



Alignment Health Plan®

SEPT 2025

PROVIDER NEWSLETTER



TO LEARN MORE about how we can help your patients, please contact your local Alignment Health Plan Provider Relations Representative at **1-844-361-4712 (TTY: 711)**, or email us at ProviderRelations@ahcusa.com.



ALIGNMENT HEATH SHARES HOW MEDICARE ADVANTAGE CAN BE DONE RIGHT WITH CONGRESS



With a successful track record for high-quality, low-cost care, Alignment Health was invited before Congress to offer perspectives and lessons, and to share how we are doing Medicare Advantage right for more than 200,000 members across five states. All of our members are enrolled in a 4-star plan or higher, and we're proud to be one of just nine Medicare Advantage organizations nationwide with 5-star plans.

Recently, Dawn Maroney, president of Alignment Health and CEO of Alignment Health Plan, served as a witness in front of the House Committee on Ways and Means Health and Oversight subcommittees in a joint hearing about the past lessons, present insights and future opportunities of Medicare Advantage (MA).

During the hearing, she shared our key learnings and successes, and how they are a model for thoughtful governmental policy—one that facilitates quality outcomes for beneficiaries and value for taxpayers in the MA program.

Of note, U.S. Rep. Terri Sewell asked about how Alignment manages to keep its denial rate low—a rate that is far below the industry average.

In response, Ms. Maroney said,

“We take pride in that. There are a lot of referrals that people go through that should be auto approved; there should be no hold time.”

Ms. Maroney also added why prevention is critical at Alignment:

“We have a belief system through our Jump Start Assessment program, for every new enrollee that enrolls into the program, it is our goal to see them immediately, within the first 90 days, or 120 days, to make sure there is no continuity of care issue.”

Rep. Sewell concluded about Alignment that,

“It sounds like on the front end, you're trying to prevent chronic diseases, and in doing so, you're saving money and obviously, saving people's lives.”

This is the beginning of an important dialogue focused on finding more solutions to support the growing U.S. senior population. We look forward to more discussions on how to best care for America's seniors.

Ms. Maroney's opening statement:

<https://waysandmeans.house.gov/event/joint-subcommittee-hearing-on-medicare-advantage-past-lessons-present-insights-future-opportunities/>



MY CHOICE CALPLUS AND HEROES+ TRANSITION

(CALIFORNIA PLANS)

Thank you for your partnership with Alignment Healthcare in advancing our mission to put the senior first in every member interaction, every plan—and every benefit. We're excited to share some important news about an upcoming 2026 plan change that will greatly enhance the care experience for our dual-eligible members.



As you may know, CMS has designated 2026 as the final transition year for “look-a-like” D-SNP plans, requiring health plans to move members into appropriate plans with dual-eligible enrollment projected to remain below the 60% threshold.

For this reason, we are proactively transitioning **Alignment Health My Choice CalPlus and Alignment Health Heroes+** members into one of the two CMS-approved plans for 2026:

- Alignment Health My Choice CalCare (HMO) 050
- Alignment Health Heart & Diabetes Choice (HMO C-SNP) 051

We are notifying members about this action, but they may receive solicitations or call you with questions. **Please assure them that there is nothing for them to do** and that it is not necessary to enroll in a D-SNP to retain their Medi-Cal benefits.

The transition process is happening internally between Alignment and CMS later this fall. It's completely automatic.

No action by members to continue receiving Alignment benefits.

And best of all, members are **keeping the same generous benefits** they've come to rely on, plus some exciting new ones:

- The same doctors and specialists they already know and **trust**.
- The same pharmacy access.
- Exceptional **personal service** from our On-Demand Concierge Program.

Alignment **welcomes this change** as an opportunity to reaffirm our commitment to meeting the needs of the dual-eligible population and promoting health equity. We are experienced in identifying and serving members with low income and chronic conditions. **Alignment is recognized for award-winning plans** that provide exceptional care and member experience, and our Net Promoter Score is more than double the Medicare Advantage plan average.

We've created a small illustration to show you how the My Choice CalPlus and Heroes+ transition will seamlessly happen.

ALIGNMENT HEALTH MY CHOICE CALPLUS (HMO)/H3815-007



ALIGNMENT HEALTH HEROES+ (HMO)/H3815-043

Full Duals with Chronic
Heart Failure, Cardiovascular
Disorder or Diabetes Mellitus.

Alameda, Fresno, Los Angeles, Madera,
Marin, Orange, Placer, Riverside, Sacramento,
San Bernardino, San Diego, San Francisco,
San Joaquin, San Luis Obispo, Santa Clara,
Stanislaus, Ventura, Yolo

Non-Duals, Partial Duals and
all other Full Duals (without
specified chronic conditions)

Alameda, Fresno, Los Angeles, Madera,
Marin, Orange, Placer, Riverside, Sacramento,
San Bernardino, San Diego, San Francisco,
San Joaquin, San Luis Obispo, Santa Clara,
Stanislaus, Ventura, Yolo

ALIGNMENT HEALTH HEART & DIABETES CHOICE (HMO C-SNP) H3815-051

ALIGNMENT HEALTH MY CHOICE CALCARE (HMO) H3815-050

Members will be automatically transferred through a crosswalk process to their new plan.
Agent of Record will stay the same.

Members will retain the same or similar level of benefits seamlessly through the transition process.



UTILIZATION MANAGEMENT PROGRAM

Alignment joins with the broader industry in committing to reducing the burden of prior authorization. This includes implementing electronic prior authorization, ensuring continuity of care when patients change health plans and enhancing communication and transparency on determinations. Utilization management serves an important role in preventing unnecessary or wasteful care. Overtreatment and fraud/abuse account for 4.7 to 7.1% of all healthcare spending, or \$135-185 billion, according to a 2019 study. Not only does this strain an already overburdened healthcare system, excess testing and interventions can result in unnecessary tests, procedures, and exposure to adverse events. **Alignment’s utilization program is intended to reduce unnecessary and inappropriate care while at the same time ensuring members receive the right care at the right time.** The below sections in this newsletter will help ensure that the utilization management program is able to fulfill this vital function in partnership with our provider community to ensure quality of care and outcomes. Some statements including may not apply to all plans offered by Alignment Health—please reference the evidence of coverage for the member’s plan.

Clinical Decision Making

Utilization management decisions are made based on published clinical utilization management criteria. Understanding these guidelines can be helpful in ensuring that the documentation submitted is comprehensive and can prevent delays in approval. As a Medicare Advantage Plan, Alignment follows Medicare’s hierarchy of coverage policies. National Medicare guidelines can be found in the Medicare Benefit Policy Manual and National Coverage Determinations. Where those guidelines do not fully establish clinical criteria, the next step is to utilize an appropriate local coverage decision issued by the local Medicare Administrative Contractor (MAC). The following is a list of Alignment states and their respective MACs for Part A and B, as well as the MACs for DME.

State	A/B MAC	DME MAC
AZ	Noridian	CGS
CA	Noridian	Noridian
NC	Palmetto	CGS
NV	Noridian	Noridian
TX	Novitas	CGS

Where neither national nor local Medicare coverage guidelines fully establish coverage criteria, we rely on Milliman Care Guidelines as well as internally developed clinical guidelines. Both can be found at <https://www.alignmenthealthplan.com/providers/provider-resources>.

Use of Network Providers

Working with a high-quality network of providers is essential to allowing us to deliver a coordinated care experience to our membership, as well as ensuring that members receive the benefits of our quality management programs. Alignment HMO plans require the use of in-network providers except in cases of emergencies, urgently needed services when the network is not available, out-of-area dialysis services or when authorized on a case-by-case basis. Please ensure that care is directed in-network when clinically feasible. If an out-of-network provider or facility is required from a clinical standpoint, please ensure that the specific reason for pursuing out-of-network care is identified when submitting for prior authorization. These reasons may include specialty care not available within the network (though Alignment does partner with leading tertiary facilities), continuity of care (please include appointment dates and specifics of why continuity is needed from a clinical standpoint or provider characteristics (e.g., lack of privileges). Providing these details will assist our team in evaluating the appropriateness of the out-of-network request.

Prior Authorization List (PAL) Updates

Alignment makes updates to the Prior Authorization List (PAL) on a quarterly basis to stay up to date with new codes and to help streamline our provider and member experience. Codes on the PAL require authorization. Any code not on the PAL does not require authorization unless the service is the responsibility of a delegated IPA, the servicing provider or facility are out-of-network, the service is being rendered in certain settings or other criteria are met.

Please review the prior authorization guidelines for nondelegate providers on our prior authorization website and monitor this list to ensure that you are taking advantage of areas where we seek to minimize provider burden.

Continuous Glucose Monitors (CGM)

CMS expanded coverage for CGMs in March of 2023. Coverage guidelines can be found at LCD L33822. When requesting authorization for a CGM, please submit documentation that demonstrates these criteria are met to avoid delays in processing authorization requests or unnecessary denials. Common reasons for denial are not including evidence that ALL of the following are met:

1. The member has diabetes
2. The member has one of the following:
 - a. Treatment with insulin
 - b. Problematic hypoglycemia as evidenced by one of the following:
 - i. More than one episode of hypoglycemia with glucose <54mg/dL that persists despite multiple attempts to adjust medication(s) and/or modify the treatment plan
 - ii. A single episode of hypoglycemia with glucose <54 AND altered mental status or physical state requiring 3rd party assistance for treatment
3. The member has a provider visit within 6 months prior to ordering the CGM



PATIENT HEALTH CARE ACCESS REMINDER

Alignment Health Plan encourages providers to remind patients, especially those who are high-risk—of the multiple ways they are able to access their health care. Many members benefit from in-home care, so it is critical to remind them that receiving their health care is available in many forms, including virtual care. Regardless of the time of day, there is someone available who can assist them or help with their questions and concerns.

Emergency Room

If there is an emergency, get help as quickly as possible. Call 911 or go to the nearest emergency room. You do NOT need to get a referral or approval from your Primary Care Provider (PCP) during an emergency.

In-Network Urgent Care

When you need in-person care for an unforeseen medical illness or injury, use an in-network urgent care facility. You can find facilities in your area by visiting providersearch.alignmenthealthplan.com.

Primary Care Provider

For non-emergency situations, reach out to your Primary Care Provider (PCP). They have full access to your medical history and records, and actively work to prevent, diagnose and treat common illnesses and injuries.

Virtual Care Center

Urgently needed care is for life-threatening, unforeseen medical illnesses, injury or conditions that require medical attention. Clinicians are available 24 hours a day, 7 days a week.

For Urgently Needed Care—Contact the Virtual Care Center

Need to speak to a clinician in the middle of the night, when you're away from home, or don't have a Primary Care Provider (PCP) and need care? All Alignment Health Plan members have access to our Virtual Care Center.



Our Virtual Care Center clinicians can diagnose and treat many non-emergency medical conditions like the common cold, allergies, rash, sinus infection and back pain. They can also help with referrals, refills, medical equipment, social support services and more!

- 1. Schedule** – Request a visit with a clinician 24 hours a day, 7 days a week by calling the Virtual Care Center at 1-833-402-5803 (TTY: 711).
- 2. Consultation** – Talk to a licensed clinician by video or by phone to get a diagnosis and treatment plan.
- 3. Feel better** – If medically necessary, a prescription will be sent to the pharmacy of your choice.

In unusual circumstances where in-network providers are temporarily unavailable or inaccessible, urgently needed care from an out-of-network provider may be covered.

Provider Directory Validation

Provider directories are an important tool Medicare Advantage (MA) enrollees use to select and contact their physicians and other contracted providers who deliver medical care. MA plans must maintain accurate online provider directories that include only active, contracted providers with specific notations for providers who are not accepting new patients. Alignment requires its Participating Providers to maintain accurate provider roster information 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 any providers and any changes to provider demographic information. In addition, Alignment will perform quarterly roster data validations. Participating Providers will 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 set forth below. Notification is to be emailed to: for Delegated Providers – Provdata@ahcusa.com, for Non-Delegated Providers – ProviderRelations@ahcusa.com

	Terminating Entity	Notification Responsibility	Notification Requirements
Provider Notification to Alignment	All providers	IPA/MG/Provider	<p>Written notice: 90 days before termination effective date.</p> <p>If less than 90 days is given, providers must notify Alignment within 5 business days of becoming aware of the termination.</p> <p>PCP terminations must include: alternate PCP for member transfer, reason and effective date.</p>

Member Notification of Contracted Provider Terminations

When a contracted provider terminates from Alignment Health’s network, Alignment Health or its delegated IPAs/MGs/Providers must inform members about the termination, whether it was for cause or without cause. Alignment Health will make a good faith effort to provide notice of a for-cause termination within the timeframes, 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	Delegated	Behavioral Health	IPA/MG/ Provider	<ul style="list-style-type: none"> » 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		<ul style="list-style-type: none"> » 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	<ul style="list-style-type: none"> » Lookback period: Notices are sent all to 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 three 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.
				<ul style="list-style-type: none"> » 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	Behavioral Health		<ul style="list-style-type: none"> » Lookback period: Notices sent to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating.*
		All other specialties		<ul style="list-style-type: none"> » 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 month from a provider or facility being terminated.



RISK ADJUSTMENT AND RADV AUDITS

If you are a contracted provider with Alignment's Medicare Advantage Plans, your role in CMS' Risk Adjustment Data Validation (RADV) program is essential to ensuring accurate reporting, compliance and appropriate reimbursement. CMS conducts RADV audits to confirm that diagnosis codes submitted for payment are fully supported by the medical record documentation. Alignment Health expects its contracted providers and groups to uphold the highest standards of integrity, accuracy and accountability in all activities related to the Organization's Medicare Advantage Risk Adjustment and CMS Risk Adjustment Data Validation (RADV).

RADV Reminders to Providers

1. While accurate medical record documentation is essential for compliance and RADV audits, its **primary purpose is to ensure our members receive appropriate, coordinated and complete care.** Thorough, timely notes help every member of the care team to understand a patient's history, current conditions and treatment plan, supporting better outcomes and continuity of care.
2. Alignment relies on our providers to ensure that all submitted diagnosis codes are fully supported by clear, complete and timely medical record documentation.
3. Securely retain and provide all required documentation for RADV audits upon request, including timely cooperation during retrieval efforts. CMS regulations require Medicare Advantage Organizations to retain records for at least 10 years. This includes records related to patient care, financial transactions and administrative operations. The Agency's regulations also stipulate that Medicare Advantage Organizations' contracted providers must retain records for a minimum of 10 years. This is required by federal as well as state law.
4. Re-document chronic conditions annually.
5. When we send RADV medical record requests, timely and complete submission of legible, full chart notes is essential. Make sure this includes dates of service and provider signature on all notes.
6. Respond quickly and in full to RADV audit requests to avoid unsupported diagnoses and potential payment recoupments.



JOIN OTHERS IN OPTIMIZING YOUR PATIENT EXPERIENCE TO DRIVE 2026 CAHPS PERFORMANCE

Patients selected for the 2026 Medicare CAHPS survey are asked to think about the health care they are receiving **right now**, in the latter half of 2025.

The survey asks patients about their experiences with you, their providers, and their health plan.

There are a few simple tactics that can help promote a high-quality, memorable patient experience, which other providers have already implemented.

Here are a few simple strategies that we recommend based on areas for improvement and based on the science of human behavior:

1. Being aware and prepared builds patient trust and rapport

- Prepare for your patient visits as best as you can by reviewing or having at hand their recent lab work or tests, current medications and details about any recent specialist care

2. Set expectations

- Ambiguity is a major source of dissatisfaction
 - Even if you don't know precise times or dates for screenings, tests or specialist visits, setting a rough expectation can help assuage anxiety and frustration which is critical to maintaining happy, satisfied patients
- Communicating up front that a backlog or longer wait than usual exists is better than the member's expectations misaligning with their eventual experience
 - Ask patients if they know how to obtain their results for routine screenings and tests; it's a simple question that goes a long way
- For instance, if results are available in an online portal, you (or have an administrative member of your team) might help patients understand how to gain access

Q4 REMINDERS FROM THE STARS TEAM: FINAL PUSH FOR 5 STARS— LETS FINISH STRONG!

Controlling Blood Pressure (CBP)

- **Prioritize the most recent BP readings:** HEDIS uses the **last** blood pressure reading of the measurement year that is on or after the second diagnosis of hypertension
- **Multiple readings on the same date:** If a patient has multiple blood pressure readings recorded on a single date, use the **lowest** systolic and **lowest** diastolic BP from that date as the representative reading
- **Encourage follow-up visits:** If a member's blood pressure is elevated (>140/90), schedule a follow-up visit before the year-end to try and capture a controlled reading
- **Consider remote monitoring and member-reported readings:** Utilize telehealth or remote monitoring for obtaining member-reported blood pressure readings, especially when in-person visits aren't feasible

Exclusions: Hospice, Palliative Care, Members Death, ESRD and Dialysis, History of Nephrectomy or Kidney Transplant.

See Advanced Illness and Frailty Details Section

CBP Measure Details: [Please see pages 13–14 of the Stars Best Practice Guide](#)



Glycemic Status Assessment for Patients with Diabetes (GSD)

- **Prioritize outreach to patients with no A1c and elevated A1c results:** HEDIS uses the **last** Hemoglobin A1c result of the measurement year. Schedule members who do not have a result on file for labs prior to their appointment to ensure results are available to review during the visit. For patients with a result >9, retest before the end of the year
- **Utilize point-of-care testing:** If a POC test is performed in-office, ensure it is billed with the correct CPT-II code to report hemoglobin A1c results
- **Provide resources and diabetes education:** Offer telephonic disease management for out-of-control diabetics to identify any social determinants of health that may prevent effective diabetes care

Exclusions: Hospice, Palliative Care

See Advanced Illness and Frailty Details Section

GSD Measure Details: [Please see pages 23–24 of the Stars Best Practice Guide](#)



Breast Cancer Screening (BCS-E)

- **Acceptable date range:** Upload any records to AVA for mammograms completed between 10/1/2023-12/31/2025
- **Promote importance of complete screening:** Discuss during Breast Cancer Awareness Month (October)
- **Offer resources for scheduling:** Offer members the option to have the office schedule mammograms at a preferred facility and location

Exclusions: Hospice, Palliative Care, History of Bilateral Mastectomy, History of Right Mastectomy, History of Left Mastectomy (Both Right and Left will need to be done for full exclusion)

See Advanced Illness and Frailty Details Section

BCS Measure Details: [Please see pages 9–10 of the Stars Best Practice Guide](#)

Colorectal Cancer Screening (COL-E)

- **Upload records that have self-reported data to AVA:** Upload records that are within the acceptable date ranges
 - FOBT: Current year
 - Colonoscopy: 2016 – Current year
 - Cologuard: 2023 – 2025
 - CT Colonography: 2021 – Current year
 - Flexible Sigmoidoscopy: 2021 – Current year

- **Document self-reported history data in EMR**
- **Stock FOBT kits in office to provide during appointments**
- **Offer scheduling assistance for referrals to Gastroenterology**

Exclusions: Hospice, Palliative Care, Colorectal Cancer Diagnosis, Total Colectomy

See Advanced Illness and Frailty Details Section

COL-E Measure Details: [Please see pages 11–12 of the Stars Best Practice Guide Part D](#)

- **Offer 100-day supply for all medication adherence measures**

Exclusions: Hospice, Palliative Care

Additional Exclusion Details: [Please see pages 55–64 of the Stars Best Practice Guide](#)

See Advanced Illness and Frailty Details Section

Supplemental Data Reminder

To ensure accurate and timely monitoring of your performance and to support our quality improvement initiatives, it is essential that all providers submit supplemental data monthly. We **require** that your team submit data each month per our Provider Operations Manual and/or your current agreement through the 2 methods approved of either secure FTP (SFTP) or the AVA Provider Portal. If you need access set up for one of these methods, please work with your Alignment network contact.



Alignment Health Plan®

QUESTIONS?

Contact Alignment Health Plan Provider Relations at ProviderRelations@ahcusa.com or **1-844-361-4712**.

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