’s request for correcting erroneous information supplied by primary sources. IPA/Medical Groups and delegated Participating Provider Groups must have a policy and process to address the Providers or Participating Providers right to review information submitted to support their credentialing application, to correct erroneous information, and upon request, to be informed of the status of their credentialing or re-credentialing application.

4. Ongoing Monitoring of Sanctions, Complaints and Quality Issues
All IPA/Medical Groups and delegated Participating Provider Groups are required to monitor Medicare and Medicaid Sanctions as well as State Sanctions, restrictions on licensure or limitations on scope of practice in all states where a practitioner/provider provides care to
Alignment Members. Monitoring must occur initially and throughout the credentialing cycle.

5. **Appeal and Fair Hearing**
   When a decision is made by the IPA/Medical Group’s and delegated Participating Provider Group’s Credentialing Committee to deny credentialing or recredentialing to a provider/practitioner or takes action for quality issues, the IPA/Medical Group and delegated Participating Provider Group must offer the Provider and Participating Provider a formal appeal process.

6. **Non-discrimination**
   IPA/Medical Groups and delegated Participating Provider Groups must have a policy that explicitly describe how it both monitors and prevents discriminatory practices to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner and how it is taking proactive steps to protect against discrimination occurring in the credentialing/recredentialing process. These practices may include, but are not limited to, periodic audits of credentialing files and Provider and Participating Provider complaints, as well as documenting a heterogeneous credentialing committee’s decision to sign a statement affirming that it does not discriminate.

7. **Credentialing Committee**
   IPA/Medical Groups and delegated Participating Provider Groups must establish a peer review process by establishing a Credentialing Committee that includes representation from a range of Participating Providers. The credentialing process can encompass separate review bodies for each specialty (e.g., Practitioner, dentist, and psychologist) or a multidisciplinary committee with representation from various types of Practitioners and specialties.

   An IPA/Medical Group and delegated Participating Provider Group must notify the Provider and Participating Provider, in writing, of any adverse actions taken regarding the Provider or Participating Provider. The IPA/Medical Group and delegated Participating Provider Group must also notify Alignment of its action taken as soon as the IPA/Medical Group and delegated Participating Provider Group has knowledge of the adverse action. The IPA/Medical Group and delegated Participating Provider Group must require the Provider and Participating Provider to notify the IPA/Medical Group and delegated Participating Provider Group of any adverse action taken against the Provider and Participating Provider within 14 days of knowledge. For each adverse event, an IPA/Medical Group and delegated Participating Provider Group must document the review, actions taken, monitoring and follow through of the process, including timeframes and closure.

   IPA/Medical Group and delegated Participating Provider Group must promptly notify Alignment in writing if any contracted Participating Provider has any adverse action or criminal action taken against him/her. This must be no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of Participating Providers. Failure to do so may result in the removal of the Participating Provider from Alignment’s network.

   Providers and Participating Providers must not have limitations or restrictions on hospital privileges. Alignment’s Credentialing Committee will make decisions based on review of any limitations or restrictions that have been imposed. If a facility should require a proprietary release form to release information on a Provider’s or Participating Provider’s hospital status,
the prospective Provider or Participating Provider will be required to complete the required proprietary form. Failure to do so will be considered non-compliance with the credentialing/recredentialing process.

IPA/Medical Group and delegated Participating Provider Group must review, investigate and take appropriate action for any adverse events or criminal actions taken against a Participating Provider including, but not limited to, fair hearings and reporting to appropriate authorities as Alignment retains the right to approve, close panels to new Membership, and/or terminate Participating Providers at all times.

Alignment reserves the right to coordinate, consolidate and participate in any IPA/Medical Group and delegated Participating Provider Group Participating Provider disciplinary hearing. Hearings must be conducted in accordance with Alignment Policy and Procedures, and California Business and Professions Code Section 805.

IPA/Medical Group and delegated Participating Provider Group must advise Alignment of any changes to its credentialing and recredentialing policies and procedures, processes, delegation or sub-delegation, and criteria within thirty (30) days of the change. If Alignment deems the changed items do not comply with Alignment, NCQA, DHCS, and/or CMS requirements, Alignment will notify the IPA/Medical Group and delegated Participating Provider Group immediately. The IPA/Medical Group and delegated Participating Provider Group will have 30 days to comply. If the IPA/Medical Group or delegated Participating Provider Group does not comply, Alignment may de-delegate credentialing and assume responsibility for all or part of the credentialing functions.

IPA/Medical Group and delegated Participating Provider Group must provide monthly and quarterly reports to Alignment following the end of each report month with accurate and complete delegate Provider and Participating Provider data. IPA/Medical Group and delegated Participating Provider Group must provide Board certification status and Board expiration date, if applicable, when adding a Provider to Alignment’s network and any updates.

- Use the standardized ICE format and Excel grid to include the following:
- Number of adds/deletes of PCPs, SCP’s, Mid-levels (i.e., MDs, DOs, P.A’s, N.P’s etc.)
- Number of adds/deletes of HDO (i.e., MDs, and DOs, etc.)
- Numbers of adds/deletes of independent Practitioners (i.e., DCs, DPMs, etc.)
- Any new or revised policies and procedures, additions of a computer system, CVO
- Practitioners termed for quality issues

IPA/Medical Group and delegated Participating Provider Group must ensure that Providers and Participating Providers and all of their contracted sites are reviewed in accordance with Alignment, NCQA, DHCS and CMS requirements. All Participating Providers must have a current and valid (i.e., within three (3) years of the date of initial credentialing/recredentialing) full scope site review at the time of initial credentialing/recredentialing. Providers contracted only for Medicare must undergo a medical record review.

8. **Practitioner’s Rights**
IPA/Medical Group and delegated Participating Provider Group must require all Providers and Participating Providers to sign a Providers Rights Notification Form, which advises Providers and Participating Providers of their rights to review information obtained for the purpose of
evaluating Provider’s and Participating Provider’s initial credentialing, or re-credentialing application. This includes non-privileged information obtained from an outside source (i.e., malpractice insurance carriers, state licensing boards, NPI bank), but does not extend to review of information references or recommendations protected by law from disclosure.

9. Policies and Procedures
IPA/Medical Group and delegated Participating Provider Group must have policies and procedures that address the Credentialing of Providers, Practitioners, Non-Practitioner health care professionals, licensed independent Practitioners, UM Practitioners making medical decisions and HDOs that fall within its scope of credentialing. IPA/Medical Group and delegated Participating Provider Group will establish standards, requirements and processes for the practitioner/ HDOs performing services for Alignment Members to ensure that Providers and HDOs are qualified, licensed and/or certified consistent with Alignment, NCQA, DHCS, and CMS requirements. These standards, requirements and processes are applicable whether or not credentialing and recredentialing activities are delegated.

10. Provider/Practitioner Credentialing
A. Provider Credentialing Overview
Alignment requires IPA/Medical Groups and delegated Participating Provider Groups to credential all Providers and Participating Providers who are providing health care services to Alignment Members.

The IPA/Medical Group and delegated Participating Provider Group must have methods in place to ensure Providers/Practitioners do not see Members until the credentialing process is completed and he/she is approved for participation. An active, unrestricted, current license must always be maintained to provide patient care to Alignment Members.

IPA/Medical Groups and delegated Participating Provider Groups who utilize the services of a Physician Assistant (PA) or Advanced Registered Nurse Practitioner (ARNP) who provide direct patient care to an Alignment Member under the supervision of a Participating Provider are also required to undergo the credentialing process. Scope of practice is limited to the rules and regulations established by the state in which they practice, and the policies and procedures of Alignment.

Alignment requires IPA/Medical Groups and delegated Participating Provider Groups to Credential/Recredential the following types of practitioners/providers:

<table>
<thead>
<tr>
<th>Doctor of Medicine (M.D.)</th>
<th>Marriage Family Child Counselor/ (Marriage Family Therapist (M.F.C.C./ M.F.T.)</th>
<th>Speech Language Pathologist (SLP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor of Osteopathy (D.O.)</td>
<td>Licensed Clinical Social Worker (LCSW)</td>
<td>Audiologist (AuD)</td>
</tr>
<tr>
<td>Doctor of Addiction Medicine (M.D.)</td>
<td>Licensed Professional Clinical Counselor (LPCC)</td>
<td>Dietician/Nutritionist</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine (D.P.M.)</td>
<td>Post-Master Nurse Practitioner Diploma (PMNP)</td>
<td>Clinical Nurse Specialist (CNS)</td>
</tr>
<tr>
<td>Doctor of Chiropractic (D.C.)</td>
<td>Nurse Practitioner (NP/ARNP)</td>
<td></td>
</tr>
<tr>
<td>Doctor of Optometry (O.D.)</td>
<td>Physician Assistants (PA)</td>
<td></td>
</tr>
<tr>
<td>Doctor of Acupuncture (ACU)</td>
<td>Educational Psychologist (M.A/Ph.D.)</td>
<td></td>
</tr>
</tbody>
</table>
All covering practitioners (locum tenens) or temporary providers with an independent relationship with the IPA/Medical Group and delegated Participating Provider Group must also be credentialed if they serve in this capacity for more than ninety (90) calendar days.

### B. Recredentialing
IPA/Medical Group and delegated Participating Provider Group must perform recredentialing at least every thirty-six (36) months in accordance with regulatory requirements, accreditation and Alignment’s policies and procedures. IPA/Medical Group and delegated Participating Provider Group should have a process in place that requires the Participating Provider complete a re-credentialing application, along with the requested documentation. IPA/Medical Groups and delegated Participating Provider Groups must ensure that recredentialing files are reviewed by the Credentialing Committee to approve, deny, or modify the Participating Provider status according to established policies. The Participating Provider will be notified of the outcome by way of a letter.

### C. Provider Credentialing Requirements
The IPA/Medical Group and delegated Participating Provider Group must have a policy outlining the credentialing requirements for providers/practitioners and HDOs. The IPA/Medical Group and delegated Participating Provider Group must require a Provider and Participating Provider to complete and submit a credentialing application or participate with the Council for Affordable and Quality Healthcare (CAQH). For information on CAQH please contact the CAQH ProView Support Desk at 1-888-599-1771. Or access CAQH’s website at [https://www.caqh.org/solutions/caqh-proview-faqs](https://www.caqh.org/solutions/caqh-proview-faqs).

IPA/Medical Groups and delegated Participating Provider Groups will ensure all information is validated through primary or secondary sources as required by regulatory, accreditation or Alignment requirements. Items for validation include, but are not limited to:

- A current and valid license to practice
- A valid DEA or CDS certificate, if applicable
- Board certification status, if applicable
- Education and training
- Work history
- A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner
- The Attestation Questions and Information Release/Acknowledgment forms must be signed, and dated, by the applicant. A signature/date stamp is not acceptable to authenticate these documents. An attestation that includes:
  - Reasons for any inability to perform the essential duties of the position, with or without accommodation
Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage
- The correctness and completeness of the application
- The past five (5) years of work history must be documented and must include the beginning and ending month and year for each work experience within that five (5) years. Any gaps of over six (6) months require an explanation from the applicant.

11. Healthcare Delivery Organization (HDO) Credentialing Requirements

A. HDO Credentialing Overview
IPA/Medical Groups and delegated Participating Provider Groups must ensure all contracted HDOs meet the credentialing criteria and the standards and requirements of the National Committee on Quality Assurance (NCQA®), and Centers for Medicare & Medicaid Services (CMS) and be approved by the Credentialing Committee. All HDOs providing health care services to Alignment Members must be credentialed prior to caring for Alignment Members.

IPA/Medical Groups and delegated Participating Provider Groups must ensure that HDO are assessed initially and at least every thirty-six (36) months thereafter. The following is a list of organizational providers and other health care professionals that Alignment requires credentialing, re-credentialing and ongoing monitoring by the IPA/Medical Group and delegated Participating Provider Group.

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Comprehensive Outpatient Rehabilitation Facilities</th>
<th>Portable X-Rays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Agencies</td>
<td>Outpatient Physical Therapy and Speech Pathology Therapy providers</td>
<td>Rural Health Clinics</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>Providers of End Stage Renal Disease</td>
<td>FQHC</td>
</tr>
<tr>
<td>Free-Standing Surgical Centers</td>
<td>Durable Medical Equipment</td>
<td>Home Infusion Care</td>
</tr>
<tr>
<td>Behavioral Health Facilities-inpatient, residential or ambulatory setting</td>
<td>Outpatient Rehabilitation Centers</td>
<td>Urgent Care Centers</td>
</tr>
<tr>
<td>Laboratories</td>
<td>Outpatient Diabetes Self-Management</td>
<td>Portable X-Rays</td>
</tr>
</tbody>
</table>

B. HDO Credentialing Requirements
IPA/Medical Groups and delegated Participating Provider Groups must ensure there are policies and processes ensure that HDOs complete and submit a credentialing application.

The following items must be included in the assessment during the HDO credentialing process. The IPA/Medical Group and delegated Participating Provider Group must ensure that information provided is verified from primary and/or secondary sources, and all Providers must sign the “Attestation and Disclosure Statement,” in addition to the “Authorization and Release.”
• Provider is in good standing with state and federal regulatory bodies
• Provider has been reviewed and approved by an accrediting body
• Confirmation of approval by an accrediting body or completion of recent onsite quality assessment if the provider is not accredited. State or federal quality reviews can be used in lieu of an onsite visit.

C. HDO Re-Credentialing
IPA/Medical Group and delegated Participating Provider Group must have policies and process in place that outline HDO re-credentialing at least every thirty-six (36) months in accordance with regulatory requirements, accreditation and Alignment’s policies and procedures. Policies should include that HDOs complete a re-credentialing application, along with the requested documentation, and the Credentialing Committee must approve, deny, or modify the HDO status according to established policies. The Participating Provider must be notified of the outcome by way of a letter.

12. Oversight of Delegated Credentialing
Delegation is a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although the organization can delegate the authority to perform such a function, it cannot delegate the responsibility for assuring that those functions are performed appropriately.

Alignment requires its IPA/Medical Groups and delegated Participating Provider Groups to credential their own providers; however, Alignment is responsible for monitoring all IPA/Medical Group’s and delegated Participating Provider Group’s credentialing and recredentialing activities. An IPA/Medical Group and delegated Participating Provider Group must pass Alignment’s Credentialing Department’s Due Diligence (pre-delegation) credentialing audit to be delegated with the credentialing responsibility. Otherwise, Alignment Credentialing Department is responsible for an IPA/Medical Group’s and delegated Participating Provider Group’s credentialing activities. Regardless of IPA/Medical Group’s and Participating Provider Group’s credentialing delegation status, Alignment always retains the right to approve new Providers, Practitioners and sites, as well as to terminate or suspend individual Participating Providers based on credentialing issues.

An IPA/Medical Group and delegated Participating Provider Group that has been delegated the credentialing responsibility is accountable for credentialing and recredentialing its Providers and Participating Providers, even if it delegates all or part of these activities. If the credentialing and recredentialing activities are delegated, there must be evidence of oversight of the delegated activity. There must be annual evidence of a mutually agreed upon delegation agreement. The delegation agreement must meet all the elements of NCQA’s standards. As a note, CMS does not recognize NCQA certified CVOs. As such, all files are subject to full file CMS review.
Section 16: Prescription Drug Benefit and Pharmacy Services

Overview
Alignment Health Plan is a Medicare Advantage Prescription Drug Plan (MAPD), offering comprehensive pharmacy services, including formulary management, clinical programs, and pharmacy network management. Alignment contracts a Pharmacy Benefit Management (PBM) company to administer its Part D prescription drug benefit.

1. Formulary
Alignment is committed to covering safe and effective prescription drugs on our formulary – a list of drugs covered by Alignment. The formulary is reviewed and approved by a Pharmacy and Therapeutics (P&T) Committee, which consists of a group of practicing physicians and pharmacists who have expertise in pharmacology and therapeutics. The formulary meets the requirements set by Medicare and has been approved by the Centers for Medicare & Medicaid Services (CMS).

Prescribers are encouraged to adhere to prescribing drugs on formulary, whenever possible, and to review drugs for any applicable utilization management requirements, such as prior authorization, step therapy, and quantity limits prior to prescribing. See the table below to access Health Plan Formularies.

2. Part D Resources
Prior authorization criteria, coverage determination forms, pharmacy directory, and other resources for the Part D prescription drug plan are available at the websites below:

<table>
<thead>
<tr>
<th>Formularies and Part D Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
</tr>
<tr>
<td>FL</td>
</tr>
<tr>
<td>NC Humana</td>
</tr>
<tr>
<td>NC FirstMedicareDirect</td>
</tr>
</tbody>
</table>

3. Vaccines
Alignment provides coverage for Part D vaccines, such as the Shingles vaccine. To improve vaccine access and reduce out-of-pocket costs to Members, prescribers are encouraged to provide Members with prescriptions for Part D vaccines to be dispensed and, if applicable, administered at a network retail pharmacy. Members pay the pharmacy the required Part D copayment.

Alternatively, if Members pay the full out-of-pocket charge for Part D vaccines in office to prescribers, Members must submit a claim for reimbursement from the plan. If the prescriber’s charges exceed the plan’s allowable charge, the Members must pay the difference.

Some vaccines are considered medical benefits. Flu shots, pneumonia vaccines, and Hepatitis B vaccines (for patients at high or intermediate risk) are covered under Medicare Part B. Vaccines directly related to the treatment of an injury or direct exposure to a disease...
or condition are also covered under Part B.

4. **Medication Therapy Management Program**
   Alignment offers a free voluntary medication therapy management program (MTMP) for eligible Members that have multiple qualifying medical conditions, take many prescription drugs, and have high drug costs that meet a certain dollar threshold. The MTMP offers a comprehensive medication review of all Members’ medications and discusses with Members how to better manage their conditions with drug therapy. It is designed to ensure that covered Part D drugs prescribed to Members, are appropriately used to optimize therapeutic outcomes through improved medication use, reduce the risk of adverse events, and improve medication adherence. The MTMP eligible Members prescriber(s) are also provided with recommendations of drug therapy changes to resolve medication related problems or optimize therapy. We also perform targeted drug utilization reviews quarterly and may contact Members or their providers directly if there are questions or recommendations for their medications.

5. **Drug Utilization Reviews**
   We conduct drug utilization reviews for Members to help make sure that they are getting safe and appropriate care. These reviews are especially important for Members who have more than one provider who prescribes their drugs. We review prescription records on a regular basis to check for potential medication therapy problems, such as duplicate therapy, drug interactions, and safety concerns. If we identify a possible problem, we will work with providers to correct the problem.

6. **Opioid Overutilization Policies**
   The Centers for Medicare and Medicaid Services (CMS) finalized new opioid policies for Medicare drug plans starting on January 1, 2019. These new Medicare Part D opioid overutilization policies encourage interdisciplinary collaboration as well as care coordination among Part D plans, pharmacies, prescribers, and patients in improving opioid utilization management, preventing opioid misuse, reducing serious adverse risks, and promoting safer prescribing practices. The new policies include improved safety alerts when opioid prescriptions are dispensed at the pharmacy and drug management programs for patients determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs.

6a. **Opioid Safety Alerts**
   In accordance with CMS policy, Alignment implements opioid safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing a medication to prevent the unsafe utilization of drugs. Prescribers are expected to respond to pharmacists’ outreach in a timely manner and give the appropriate training to on-call prescribers when necessary to resolve opioid safety edits expeditiously and avoid disruption of therapy. To avoid a prescription from being rejected at the pharmacy, prescribers may also proactively request a coverage determination in advance of prescribing an opioid prescription.

<table>
<thead>
<tr>
<th>Opioid Safety Alert</th>
<th>Prescriber’s Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seven-day supply limit for opioid naïve patients</td>
<td>Patient may receive up to a 7 days supply or request a coverage determination for full days supply as written.</td>
</tr>
<tr>
<td>Medicare Part D patients who have not filled an opioid prescription recently (such</td>
<td>The physician or other prescriber has the</td>
</tr>
<tr>
<td>Opioid Safety Alert</td>
<td>Prescriber’s Role</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>as within the past 60 days) will be limited to a supply of 7 days or less.</td>
<td>right to request a coverage determination on patient’s behalf, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.</td>
</tr>
<tr>
<td>Limiting the amount dispensed with the first opioid prescription may reduce the risk of a future dependency or overuse of these drugs.</td>
<td>Prescriber only needs to attest to plan that the days supply is the intended and medically necessary amount.</td>
</tr>
<tr>
<td></td>
<td>Subsequent prescriptions written by prescribers are not subject to the 7 days supply limit, as the patient will no longer be considered opioid naïve.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opioid care coordination alert at 90 morphine milligram equivalent (MME)</th>
<th>Regardless of whether individual prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative MME per day across all of their opioid prescription(s) reaches or exceeds 90 MME and there is utilization from more than two pharmacies and two prescribers.</td>
<td>The prescriber who writes the prescription will trigger the alert and will be contacted even if that prescription itself is below the 90 MME threshold.</td>
</tr>
<tr>
<td>The prescriber will be contacted to resolve the alerts and to be informed of other opioid prescribers or increasing level (MME) of opioids.</td>
<td>Once a pharmacist consults with a prescriber on a patient’s prescription for a plan year, the prescriber will not be contacted on every opioid prescription written for the same patient after that unless the plan implements further restrictions.</td>
</tr>
<tr>
<td>This is not a prescribing limit. Decisions to taper or discontinue prescription opioids are individualized between the patient and prescriber.</td>
<td>On the patient’s behalf, the physician or other prescriber has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concurrent opioid and benzodiazepine use or duplicative long-acting opioid therapy</th>
<th>The pharmacist will conduct additional safety reviews to determine if the patient’s opioid use is safe and clinically appropriate. The prescriber may be contacted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The alerts will trigger when opioids and benzodiazepines are taken concurrently or if on multiple duplicate long-acting opioids.</td>
<td></td>
</tr>
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6b. **Drug Management Programs**

If a patient is identified as being potentially at-risk for prescription drug abuse, as part of the case management process, providers who prescribed opioids and benzodiazepines will be contacted for clinical information needed to make a decision on whether a patient is at-risk and should have his or her access to frequently abused drugs limited. Prescribers are expected to respond if contacted for information about a patient's prescription use history.
Alignment’s Star team works with IPA/Medical Groups and other Participating Providers towards the common goal of achieving a 5 Star rating from the Center for Medicare and Medicaid Services (CMS). These ratings are based on HEDIS® data, CAHPS survey, HOS survey, pharmacy data, and administrative outcomes. The Star Rating program supports CMS’s goal to improve the level of accountability for the care provided by physicians, hospitals, and IPA/Medical Group and other Participating Providers.

For best practices, improvement ideas, and additional information around the Star Program, email stars@ahcusa.com.

For additional information, please view: Medicare Stars Program. This detailed guide is an invaluable resource for learning about the Star measures, data requirements, and improvement processes.
Overview of Risk Adjustment
The Centers for Medicare & Medicaid Services (CMS) pays Health Plans for the expected costs of treating a Member based on their overall health status and demographic information. A portion of the cost is determined by the Member’s diagnoses. Hierarchical Condition Categories (HCC) are relevant to the Member. HCCs are comprised of most chronic conditions and a few acute conditions. All conditions the patient has and those that require care and treatment or impact the overall care and treatment of the patient should be documented and reported at the time of the encounter. The Member’s score is based on the validated codes supported by the documentation submitted by our IPAs/Medical Groups and Participating Providers.

Inappropriate coding, which does not reflect the severity of illness and quality of care, can result in inaccurate identification of Member needs and impact reimbursement for the patient’s overall care. CMS requires that each disease state and co-morbidity be documented at least once, every year. Starting every January 1st, the IPA/Medical Groups and Participating Providers must redocument the Member’s conditions. To improve the accuracy of medical coding and its supporting documentation, Alignment will provide its Primary Care Physicians with the following:

1. A current list of the Primary Care Physician’s assigned Alignment Members
2. The Member’s profile which shows the Member’s diagnosis history, potential undiagnosed disease states, current medication and lab information, and any CMS quality measures the Member may be eligible
3. The guidelines for acceptable CMS regulated coding and documentation practices

1. Documentation Requirements
The four (4) key elements of proper documentations, each of which must be included in the documentation in order to be CMS compliant:

1. A diagnosis documentation supporting a face-to-face encounter
2. Primary diagnosis or reason for encounter
3. The current status of the Member’s conditions, reported as stable, improved or worsening
4. Each condition addressed and/or treated, or those impacting the overall care and treatment of the patient must have a corresponding treatment plan. CMS requires that all codes reported on the encounter are supported by the documentation.
2. **Risk Adjustment Submission**
Providing the best care for Medicare Members with chronic diseases is crucial. In order to serve the greatest good for health care and cost containment, complete data must be gathered through the documentation of services provided to each Member at every visit. There are a number of reasons why capturing this information is important:
- System efficiencies across IPAs/Medical Groups and Participating Providers
- Care coordination
- Managing transitions across settings
- Share clinical information
- Reduce duplicative tests and procedures
- Improve processes and outcomes
- Increase guideline compliance
- Avoid unnecessary inpatient admissions and readmissions as well as emergency room visits
- Substitute outpatient services for inpatient services
- Less invasive procedures vs more invasive procedures
- Shorten length of stay

3. **Risk Adjustment Program**
The CMS risk adjustment model is used to calculate risk scores to adjust capitated payments for Members enrolled in Medicare Advantage (MA) Heath Plans and certain Medicare demonstrations. The overall goals are to mitigate the impacts of potential adverse selection and stabilize premiums.

CMS calculates a Value Modifier that adjusts the Medicare Physician Fee Schedule payments upward, downward or not at all, and is applied at the Taxpayer Identification Number (TIN) level to physicians. In the absence of risk adjustment, TINs treating a large number of beneficiaries with multiple chronic conditions could perform worse on certain quality and cost measures than TINs with relatively healthy Members, due at least in part, to differences in their Member population. For more information of Value-Based Payment Modifiers, refer to: [CMS.gov Centers for Medicare & Medicaid Services Professional Paper Claim Form: Value-Based Payment Modifier](https://www.cms.gov).

<table>
<thead>
<tr>
<th>Risk Score Run</th>
<th>Dates of Service</th>
<th>Deadline for Submission of Risk Adjustment Data</th>
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<tbody>
<tr>
<td>2019 Initial (RAPS &amp; EDS)</td>
<td>07/01/2017 – 06/30/2018</td>
<td>09/07/2018</td>
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<tr>
<td>2018 final Run (RAPS &amp; EDS)</td>
<td>01/01/2017 – 12/31/2017</td>
<td>01/31/2019</td>
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<tr>
<td>2019 Mid-Year (RAPS &amp; EDS)</td>
<td>01/01/2018 – 12/31/2018</td>
<td>03/01/2019</td>
</tr>
<tr>
<td>2020 Initial (RAPS &amp; EDS)</td>
<td>07/01/2018 – 06/30/2019</td>
<td>09/06/2019</td>
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Overview
Alignment’s Finance Department monitors its IPA/Medical Groups to assure they are financially viable, financially solvent and that they have the ability to pay timely claims submitted by their contracted providers on behalf of Alignment Members, and in accordance with law. This policy encompasses all IPA/Medical Groups to whom financial risk has been delegated contractually by Alignment.

1. Financial Requirements
IPA/Medical Group is required to maintain adequate financial reserves, working capital and contingency plans sufficient for prudent and sound operations and that are satisfactory to Alignment and government agencies. Alignment will monitor the financial viability of its contracted entities. For the purpose of this Section, Financial Statements shall be defined as copies of audited annual and audited or unaudited quarterly financial statements, which shall include a balance sheet, statement of income and a statement of cash flow (“Financial Statements”) prepared in accordance with generally accepted accounting principles (“GAAP”). All such Financial Statements shall be certified by the IPA/Medical Group’s Chief Financial Officer as accurately reflecting the financial condition of IPA/Medical Group. IPA/Medical Group shall provide to Alignment no later than forty-five (45) calendar days following the end of each of IPA/Medical Group’s fiscal quarters, quarterly Financial Statements for the immediate prior three (3) month period. Annually IPA/Medical Group shall provide Alignment with copies of IPA/Medical Group’s audited annual Financial Statements for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm which completed the audit on these Financial Statements. Said Financial Statements shall be provided to Alignment no later than one hundred fifty (150) calendar days after close of IPA/Medical Group’s fiscal year. Alignment also agrees to maintain these statements in a confidential manner. IPA/Medical will provide the following:

a. A statement as to whether or not it has estimated and documented, on a monthly basis, its liability for Incurred But Not Reported (IBNR) claims pursuant to a method specified in Title 10, CCR Section 1300.77.2. If the estimated and documented liability has not met the requirement in any way, the statement shall be accompanied by a report that describes in detail the nature of the reason for the deficiency, and action taken to correct the deficiency and the results of that action. This document is the Corrective Action Plan (“CAP”).

b. A statement as to whether or not the IPA/Medical Group has at all times during the quarter maintained a Positive Tangible Net Equity (TNE) and positive working capital according to GAAP. If not, the statement shall be accompanied by a report that describes in detail the nature of the deficiency, the reason for the deficiency, and action taken to correct the deficiency and the results of that action. The IPA/Medical Group may reduce its liabilities for purposes of calculating its TNE and working capital in a manner allowed by the Safety Code 13775.4(b)(1)(B). With reference to Health and Safety Code 13775.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it
is guaranteed to all persons or entities, or a TNE in an amount approved and met the compliance guideline by the Department of Managed Health Care.

c. Written verification attached to each report stating that the report is true and correct to the best knowledge of the Financial Officer of the IPA/Medical Group and is signed by the Financial Officer.

Outcome and financial status of the IPA/Medical Group will be discussed at Alignment’s Delegation Oversight Committee (DOC) meeting held quarterly.

2. **Shared Risk Pool Settlements**
The annual Risk Pool Settlement Reports are prepared by Alignment’s Finance department and forwarded to each IPA/Medical Group electronically by April 30th of the following calendar year. The reports contain the Risk Pool Settlement Summary, Claims Data and Part B drugs data. The IPA/Medical Group has thirty (30) days following receipt of notice to report any inquiries or any disagreement with the reports.