Alignment Health Plan®

JULY 2026

PROVIDER NEWSLETTER

TO LEARN MORE about how we can help your patients, please contact your local Alignment Health Plan Provider Relations Representative at **(844) 361-4712 (TTY: 711)** or email us at **ProviderRelations@ahcusa.com**.

ALIGNMENT HEALTHCARE NAMED TO

THE FORTUNE 1000 2026 LIST FOR SECOND CONSECUTIVE YEAR

We are pleased to share we have been named to the Fortune 1000® 2026 List, for the second consecutive year, recognizing us among the largest public companies in the United States by revenue.

Alignment ranked No. 791, rising 196 positions from last year:

"We are honored to be recognized on the Fortune 1000 list for the second consecutive year and to have been named earlier this year to the Fortune *World's Most Admired Companies™ list," said John Kao, chairman and CEO. "Together, these recognitions reflect both the strength of our business and how we are building it – delivering high-quality care and meaningful benefits in a way that remains affordable for the seniors we serve."*

This milestone signals our continued growth and the increasing number of people choosing Alignment for their care.

We remain focused on what matters most: putting seniors first, staying connected to their needs and delivering care that helps them stay healthier.

Founded more than a decade ago, Alignment now serves approximately 284,800 seniors across five states, with 100% of our members enrolled in 4-star or higher-rated plans for the second year in a row.

To learn more about this recognition, visit **https://fortune.com/fortune500/.**

The Fortune 1000 list is an annual ranking of the largest public U.S. companies by revenue. Alignment was one of seven companies included in Fortune's Healthcare: Insurance and Managed Care category and was the only company exclusively focused on Medicare Advantage. The full list is available at https://fortune.com/fortune500.

ALIGNMENT HEALTH PLAN Q1 2026 EARNINGS

We are pleased to share our Q1 2026 results, which mark a solid start to the year and continuous progress in building a disciplined, durable enterprise. This quarter is defined not by a single metric, but by our focused, responsible execution, driving year over year improvements in profitability. As Alignment Health Plan enters our fifth year as a public company, Q1 proved that our strengthened operating foundation is translating into sustainable, repeatable performance.

284,800

MEMBERS

As of March 31, 2026

30.9%

GROWTH

Year Over Year

+

88.2%

MBR

(Medical Benefits Ratio) An improvement of 20 basis points year over year

WHAT THIS QUARTER TELLS US

In Q1, Alignment delivered substantial growth year-over-year. This success was driven by concrete execution across sales, clinical operations and cost management. We met or exceeded guidance across all key proving our results stem from disciplined operations rather than seasonality. This out performance sets a new, consistent standard for Alignment moving forward.

At the same time, progress is not linear. MBR requires active, hands-on management as we scale. While our year over year MBR improved, maintaining control requires tighter clinical execution, faster operational follow-through and closer coordination across teams and markets.

We achieved this progress while continuing to invest in our people, process and technology—a balance built over years of work to embed earnings potential into the business. As we grow, the margin for error narrows. Continued success will depend on disciplined execution every day, in every function, to deliver a consistent and reliable experience for the members who rely on us.

WHY THIS MATTERS

- **For our members, it means care they can depend on.**
- **For our partners, it means consistency and trust.**
- **For us, it means we are building something that lasts – if we stay focused.**

ALIGNMENT HEALTH PLAN RECEIVES

2026 PQA EXCELLENCE IN QUALITY AWARD

Only 1.6% of Medicare Advantage Prescription Drug contracts earned this prestigious recognition—our seventh win marks continued excellence in medication safety and adherence.

We are excited to share that Alignment Health Plan has once again been recognized with the Excellence in Quality Award from the Pharmacy Quality Alliance (PQA). Out of 613 eligible Medicare Advantage prescription drug (MAPD) contracts nationwide in 2026, only 1.6% earned this distinction, placing us among a very select group of high-performing plans.

This recognition reflects the leadership and sustained work of our pharmacy team. Their unwavering focus on medication safety, adherence and appropriate use for the members we serve–in close partnership with our clinical, operational and member-facing teams–continues to drive outcomes that matter for both our members and our business.

The 2026 PQA Laura Cranston Excellence in Quality Award recognizes MAPD plans that achieved a minimum 4.5-star Part D summary rating and a perfect 5-star rating on all five PQA medication measures used in the Centers for Medicare and Medicaid Services' (CMS) Star Ratings Program. Each year, CMS evaluates plans based on a 5-star rating. Alignment earned a perfect rating on the following five PQA measures:

- **Medication adherence for diabetes medications**
- **Medication adherence for hypertension (RAS antagonists)**
- **Medication adherence for cholesterol (statins)**
- **Medication therapy management program completion rate for comprehensive medication reviews**
- **Statin use in people with diabetes**

Since 2006, PQA has played a critical role in advancing medication safety and quality for CMS, with the implementation of the PQA measurements. This recognition continues to be a meaningful benchmark of excellence across the industry. Earning this award for the seventh time speaks to the consistency and dedication across our teams to delivering high-quality, personalized care.

Visit our **newsroom** for more information.

UPDATE TO SUPPLEMENTAL HCC DATA SUBMISSION REQUIREMENTS

Under the CMS Calendar Year 2027 guidelines, the risk adjustment data submission process is changing. CMS has mandated that all submitted HCC diagnoses must be substantiated by valid encounter or claim submissions.

Effective April 6, 2026:

- HCC diagnoses will only be accepted if received through standard claims/ encounter data or through LINKED Supplemental Data submissions.
- **To be LINKED, all supplemental HCC data submissions must include the associated claim number that links each diagnosis to its originally submitted claim or encounter.**
- Supplemental HCC data submissions that do not include an original claim number **WILL NOT be accepted**. Such incomplete submissions will be rejected and returned to the submitter for correction, which may negatively impact RAF for the provider group.

This requirement ensures that all supplemental diagnoses:

- Align with the current CMS guidance, which eliminates HCCs that are not submitted on a valid claim/encounter or linked to a previously submitted claim/encounter; and
- Can be validated under RADV audit protocols

This change may require updates to internal processes. Our team is committed to supporting a smooth transition and is available to provide guidance on submission requirements.

Thank you for your continued partnership and commitment to compliant and accurate risk adjustment practices. These updates are critical to maintaining compliance with CMS regulations and ensuring the integrity of our claims and encounter data submissions.

Please reach out to us at **(844) 361-4712** if you have questions or contact your designated Network contact with any questions or to discuss implementation details.

Reference: **CY 2027 FINAL Notice**

CLOSE THE GAP: CAPTURE BLOOD PRESSURE AND A1C BASELINES NOW!

Patients missing baseline blood pressure reading and/or hemoglobin A1c present a clear actionable opportunity to strengthen preventive care.

What Providers Can Do:

Review your panel for patients without a documented baseline blood pressure reading or A1c on file and schedule a screening during their next routine visit.

Why It Matters:

Baseline blood pressure readings are essential for monitoring and managing hypertension. For patients with diabetes, baseline A1c helps identify prediabetes and supports ongoing diabetes management.

Completing these screenings during Annual Wellness Visits, and other routine visits can improve preventive care, support chronic disease management and positively impact quality performance.

MEDICARE GLP-1 BRIDGE PROGRAM UPDATE

EFFECTIVE JULY 1, 2026

Beginning July 1, 2026, the Centers for Medicare & Medicaid Services (CMS) will launch a **temporary demonstration program designed to expand access to certain GLP-1 medications.** This applies to eligible Medicare beneficiaries who do not currently qualify for coverage under their Medicare Part D benefit.

Through the Medicare GLP-1 Bridge Program, eligible beneficiaries may access select GLP-1 medications, including Foundayo®, Wegovy® (injection and tablets) and Zepbound® (KwikPen®), for $50 per month from July 1, 2026, through December 31, 2027.

About the Program

Who Should Use the Bridge Program?
The Bridge Program is intended for members who do not qualify for GLP-1 medication coverage through Medicare Part D.

Access GLP-1 medications through Medicare Part D
Members who have any of the following conditions should pursue coverage through their Part D prescription drug plan, not the Bridge Program:

- Moderate-to-severe obstructive sleep apnea (OSA)
- Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with moderate-to-advanced fibrosis
- Type 2 diabetes
- Established cardiovascular disease when the medication is prescribed to reduce the risk of major adverse cardiovascular events

Bridge Program Clinical Eligibility and Access
For members who do not qualify for Medicare Part D coverage, the GLP-1 Bridge Program may be available when the medication is prescribed for weight reduction and maintenance in combination with ongoing lifestyle modifications, including structured nutrition and physical activity, consistent with FDA-approved labeling.

In addition, members must meet one of the following criteria:

- BMI 35 or greater OR
- BMI 30 or greater and at least one of the following:
  - Heart failure with preserved ejection fraction (HFpEF)
  - Uncontrolled hypertension
  - Chronic kidney disease (Stage 3a or higher) OR
- BMI 27 or greater and at least one of the following:
  - Prediabetes (per American Diabetes Association guidelines)
  - Prior myocardial infarction (heart attack)
  - Prior stroke
  - Symptomatic peripheral artery disease

Quick Reference Guide

Access & Prior Authorization (PA)

- Members must go through their provider—both a prescription for weight management or maintenance and prior authorization (PA) are required for eligible GLP-1 medications
- **Providers should not submit PAs for the Bridge Program to the health plan. All GLP-1 Bridge PAs are submitted directly to CMS** (electronic preferred; CMS fax form available)
- No PA submissions for GLP-1 Bridge Program will be accepted by CMS before July 1, 2026.
- Full PA instructions and the official fax form can be found on the **CMS GLP-1 Bridge program** webpage.

Cost Share & Benefit Design Difference

- The GLP-1 Bridge is outside the Part D benefit, meaning:
  - No Part D deductible applies
  - The $50 co-pay does not count toward TrOOP
  - No Low-Income Subsidy (LIS) applies, even for LIS-eligible members

Additional Information

For complete program details, please visit the CMS GLP-1 Bridge Program webpage. **(https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge)**

Members with questions about accessing GLP-1 medications through the Bridge Program may contact **1-800-MEDICARE.**

CMS is expected to release additional guidance as implementation continues. Thank you for your continued partnership and commitment to helping members access the care and medications they need.

EVERYDAY CONVERSATIONS THAT DRIVE BETTER OUTCOMES AND PATIENT EXPERIENCE

Conversations between doctors and their patients are a powerful tool for supporting better outcomes and improving the overall care experience.

The Health Outcomes Survey (HOS), conducted annually from July through November, captures patients' perceptions of their physical and mental health over time including whether providers have discussed topics such as physical activity, bladder control and fall prevention. These same patients are surveyed again two years later to assess changes in their health status.

Annual wellness visits (AWVs) and routine encounters are critical opportunities to reinforce healthy behaviors, build patient confidence in managing their health and shape how patients perceive their overall well-being. These interactions also serve as an important recall anchor when patients complete the HOS, helping address "recall gaps," a key driver of under-performance in survey results.

On the next page are practical tips to help integrate key HOS clinical elements into your workflow. These approaches support more proactive identification, management, and improvement of your patients' overall well-being, driving better outcomes and care experiences.

Tips for Driving Better Outcomes and HOS Performance

HOS Measure	Example Question	Clinical Best Practices	Ask & Act
Improving or Maintaining Physical Health	Does your health limit your ability to do moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?	Assess functional status and pain using standardized tools (e.g., Barthel Index). Encourage goal setting and self-management strategies.	**What types of physical activities do you do each day?** If sedentary, advise on light activity options and document recommendations.
Improving or Maintaining Mental Health	During the past 4 weeks, have you accomplished less than you would like because of any emotional problems?	Conduct routine screening (e.g., PHQ-2) at the minimum during AWVs. Identify social isolation, grief or life transitions. Provide referrals and ensure follow-up when concerns are identified.	**How has your mood or energy been recently?** If concerns are raised, document and schedule a follow up appointment.
Monitoring Physical Activity	In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?	Document individualized activity recommendations. Connect patients to helpful resources (e.g., fitness benefits).	**How often do you exercise or move around during the week?** Provide guidance on starting, increasing or maintaining specific, achievable exercise goals.

Tips for Driving Better Outcomes and HOS Performance, Cont.

HOS Measure	Example Question	Clinical Best Practices	Ask & Act
Improving Bladder Control	In the past 6 months, have you experienced leaking of urine?	Normalize discussion of bladder control and proactively assess symptoms. Have informative brochures and/or posters readily available to educate patients including behavioral and clinical interventions.	**Have you ever had a difficult time controlling your bladder?** If yes, discuss treatment options like bladder training, medication or urology referral.
Reducing the Risk of Falling	In the past 12 months, have you talked to your doctor or other health care provider about falling or problems with balance or walking?	Complete fall assessment and review contributing factors (e.g., vision test, physical therapy). Recommend home safety modifications and appropriate referrals.	**Have you fallen or nearly fallen in the past 12 months?** If yes, conduct a full fall risk assessment, review medications and physical therapy referral, if needed.

Please encourage your patients to participate in the survey, if selected.

Alignment Health Plan is committed to supporting you during this HOS season and beyond. For questions or additional support, please contact your Provider Engagement Specialist.

Thank you for your continued partnership in delivering high-quality care to our health plan members!

CLAIMS, EXPLANATION OF PAYMENT (EOP) AND ELECTRONIC REMITTANCE ADVICE (ERM) INQUIRIES

To submit a claim, you may send electronically or mail in a paper claim.

Claims Mailing Address:

PO Box 14012
Orange, CA 92863
Payer ID: CCHPC

To check claim status, contracted providers may log in to their provider portal at https://ava.alignmenthealth.com/ or you may call our Provider Line at (844) 361 4712 for additional **claims** information on your claim.

If you are pending access to the portal or are non contracted, you may use our self service tool at https://avaprovidertools.alignmenthealth.com/check-claim status.

To obtain a copy of the EOP / ERA, or to update/register for EFT, please log into the Zelis portal. If you are not yet set up with an account, please refer to the link below or call Zelis at (877) 828 8770, 8:00AM - 7:00PM EST, Monday - Friday.

https://provider.zelis.com/data-exchange-partners-already-receive

To submit an appeal, please fax the Provider Dispute Resolution team at (562) 261-8385. To submit medical records for a claim, please fax (562) 207-4619. Currently, our Provider Portal and Self Service Tools are not able to provide the status of appeals and medical records.

Portal Submissions

For contracted providers needing access to our provider portal, or to update your account, please use the following link to submit your request:
https://avaprovidertools.alignmenthealth.com/user registration

If you are currently waiting for access to the portal, you may use our self service links for support: https://avaprovidertools.alignmenthealth.com/

Unfortunately, non contracted providers are not eligible for portal access.
Alternatively, you may verify eligibility, claims, and authorizations at the following link:
https://www.alignmenthealthplan.com/providers/non-contracted-providers

If you have questions or require additional assistance, please call our Provider Line (844) 361-4712.

COMPLIANCE ALERT:

SPECIAL NEEDS PLAN (SNP) MODEL OF CARE PROVIDER TRAINING

ATTENTION PROVIDERS:

CMS requires that all Providers who manage Alignment Health's SNP members complete the SNP Model of Care (MOC) training upon contracting and annually thereafter.

» **Training Schedule:**

- The Quality Management Department will send email notifications between Q1-Q3 2026.
- Providers must complete the training within 60 days of receiving the notification.

» **Access Training:**

- Visit the Alignment Health Plan website to access training material: https://www.alignmenthealthplan.com/providers/special-needs-plan-training.
- Please confirm receipt of the training materials when contacted by the Quality Management team via email or fax.

» **Completion Options:**

Providers can complete and access the Model of Care training through various channels facilitated by their group's designated contact, including, but not limited to:

- Routine scheduled meetings
- Provider portals
- Group training sessions

» **Escalation Process:**

If providers do not respond or have invalid contact information, the Alignment Network Management team and Market Presidents will assist in attaining the current contact information and training completion.

PROVIDER DIRECTORY VALIDATION

Provider directories are an important tool Medicare Advantage (MA) enrollees use to find and contact their physicians and other contracted providers. MA plans are required to maintain accurate online provider directories that include only active and contracted providers. Additionally, providers listed must indicate those who have closed panels (not accepting new patients).

Alignment requires its participating providers to maintain accurate provider rosters and to promptly notify Alignment of any changes to the provider roster including but not limited to, the addition of new providers, the termination of providers and changes to provider demographic information. Alignment performs quarterly roster data validations. Participating providers have thirty (30) calendar days to respond to Alignment's directory validation requests.

MEMBER/PROVIDER DATA UPDATES

Notifications to Alignment of Provider Data Updates

Providers and provider groups are responsible for timely notifications to Alignment when individual providers terminate from provider group's practice. Unless otherwise stated in the contract between the provider or the provider group and Alignment, Alignment requires notification of provider terminations as indicated below.

Notifications should be emailed to:

Delegated Providers: **Provdata@ahcusa.com**

Non-Delegated Providers: **ProviderRelations@ahcusa.com**

Provider Notification to Alignment		
Terminating Entity	**Notification Responsibility**	**Notification Requirements**
All providers	IPA/MG/ Providers	• Written notice is required 90 days before termination effective date. If less than 90 days is given, providers must notify Alignment within 5 business days of their knowledge of the termination. • PCP terminations must include alternate PCP for member transfer, reason and effective date.

MEMBER NOTIFICATION OF CONTRACTED PROVIDER TERMINATIONS

When a contracted provider terminates from Alignment Health Plan's network, Alignment or its delegated IPAs/MGs/Providers must inform members about the termination, including whether it was for cause or without cause. Alignment will make a good faith effort to provide notice of a for-cause termination within the time frames, as described below. These member notification and timeframe requirements are in accordance with the Code of Federal Regulations 88 FR 22120, as follows:

Member Notification

Terminating Entity		Notification Responsibility	Notification Requirements
Delegated	**Behavioral Health**	**IPA/MG/ Provider**	• Lookback period: Notices sent to all enrollees who have been patients of the behavioral health provider within the last 3 years. • Written notice: At least 45 calendar days before termination effective date. • Telephonic notice: At least one attempt 45 calendar days before the termination effective date.
	All other specialties		• Lookback period: Notices sent to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating.* • Written notice at least 30 calendar days prior to the termination effective date.
Delegated & Non-Delegated IPAs/MGs	**Primary Care Provider**	**Alignment Health Plan**	• Lookback period: Notices sent to all enrollees who are currently assigned to that primary care provider and to enrollees who have been patients of that primary care provider within the past 3 years. • Written notice: At least 45 calendar days before termination effective date. • Telephonic notice: At least one attempt 45 calendar days before the termination effective date.
	Behavioral Health		• Lookback period: Notices sent to all enrollees who have been patients of the behavioral health provider within the last 3 years. • Written notice: At least 45 calendar days before termination effective date. • Telephonic notice: At least one attempt 45 calendar days before the termination effective date.
Non-Delegated	**All other specialties**		• Lookback period: Notices sent to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating.* • Written notice at least 30 calendar days prior to the termination effective date.

* CMS defines "enrollees who are patients seen on a regular basis by the provider whose contract is terminating" as enrollees who are assigned to, currently receiving care from or have received care within the past 3 months from a provider or facility being terminated.

COMPLIANCE ALERT:

APPOINTMENT AVAILABILITY AND AFTER-HOURS ACCESS TO CARE

ATTENTION PROVIDERS:

Alignment follows appointment availability and after-hours standards established by CMS, NCQA® and the Departments of Health Services. All IPAs/medical groups and providers must comply with the timeliness access standards. In cases where state standards differ from CMS requirements, Alignment adheres to the most restrictive applicable standard:

» **Routine Visit Appointment Availability:**

- PCP (Primary Care Provider): Within 7 business days of request
- SPC (Specialist Care): Within 15 business days of request
- BH (Behavioral Health): Within 7 business days of request

» **Urgent Visit Appointment Availability (All provider types)**

- No prior authorization: Within 48 hours of request
- With prior authorization: Within 96 hours of request

» **Behavioral Health/Substance Use Disorder Follow-Up:**

- Within 10 business days of request

» **After-Hours Access to Care:**

- 24/7 member access to covered services
- Life-threatening emergency care: Call 911 or go to the nearest emergency room

2026 Studies

Press Ganey is conducting the Access and After-Hours studies on behalf of Alignment Health in Q2 2026. Results will be shared in Q3 2026.

Together, these requirements help promote continuity of care, improve patient outcomes and enhance overall patient satisfaction.

Questions?

Please contact the Alignment Health Plan Quality Management Department via email at **QualityManagement@ahcusa.com**.

THE 150+ HEALTH WELLNESS PROGRAM:

Alignment Health teamed up with 150+ Health to host pickleball events in Santa Clara and Los Angeles in California and throughout Clark County in Nevada.

150+ Health is a wellness program empowering older adults to lead an active, community-driven lifestyle through the game of pickleball.

Pickleball is a low-impact way to meet CDC (Centers for Disease Control and Prevention) and WHO (World Health Organization) activity goals, which help reduce risks of heart disease and depression.

88

PARTICIPANTS

79%

OVER AGE 60

68.2%

NEW TO PICKLEBALL

WHAT PARTICIPANTS SAID:

"**I needed this!** Refreshing approach to pickleball and exercise."

"Better than a gym! Love the **community.**"

"It gave me something **fun** to add to my life."

"**Learned** new warm-up ideas to protect me against injury."

"It got me **out of my house** since I retired."

Love the **warm interactions** with others."

100% OF THE PARTICIPANTS SAID THEY WOULD RETURN!

Alignment Health Plan®

1100 W. Town and Country Road
Suite 1600 Orange, CA 92868

QUESTIONS?

Contact Alignment Health Plan Provider Relations at **ProviderRelations@ahcusa.com** or **(844) 361-4712**.

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