Alignment Health™

PROVIDER OPERATIONS MANUAL

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EXHIBITS

SECTION 1 | INTRODUCTION

WELCOME TO ALIGNMENT HEALTH!

We are an innovative, data-driven healthcare company dedicated to serving Medicare Advantage beneficiaries.

We serve the most vulnerable people in our communities because it is our calling. We do this by designing products and services that help improve quality of life, mobility, and connection. As a result, the people we serve are more independent, and they know we are there for them.

Alignment Health **("Alignment")** offers Medicare Advantage plan options through Alignment Health Plan and AHP affiliates (collectively known throughout this manual as Alignment or the Health Plan). Based in Orange, California, Alignment operates as a clinically integrated healthcare delivery system in select markets and is a Medicare Advantage plan in several counties in California, North Carolina, Nevada, Arizona and Texas. We work in diverse communities to promote health and wellness and deliver high-quality care and services to its Medicare Advantage members.

We offer our network providers a variety of contracts, enabling them to better serve their Medicare and Medicare/ Medicaid (Medi-Medi) population.

We are changing healthcare one person at a time, and we are excited to accomplish that together.

PURPOSE OF THE PROVIDER OPERATIONS MANUAL

This manual describes Alignment's operational policies, procedures, programs and services for our providers and their staff. It also contains key contacts, addresses, phone numbers and websites. This manual is an extension of the Participating Provider Services Agreement, and it supplements Participating Provider Services Agreements and their addenda. When the contents of this manual conflict with a Participating Provider Services Agreement, the agreement takes precedence.

This manual applies to all Alignment-contracted participating providers. A participating provider (or provider) is an independent practice association (IPA), medical group, primary care provider (PCP), specialist, ancillary provider, hospital, supplemental provider, or other healthcare provider or practitioner who is contracted to provide services to Alignment's members.

Unless otherwise specified, this manual applies to both delegated and non-delegated providers. For our purposes, delegated providers perform certain managed-care functions under their agreement with Alignment, such as utilization management (UM), claims payment and credentialing. By contrast, Alignment performs those managed-care functions on behalf of non-delegated providers, such as directly contracted physicians, ancillary providers and hospitals.

CLAIMS

Processes claims for payment to participating providers and assists with claims status inquiries. Maintains provider files and information to ensure proper reimbursement according to contracted rates.

COMPLIANCE

Oversees Alignment's compliance program to ensure that regulatory requirements are met.

CREDENTIALING

Responsible for collecting, evaluating and ensuring all mandated licensing qualifications have been met and are maintained for a healthcare professional or facility to participate in the Alignment Health network.

DELEGATION OVERSIGHT (DO)

When delegated, responsible for initial validation and ongoing oversight of capabilities, processes and procedures of the following functions to ensure adherence to federal and/or state regulations: Claims Processing, Credentialing, Utilization Management and General Case Management.

ELIGIBILITY

Processes all member enrollment and disenrollment and verifies member eligibility for participating providers' offices, pharmacies and vendors.

FINANCE

Processes, as appropriate, percent-of-premium payments for PCPs and capitation and fee-for-service payments for Alignment's providers and other medical service vendors.

MARKETING

Promotes Alignment's benefits within service-area communities through events, orientations for new members, distribution of educational materials, and participation in community activities.

MEMBER SERVICES

Answers all member calls regarding benefits inquiries, replacement ID cards, complaints and appeals. Assists with scheduling interpreter services, transportation and PCP transfers. Maintains a member-retention unit. Resolves customer service issues. Inquiries and appeals about prescription drug coverage are delegated to Alignment's pharmacy benefits manager.

NETWORK MANAGEMENT

Negotiates and maintains all contracts for health care services provided to our members and works with providers on contract inquiries. Responsible for educating providers about Alignment and providing access to provider educational materials, bulletins, newsletters and reports.

PHARMACY

Administers Medicare Part D Prescription Drug Coverage benefits and offers a comprehensive pharmacy services program, including formulary management, utilization management and pharmacy network management.

PROVIDER DATA MANAGEMENT

Inputs and maintains all provider data, practice information (e.g., demographics) and applicable contract information.

QUALITY MANAGEMENT (QM)

Responsible for monitoring, evaluating, and improving the quality and safety of clinical care and quality of service provided to Alignment members. Monitors whether the delivery and utilization of services meets professional and evidence-based standards of care and practice. Oversees quality activities to ensure compliance with the Centers for Medicare & Medicaid Services (CMS) guidelines.

RISK ADJUSTMENT

Ensures that complete and accurate diagnosis data is gathered through coding of documented services provided to our members. Aims to accurately reflect the disease burden of the membership so that payments to the health plan by CMS are consistent with expected healthcare expenditures.

SALES

Schedules and conducts presentations in the community to ensure that potential members understand Alignment's benefits and enrollment process. Interacts with PCP offices and their staff regarding enrollment and retention. Coordinates all sales events and develops marketing materials.

STARS PERFORMANCE IMPROVEMENT

Establishes guidelines for achieving an overall five-star rating from the Centers for Medicare & Medicaid Services (CMS) based on clinical quality, customer services, and membership satisfaction. Helps physicians improve their individual Star ratings. Monitors members with chronic diseases, ensuring best outcomes and best practices in treatment.

UTILIZATION MANAGEMENT (UM)

Ensures that all medical services are provided appropriately in the correct settings and are referred to participating providers unless otherwise agreed upon by Alignment. Evaluates referrals based on appropriateness and medical need, according to evidence-based criteria and guidelines.

ALIGNMENT DEPARTMENT AND PARTICIPATING PROVIDER LIST

To contact Alignment departments, providers should refer to **Exhibit 1.1: Key Contact Information**.

STATE	SERVICE COUNTIES
California	Los Angeles, Orange, San Diego, Riverside, San Bernardino, Marin, San Luis Obispo, Ventura, San Francisco, Santa Clara, Stanislaus, San Joaquin, Sacramento, Placer, Yolo, San Mateo, Santa Cruz, Sonoma, Fresno, Madera, Alameda, Merced
Arizona	Maricopa, Pima, Santa Cruz
Nevada	Clark, Washoe
North Carolina	Chatham, Johnston, Wake, Forsyth, Guilford, Davidson, Davie, Wilkes, Buncombe, McDowell, Mitchell, Transylvania, Avery, Henderson, Madison, Orange
Texas	El Paso, Hudspeth

EXHIBIT 1.1

KEY CONTACT INFORMATION

GENERAL RESOURCES	
Alignment Health	**https://www.alignmenthealth.com**
Providers • Provider Operations Manual • Stars Best Practice Guide • Prior Authorization for Nondelegated Providers	**https://www.alignmenthealth.com/providers**
Provider Special Needs Plan Model of Care Training	**https://www.alignmenthealthplan.com/providers/snp-training**
AVA® Login	**https://ava.alignmenthealth.com** Register for AVA® at **https://www.alignmenthealthplan.com/providers**
Office Ally™ Phone: 6am–5pm PT Mon–Fri Fax Email Live Chat	**1-360-975-7000** Option 1 **1-360-896-2151** **support@officeally.com** **https://support.officeally.com**
SFTP Login	**https://sftp.ahcusa.com**
Alignment Health Plan	**https://www.alignmenthealthplan.com**
Providers • Provider Login • Provider Newsletter • Provider Resource Guide	**https://www.alignmenthealthplan.com/providers**
Provider Newsletter	**https://www.alignmenthealthplan.com/providers/newsletter**
FirstMedicare Direct	**https://firstmedicare.com**
ACCESS ON-DEMAND CONCIERGE	
Phone 24/7	**1-833-242-2223 (TTY: 711)**
ALIGNMENT HEALTHCARE CENTERS	
California North Carolina	**https://www.alignmenthealthplan.com/find-care/find-a-care-center**
CARE ANYWHERE	
Email	**careanywherecoordination@ahcusa.com**
Phone	**1-833-902-1665 (TTY: 711)**
CLAIMS	
Website	Login to **AVA®** to check claims statuses and to submit inquiries. For more information or to request access to **AVA®** go to **https://www.alignmenthealthplan.com/providers** Non-contracted providers and contracted providers yet to have AVA portal access may check claims statuses at **https://avaprovidertools.alignmenthealth.com/check-claim-status**
Phone: 8 am–5 pm PT, Mon–Fri PDR/Appeal Fax	**1-833-902-1668** **1-562-261-8385**
PDR/Appeal Email	**apdrgroup@ahcusa.com**

Mailing Address for Claims	Alignment Health Plan Attn: Claims Department P.O. Box 14012 Orange, CA 92863
Mailing Address for Provider Payment Appeals and Disputes	Alignment Health Plan Attn: Provider Appeals & Disputes P.O. Box 14012 Orange, CA 92863
UB-1450 (Institutional)	**https://www.cms.gov/medicare/billing/electronicbillingeditrans/15_1450.htm**
CMS-1500	**https://www.cms.gov/medicare/billing/electronicbillingeditrans/16_1500.html**
COMPLIANCE	
ALIGNMENT HEALTH PLAN	
Email: Reporting Suspected Non-Compliance/FWA	**AHCFDRCompliance@ahcusa.com**
Email: Reporting HIPAA Incidents	**hipaaprivacy@ahcusa.com**
Web: Confidential or Anonymous Reporting (24/7/365)	**www.lighthouse-services.com/ahcusa**
Phone: Confidential or Anonymous Reporting (24/7/365)	English: **1-877-222-1541** Spanish: **1-800-216-1288**
Phone: Chief Compliance Officer / HIPAA Privacy Officer	**1-657-383-5394**
FIRSTMEDICARE DIRECT	
Phone: Anonymous Reporting 24/7	**1-855-367-8184**
Email	**FCCcompliance@firstcarolinacare.com**
CREDENTIALING	
Phone: 8 am–5 pm PT, Mon–Fr	**1-844-227-7599**
Fax	**1-855-903-5155**
Email	**AHCCredentialing@ahcusa.com**
DELEGATION OVERSIGHT	
Website	Log in to **AVA®** to upload reports, see instructions, and download templates. For more information or to request access to **AVA®** go to **https://www.alignmenthealthplan.com/providers**
Email	Delegation Oversight Claims Audits **DelegationOversight_ClaimsAudits@ahcusa.com** Delegation Oversight Claims Monitoring **DelegationOversight_ClaimsMonitoring@ahcusa.com** Delegation Oversight UM Audits Delegation **Oversight_UMAudits@ahcusa.com** Delegation Oversight UM Monitoring Delegation **Oversight_UMMonitoring@ahcusa.com** Delegation Oversight Credentialing Audits Delegation **Oversight_CredentialingAudits@ahcusa.com** Delegation Oversight Credentialing Monitoring **DelegationOversight_CredentialingMonitoring@ahcusa.com** Delegation Oversight Preclusion List **DelegationOversightPreclusionList@ahcusa.com**

ELECTRONIC FUND TRANSFER (EFT) & ELECTRONIC EXPLANATION OF BENEFITS (EOB)	
Website	**https://alignmenthealth.epayment.center**
Phone: Zelis	**1-855-774-4392** Reference code: **400020**
ELECTRONIC DATA INTERCHANGE (EDI) – ALIGNMENT HEALTH PLAN ONLY	
Email	**ahcedi_support@ahcusa.com**
Phone: 6 am–5 pm PT, Mon–Fri	**1-844-286-2855**
ELIGIBILITY	
ALIGNMENT HEALTH PLAN	
Website	Log in to **AVA®** to verify member eligibility, check and download plan benefits (PDFs), and submit inquiries. For more information or to request access to **AVA®**, go to **https://www.alignmenthealthplan.com/providers**
Email	**eligibilitygroup@ahcusa.com**
Phone: 8 am–5 pm PT, Mon–Fri	**1-888-517-2247**
FIRSTMEDICARE DIRECT	
Phone	**1-844-499-5630**
FINANCE / CAPITATION	
Email	**financialplanning@ahcusa.com**
Phone: Capitation and Externally Audited Financial Statements	**1-323-728-7232 ext. 2122**
JUMP-START SCHEDULING	
Phone	**1-844-215-2443**
MEMBER SERVICES	
ALIGNMENT HEALTH PLAN	
Phone: 8 am–8 pm, seven days a week (except Thanksgiving and Christmas) from Oct. 1 – March 31, and Mon–Fri (except holidays) from April 1 – Sept. 30	English: **1-866-634-2247 (TTY: 711)** Spanish: **1-877-399-2247 (TTY: 711)**
Address	Alignment Health Plan Attn: Member Services Department 1100 W. Town and Country Road, Suite 300, Orange, CA 92868
FIRSTMEDICARE DIRECT	
Phone: 8 am–8 pm, seven days a week (except Thanksgiving and Christmas) from Oct. 1 – March 31, and Mon–Fri (except holidays) from April 1 – Sept. 30	**1-844-499-5630 (TTY: 711)**
Address	FirstMedicare Direct Attn: Member Services Department 42 Memorial Drive, Pinehurst, NC 28374
NETWORK MANAGEMENT / PROVIDER RELATIONS	
Email: Direct Network Provider Changes/Updates	**providerrelations@ahcusa.com**

Email: Delegated Network Provider Changes/Updates	**provdata@ahcusa.com**
Email: General Inquiries	**providerrelations@ahcusa.com**
Phone: 8 am - 5 pm PT, Mon–Fri	**1-844-361-4712**
PHARMACY	
ALIGNMENT HEALTH PLAN	
Phone: Pharmacy Technical Help Desk 24/7	**1-844-227-7615 (TTY: 711)**
Phone: Member Pharmacy Help 24/7	**1-844-227-7616 (TTY: 711)**
Formulary and Part D Resources	**https://www.alignmenthealthplan.com/members/medicare-part-d**
FIRSTMEDICARE DIRECT	
Phone: Prior Approval	**1-844-499-5630**
Phone: Mail Order	**1-800-763-0044**
Formulary and Part D Resources	**https://www.firstcarolinacare.com/medicare/pharmacy**
QUALITY MANAGEMENT	
Email	**QI@ahcusa.com**
Fax	**1-562-207-4617**
Phone:	**1-833-649-2303**
RISK ADJUSTMENT	
Email: HCC Documentation and Coding	**coding@ahcusa.com**
SALES & MARKETING	
Phone: 8 am–8 pm, seven days a week (except Thanksgiving and Christmas) from Oct. 1 – March 31, and Mon-Fri (except holidays) from April 1 – Sept. 30	**1-888-979-2247 (TTY: 711)**
Email: Sales	**partnerexperience@ahcusa.com**
Email: Marketing	**marketing@ahcusa.com**
STARS	
Email	**stars@ahcusa.com**
TRANSPORTATION	
Phone: SafeRide Health	**1-866-327-2247 (TTY: 711)**
UTILIZATION MANAGEMENT	
Website	Log in to **AVA®** to submit prior authorizations, check statuses on existing authorizations, and submit inquiries. For more information or to request access to **AVA®**, visit **alignmenthealthplan.com/providers.** Contracted and non-contracted providers that do not have access to **AVA®** may submit prior authorizations and check statuses on existing authorizations at **avaprovidertools.alignmenthealth.com/authorizations.**

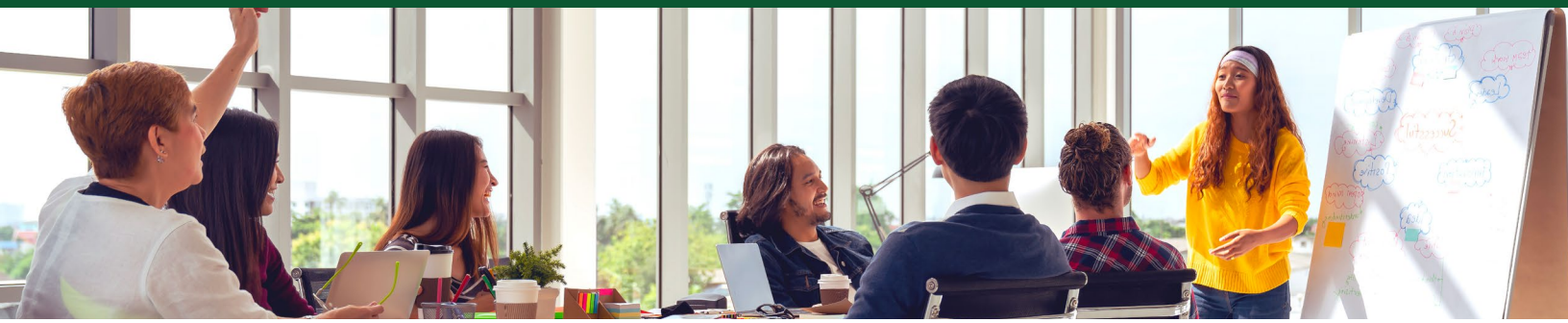
PRIOR AUTHORIZATION

Email: Pre-service	**umdept@ahcusa.com**
Phone:	**1-844-942-4226** Option 2
All States Prior Authorization	**https://avaprovidertools.alignmenthealth.com/authorizations**

HOSPITAL ADMISSIONS

Phone: All Admissions Notifications	**1-844-361-4715**
Fax: California Admission Notifications	**1-562-207-4632**
Fax: All Non-California Admission Notifications	**1-844-227-7596**

SECTION 2 | PRODUCT OVERVIEW



Below is a summary of Medicare Advantage plan types. See **Exhibit 2.1** for Alignment Health Plan's offerings.

HEALTH MAINTENANCE ORGANIZATION (HMO)

HMO is a type of Medicare Advantage plan comprised of a network of contracted medical providers and affiliated health facilities through which member care is coordinated. Most services require a referral and/or authorization prior to obtaining care. Apart from emergency services, urgently needed services, or out-of-area dialysis, out-of-network care is not covered. Members may be responsible for paying the full cost of unauthorized out-of-network care.

HMO WITH POINT-OF-SERVICE OPTION (HMO POS)

HMO POS plans function similar to HMO plans but offer some out-of-network coverage for certain services. The flexibility to receive out-of-network services may cost more to the member than if furnished in-network.

PREFERRED PROVIDER ORGANIZATION (PPO)

PPO plans contract with medical providers to create a network of participating providers. Members can receive in-network care at a lower cost but have the flexibility to seek out-of-network care for core services at a higher cost. Referrals are not required for most services. Prior authorization may be required for some services.

CHRONIC SPECIAL NEEDS PLAN (C-SNP)

C-SNP is a type of Medicare Advantage plan that provides more focused healthcare and benefits for members with chronic illness. It offers enrollment to members that meet specific requirements for qualifying conditions.

DUAL-ELIGIBLE SPECIAL NEEDS PLANS (D-SNP)

D-SNP is a type of Medicare Advantage plan that provides more focused healthcare and additional benefits for members who are entitled to both Medicare and medical assistance from a state plan under Medicaid. States may aid in Medicare costs, depending on the state and the member's eligibility status. Alignment and its providers provide the Medicare services set forth in a member's benefit plan and will coordinate with an applicable state or payer who arranges for the member's Medicaid benefit.

EMPLOYEE GROUP WAIVER PLAN (EGWP)

EGWP is a type of Medicare Advantage plan offered by certain employers to employees, retirees, unions, or government agencies. The plans are tailored to meet each employer's specifications for its eligible employer group.

EXHIBIT 2.1
ALIGNMENT HEALTH PLAN 2025

PRODUCT OFFERINGS

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
AZ	**Heart & Diabetes (HMO C-SNP)** – **the ONE + Walgreens (HMO)/ el ÚNICO + Walgreens (HMO)** – **Retiree Options (HMO)**	Maricopa, Pima, Santa Cruz	HMO members choose a primary care provider (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	smartHMO (HMO) – **Heart & Diabetes Plus (HMO C-SNP)**	Maricopa, Pima, Santa Cruz	HMO Members choose a primary care provider (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.
CA	**AllCare Preferred Plan (HMO)**	Stanislaus	HMO members choose a primary care provider (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to AllCare for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	Harmony (HMO)	Alameda, San Francisco, Santa Clara	HMO members choose a primary care provider (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	CalPlusDuals (HMO D-SNP)	San Joaquin, Stanislaus, Marin, San Francisco, Ventura, San Luis Obispo	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
CA	**ESRD Balance (HMO-C-SNP)**	Los Angeles, Orange,	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	Heart & Diabetes (HMO C-SNP) – **BreathEasy (HMO C-SNP)** – **Clarity (HMO C-SNP)** – **Heroes+ (HMO)** – **Heart & Diabetes Care (HMO C-SNP)**	Los Angeles, Orange, San Diego, San Bernardino, San Francisco, Stanislaus, Alameda, Fresno, Madera, Marin, Riverside, San Joaquin, San Luis Obispo, Santa Clara, Ventura, Sacramento, Placer, Yolo, Merced	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	Silicon (HMO C-SNP)	Santa Clara	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	CommUnity (HMO)	Fresno, Madera	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	smartSavings (HMO)	Los Angeles, Orange, San Bernardino, Riverside, San Diego	HMO members choose primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
CA	**My Choice Select (HMO)**	Los Angeles, Orange, Riverside, San Bernardino	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	Retiree Options (HMO) – **Retiree Options Complete (HMO)**	Los Angeles, Marin, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Ventura, Yolo	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's assigned participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	My Choice (HMO)	Los Angeles, Orange, Riverside, San Bernardino, San Luis Obispo, Ventura	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's assigned participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.
	My Choice CalPlus (HMO)	Santa Clara, San Francisco, Alameda, Sacramento, Placer, Yolo, Los Angeles, San Diego, Orange, San Bernardino, Riverside, Stanislaus, San Joaquin, Marin, Fresno, Madera, San Luis Obispo, Ventura	HMO members choose primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network" referrals are not required to see a specialist.

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
CA	**Platinum + Instacart (HMO)**	Los Angeles, Orange	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.
	Platinum + Instacart (HMO-POS)	San Diego, Marin, San Francisco	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes - Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.
	Select (HMO)	Alameda, San Diego	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	smartHMO (HMO)	Los Angeles, Orange, Riverside, San Bernardino, San Diego, Ventura, Stanislaus, Santa Clara, Merced, Sacramento, Placer, Yolo	HMO members choose primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.
	Sutter Advantage (HMO)	Placer, Sacramento, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, Yolo	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to Sutter for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	the ONE + Walgreens (HMO)/el ÚNICO + Walgreens (HMO)	Fresno, Madera, Merced	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's assigned participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
CA	**Heart & Diabetes CalPlus (HMO C-SNP)**	Los Angeles, Orange, San Diego, San Bernardino, Alameda, Fresno, Madera, Riverside, Santa Clara, Sacramento, Placer, Yolo, Merced, San Fransico, Marin, San Luis Obispo, Ventura, Stanislaus, San Joaquin	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes - Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.
	Balance (PPO)	San Joaquin, Stanislaus	PPO members do not have to choose a network primary care physician (PCP). However, a PCP selection is strongly encouraged to help coordinate care. PPO members can see any in-network provider without a referral. PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance.	No – Referrals are not required to see a specialist for PPO members. Prior authorization may be required for certain types of tests or services received in-network. Please refer to Evidence of Coverage for the list of services that require prior authorization. Prior authorization is not required for covered services received out-of-network. However, if Alignment later determines that the services received were not covered or were not medically necessary, Alignment may deny coverage.
	My Choice (PPO)	Placer, Sacramento, San Joaquin, San Mateo, Santa Cruz, Sonoma, Stanislaus, Yolo	PPO members do not have to choose a network primary care physician (PCP). However, a PCP selection is strongly encouraged to help coordinate care. PPO members can see any in-network provider without a referral. PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance.	No – Referrals are not required to see a specialist for PPO members. Prior authorization may be required for certain types of tests or services received in-network. Please refer to Evidence of Coverage for the list of services that require prior authorization. Prior authorization is not required for covered services received out-of-network. However, if Alignment later determines that the services received were not covered or were not medically necessary, Alignment may deny coverage.
	Advantage PPO (PPO)	Los Angeles, Orange, San Diego, Fresno, Madera, Ventura, Santa Clara	PPO members do not have to choose a network primary care physician (PCP). However, a PCP selection is strongly encouraged to help coordinate care. PPO members can see any in-network provider without a referral. PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance.	No – Referrals are not required to see a specialist for PPO Members. Prior authorization may be required for certain types of tests or services received in-network. Please refer to Evidence of Coverage for the list of services that require prior authorization. Prior authorization is not required for covered services received out-of-network. However, if Alignment later determines that the services received were not covered or were not medically necessary, Alignment may deny coverage.

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
CA	**Freedom (PPO)**	Stanislaus, San Joaquin and San Diego	PPO members do not have to choose a network primary care physician (PCP). However, a PCP selection is strongly encouraged to help coordinate care. PPO members can see any in-network provider without a referral. PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance.	No – Referrals are not required to see a specialist for PPO members. Prior authorization may be required for certain types of tests or services received in-network. Please refer to Evidence of Coverage for the list of services that require prior authorization. Prior authorization is not required for covered services received out-of-network. However, if Alignment later determines that the services received were not covered or were not medically necessary, Alignment may deny coverage.
	Retiree Options (PPO) – **Retiree Options Complete (PPO)**	National	PPO members do not have to choose a network primary care physician (PCP). However, a PCP selection is strongly encouraged to help coordinate care. PPO members can see any in-network provider without a referral. PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance.	No – Referrals are not required to see a specialist for PPO Members. Prior authorization may be required for certain types of tests or services received in-network. Please refer to Evidence of Coverage for the list of services that require prior authorization. Prior authorization is not required for covered services received out-of-network. However, if Alignment later determines that the services received were not covered or were not medically necessary, Alignment my deny coverage.
NV	**smartHMO (HMO)** – **Platinum + Instacart (HMO)**	Clark, Washoe	HMO members choose a primary care provider (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.
	Heart & Diabetes (HMO C-SNP) – **the ONE (HMO D-SNP)/ el ÚNICO (HMO D-SNP)** – **Retiree Options (HMO)**	Clark, Washoe	HMO members choose primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes – Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services.

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
NC	**Heart & Diabetes (HMO-POS C-SNP)** – **Retiree Options (HMO)**	Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes	HMO members choose primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	No - Referrals are not required to see a primary care physician (PCP) and specialist. Prior authorization may be required for certain types of tests or services received in-network. Please refer to Evidence of Coverage for the list of services that require prior authorization.
	NC Duals (HMO-POS D-SNP) – **Platinum (HMO-POS)**	Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes	HMO members choose a primary care physician (PCP) from the network of participating providers.	No – Referrals are not required to see a specialist. Prior authorization may be required for certain types of tests or services received in-network. Please refer to EOC for the list of services that require prior authorization. Prior authorization is required for covered services received out-of-network.
	smartHMO (HMO)	Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes - Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.
	AVA (PPO) – **Retiree Options (PPO)**	Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes	PPO members do not have to choose a network primary care physician PCP). However a PCP selection is strongly encouraged to help coordinate care. PPO members can see any in-network provider without a referral. PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance.	No – Referrals are not required to see a specialist for PPO Members. Prior authorization may be required for certain types of tests or services received in-network. Please refer to Evidence of Coverage for the list of services that require prior authorization. Prior authorization is not required for covered services received out-of-network. However, if Alignment later determines that the services received were not covered or were not medically necessary, Alignment may deny coverage.

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
TX	**Heart & Diabetes (HMO-POS C-SNP)** – **the ONE + Walgreens (HMO) /el ÚNICO + Walgreens (HMO)** – **Heart & Diabetes Plus (HMO-POS C-SNP)** – **Premium (HMO-POS)** – **Retiree Options (HMO)**	El Paso, Hudspeth	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	No - Referrals are not required to see a primary care physician (PCP) and specialist. Prior authorization may be required for certain types of tests or services received in-network. Please refer to Evidence of Coverage for the list of services that require prior authorization
	Dual Select+ (HMO-POS D-SNP)	El Paso, Hudspeth	HMO members choose a primary care physician (PCP) from the network of participating providers.	No – Referrals are not required to see a specialist. Prior authorization may be required for certain types of tests or services received in-network. Please refer to EOC for the list of services that require prior authorization. Prior authorization is required for covered services received out-of-network.
	smartHMO (HMO-POS)	El Paso, Hudspeth	HMO members choose a primary care physician (PCP) from the network of participating providers. Members are required to see their assigned PCP to coordinate their care.	Yes - Referrals that require prior authorization, whether to a participating provider or out-of-network provider, must be submitted to the member's participating provider group for review and determination. Failure to obtain prior authorization may result in nonpayment of services. *For members with an assigned PCP that is part of "Alignment Health Plan Network," referrals are not required to see a specialist.

*All product names begin with Alignment Health Plan.

EXHIBIT 2.2
ALIGNMENT HEALTH PLAN 2025

PRODUCT OFFERINGS

STATE	PRODUCT NAME	PLAN SERVICE AREA(S)	HOW DO MEMBERS ACCESS PHYSICIANS AND HEALTHCARE PROFESSIONALS?	DOES A PRIMARY CARE PROVIDER HAVE TO MAKE A REFERRAL TO A SPECIALIST?
NC	**FirstMedicare Direct smartHMO (HMO)**	Wake	Members can self-refer to Physicians and Healthcare Professionals within our network.	No – Referral from a PCP is not needed. Members can self-refer to contracted specialists for consultations.

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 Alignment in conjunction with CMS. There are six types of election periods during which beneficiaries may make enrollment requests. They are:

- The Annual Election Period (AEP)
- The Initial Coverage Election Period (ICEP)
- The Initial Enrollment Period for Part D (IEP for Part D)
- The Open Enrollment Period for Institutionalized Individuals (OEPI)
- The All Special Election Periods (SEP)
- The Medicare Advantage Open Enrollment Period (MA OEP)

1. ELIGIBILITY REQUIREMENTS

To be eligible, a beneficiary must be enrolled with Medicare Part A and Part B coverage, reside within Alignment's approved service area, and be a United States citizen or lawfully present in the United States.

Enrollment in, or voluntary disenrollment from, Alignment constitutes an "election."

2. LIMITATIONS ON ENROLLMENT

Medicare beneficiaries who have elected Medicare hospice coverage prior to enrollment are still eligible to enroll in Alignment. Original Medicare is responsible for hospice services and for Part A and Part B services related to the member's terminal prognosis. Alignment is responsible only for covered services that are not related to the member's terminal condition. Alignment follows the CMS enrollment periods, as indicated in Chapter 2 of the **Medicare Managed Care Manual: Medicare Advantage Enrollment and Disenrollment**.

Members that are newly enrolled in Alignment and are currently inpatient on the effective date of enrollment will be covered by Alignment following discharge from the hospital or upon transfer to a lower level of care. Payment for inpatient hospital services continues to be the responsibility of Medicare or the previous MA organization/health plan until the date of discharge. Alignment assumes responsibility for all other Part A and Part B coverage (except inpatient hospital care) on the effective enrollment date.

3. MEMBER ELIGIBILITY

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 the MARx online query process (M232 screen).

Generally, the member's enrollment becomes effective on the first day of the following month after an election is made. The member's enrollment under any other Medicare Advantage Plan or standalone 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 its prospective members and the names of the members' PCP on the eligibility report. But until confirmation and payment are received from CMS, Alignment does not include the member's name on capitation reports. All confirmed retroactive capitation shall be paid accordingly to each capitated provider. All members who appear on the Alignment eligibility report are to be rendered care when they present their member identification card to their assigned PCP's office. Members are not to be denied services due to their name not appearing on the capitation report. Contact Alignment for verification of eligibility pursuant to Section 4 below.

4. ELIGIBILITY VERIFICATION

Participating providers are responsible for verifying eligibility each time a member receives care. Member eligibility can be verified through any of the following methods:

- By registering for access to **AVA®** (see **Exhibit 1.1 Eligibility**). To obtain eligibility through **AVA®** , providers must have the Member ID number (example: 00012345601), the Medicare Beneficiary Identifier (MBI) number, or full name and date of birth. In **AVA®** , providers can verify members' current and past eligibility since their original enrollment with Alignment. Additionally, providers can also submit and track inquiries related to member eligibility and benefits.
- Using Interactive Voice Response (IVR) system (see **Exhibit 1.1: Eligibility**). To obtain eligibility through the IVR, providers must have the Member ID number (example: 00012345601), Medicare Beneficiary Identifier (MBI) number, and date of birth. Through the IVR, you may verify the member's eligibility as far back as January 1 of the previous calendar year. For dates of service prior to this, please contact the Eligibility Department (see **Exhibit 1.1: Eligibility**).
- By utilizing Alignment's Secure File Transfer Protocol (SFTP) site method for obtaining eligibility reports. For details on SFTP access, see Eligibility Reports.
- By calling Alignment's Eligibility Department (see **Exhibit 1.1: Eligibility**). Providers must provide their National Provider Identifier (NPI) and Tax Identification Number (TIN) to verify member eligibility and benefits. If issues arise during this process, please contact Network Management (see **Exhibit 1.1: Network Management/Provider Relations**).
- By registering as trading partners with Office Ally for 270/271 (HIPAA-5010) Health Care Eligibility and Benefit Inquiry and Response (see **Exhibit 1.1: Eligibility**). This vendor facilitates real time requests of eligibility and benefit inquiries.
- To receive a 270/271 transaction, you must register as a trading partner with Office Ally at **https://cms.officeally.com/**.
- FirstMedicare Direct providers can access members' eligibility status either through the Health Plan's website or by calling the Health Plan's Eligibility Department (see **Exhibit 1.1: Eligibility**).
- Non-contracted providers and contracted providers – yet to have AVA portal access may verify member eligibility through Alignment's self-service Member Eligibility Verification Provider Tool (that does not require a portal login) (see **Exhibit 1.1: Eligibility**).

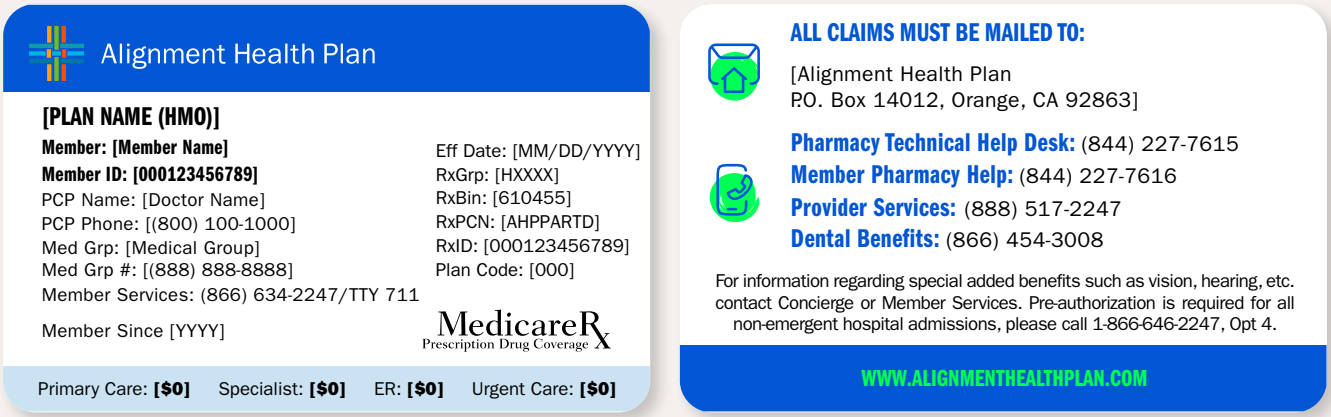
Members with future effective dates can be verified only on or after their effective date.

5. MEMBER IDENTIFICATION CARD

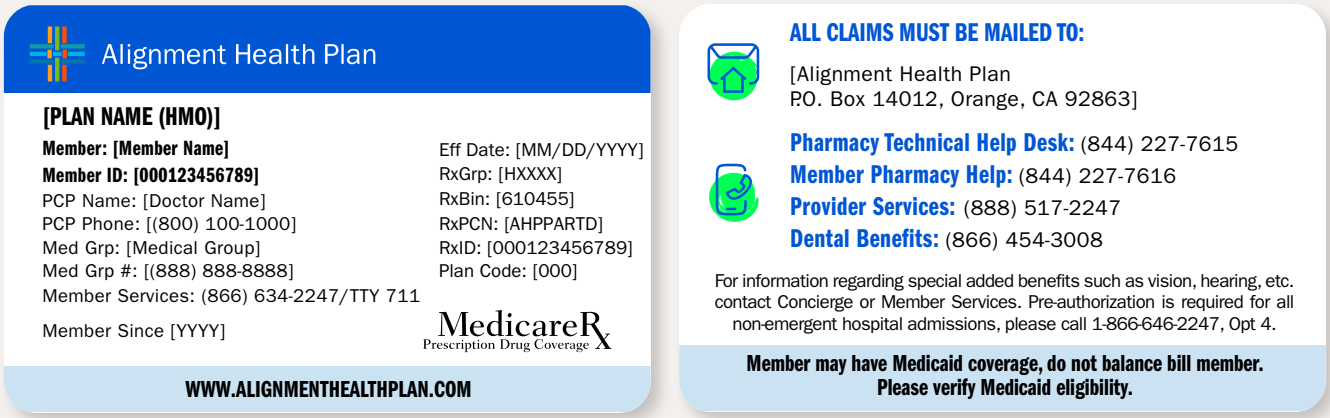
New members are mailed their member identification card and welcome packet upon enrollment with Alignment. If a member requires services prior to receiving a member ID card, the member's confirmation/acknowledgment letter or enrollment form may be used. A member ID card or enrollment form does not constitute Alignment coverage. Providers should always verify eligibility prior to rendering services to any member. To verify eligibility, contact the Eligibility Department (see **Exhibit 1.1: Eligibility**).

EXHIBIT 3.1
ALIGNMENT HEALTH PLAN MEMBER ID CARD SAMPLES

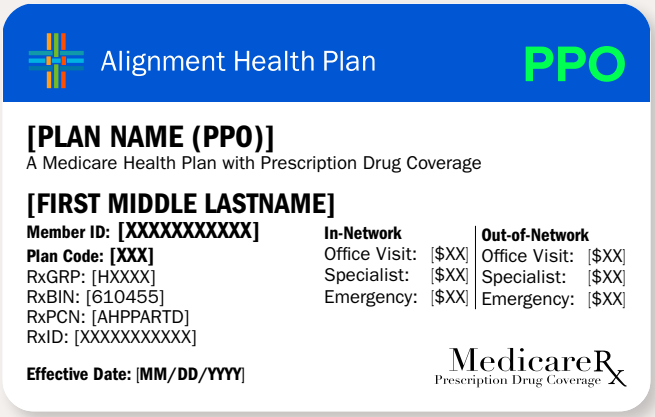
ALIGNMENT HEALTH PLAN HMO



ALIGNMENT HEALTH PLAN HMO D-SNP



ALIGNMENT HEALTH PLAN PPO



ALIGNMENT HEALTH PLAN PPO MULTIPLAN

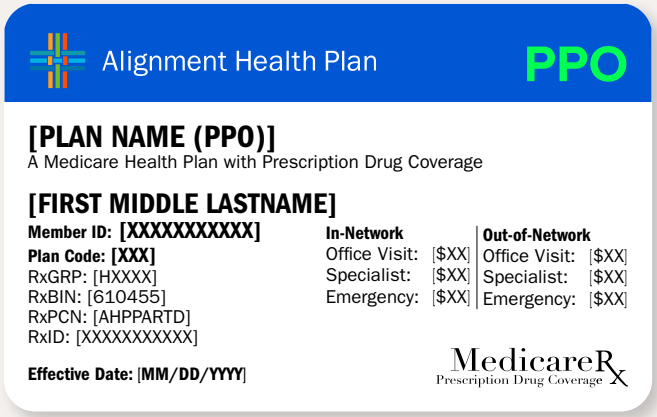
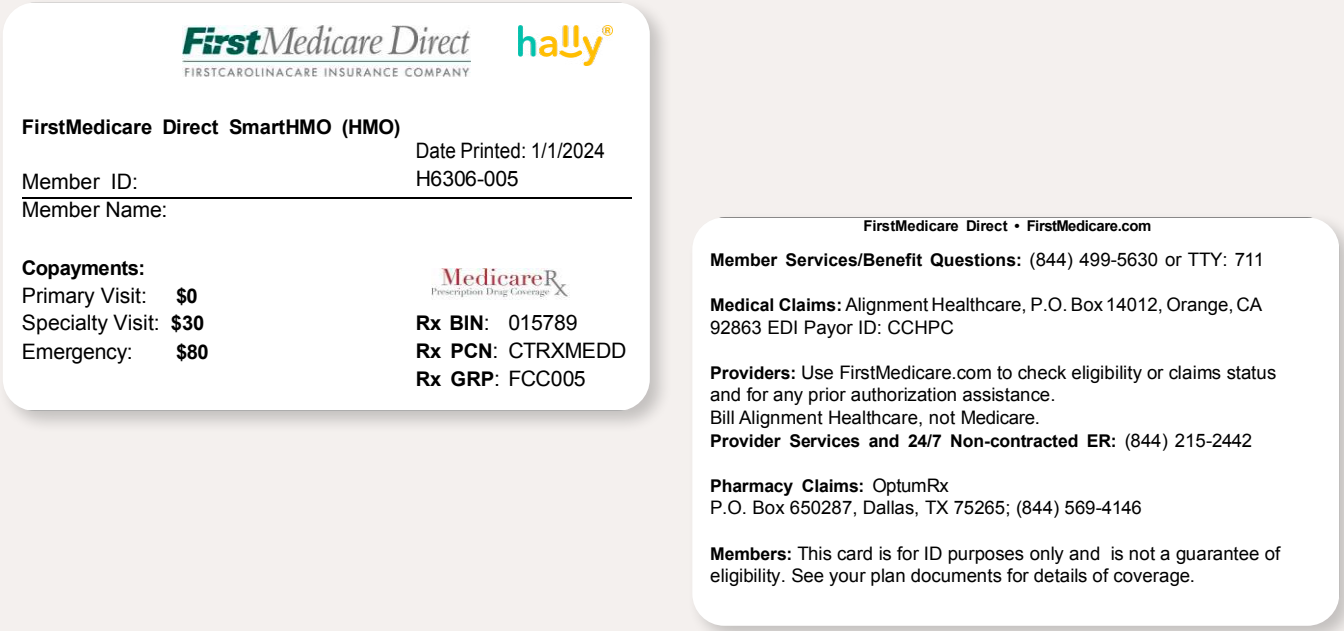


EXHIBIT 3.2
FIRSTMEDICARE DIRECT MEMBER ID CARD SAMPLES

FIRSTMEDICARE DIRECT SMARTHMO (HMO)



6. LOCK-IN PROVISION

Prior to enrolling with a health plan, the beneficiary is educated on the lock-in provision, which requires that the beneficiary obtain all medical care through the selected health plan. This provision applies from the effective date of coverage forward.

7. ELIGIBILITY REPORTS FOR CAPITATED / HMO MEMBERS

IPAs/medical groups, capitated participating provider groups, or the PCP will receive weekly eligibility reports that contain a list of all eligible members. Providers should check the member's effective and termination dates to ensure eligibility before rendering services. This report can be reconciled with the capitation report to verify that correct capitation has been received and that capitation includes retroactive activity. Alignment strives to ensure that our IPAs/medical groups, providers and staff receive the most current information as soon as possible to facilitate patient care and referrals.

Alignment has a SFTP site method for obtaining eligibility reports, Qualified Medicare Beneficiary (QMB) reports, capitation reports, and any other format that contains Protected Health Information (PHI). PCPs and other providers can download monthly reports on our SFTP site, as stated in the provider's contract with Alignment. These secure servers allow providers to download multiple files at once.

To access monthly reports, log in to the SFTP site (see **Exhibit 1.1: General Resources**), and follow these steps:

1. Select "**Web Client**." Click "**OK**"; then click "**Continue**."
2. Double-click the "**OutBoundFromAHC**" folder to open and locate the file corresponding to the desired report.
3. Double-click on the desired file. It will download to the Participating Provider's computer.
4. Double-click on the downloaded file to open.

REPORTS	REPORT FORMAT
Capitation	IPACODE_CAP_YYYYMMDD.EXT
Eligibility	IPACODE_ELIGIBILITY_YYYYMMDD.EXT IPACODE_MEMBERREPORTINGCATEGORIES_YYYYMMDD.EXT
Pharmacy	IPACODE_RXCALINX_YYYYMMDD.EXT
Stars	IPACODE_STARS_YYYYMMDD.EXT
Monthly Membership	IPACODE_MMR_YYYYMMDD.EXT
Model Output	IPACODE_MOR_ YYYYMMDD.EXT
Performance Dashboard Report	IPACODE_PERFORMANCEDASHBOARD_YYYYMMDD.EXT

The file name corresponds to the letters of IPA name, type of file (cap, eligibility, etc.), year, month, day and file extension.

For assistance, please contact Network Management (see **Exhibit 1.1: Network Management/Provider Relations**) or the EDI Department (see **Exhibit 1.1: Electronic Data Interchange**).

IPAs/medical groups will also receive the QMB report each month. This report can be used to identify dual-status beneficiaries.

Alignment distributes the eligibility report in two formats: Excel and fixed-length file.

Alignment can also distribute eligibility in an 834 format. If the 834 format is desired, please contact Network Management/ Provider Relations. (see **Exhibit 1.1: Network Management/Provider Relations**)

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

1. Member ID # (The ID # that is assigned to the Member by Alignment.)
2. Last Name
3. First Name
4. Middle Initial
5. Sex
6. Birth date
7. SSN (Social Security Number; due to PHI, Alignment will no longer provide the SSN.)
8. MBI #
9. Address 1
10. Address 2 (Apartment numbers only.)
11. City
12. State
13. ZIP Code
14. Phone
15. HP Effective Date (The date the Member enrolled with Alignment.)

16. Medicaid (This field is populated with either "Y" or "N." If "Y" is populated, the member HAS Medicaid – if "N" is populated, the member DOES NOT have Medicaid.)
17. PCP ID #
18. PCP Name
19. PCP Effective Date (The date the Member is eligible with his/her assigned PCP.)
20. Prospective (This field will identify the Members who are PROSPECTIVE, meaning that these Members are in the process of enrollment and their CMS confirmation is pending)
21. Tran Status
22. Term Date
23. Prior PCP Name
24. Prior IPA/Medical Group Name
25. New Mbr History
26. Mailing Address
27. Mailing Address 2
28. Mailing City
29. Mailing State
30. Mailing ZIP Code
31. RAF Score
32. RAF Type
33. LIS Level
34. LIS Date
35. Working Aged/Coordination of Benefits (COB)
36. Resident County
37. IPA/Medical Group POD
38. Primary Language
39. Benefits Option
40. Member Email
41. Contact Name
42. Contact Phone #
43. Contact Email
44. Contact Relationship
45. PCP Street
46. PCP Street 2
47. PCP City
48. PCP State
49. PCP ZIP Code
50. PCP Phone #
51. PBP (Plan Benefits Package)
52. Info Method

- Mailing Address: "Mailing Address," "Mailing Address 2," "Mailing City," "Mailing State," and "Mailing ZIP Code," if populated, will indicate the member's alternative address, which is NOT the member's permanent address. The mailing address will populate only if the member designates an alternative address to Alignment.
- Prior PCP Name + IPA/Medical Group Name: "Prior PCP Name" and "Prior IPA/Medical Group Name," if populated, will indicate that an existing Alignment member has transferred into your office. These columns will help your current PCPs to contact a member's prior PCP/IPA/Medical Group to obtain the member's medical chart.
- New Mbr History: Identified members who are new to your office are designated with an asterisk (*). Each asterisk accounts for one calendar month of enrollment and this will remain on file for four months. For each member transferred into your office, a plus sign (+) will be included, followed by an asterisk. Our goal is to assist you in identifying new members, so that an initial health assessment or physical can be completed.

- Working Aged/COB: "Working Aged/COB" shall identify members with other coverage for coordination of benefits. This field will be populated with a "Y" (yes) or "N" (no). If the column is fagged with a "Y," the member has other coverage, and additional information can be provided upon request from the Eligibility Department.
- RAF Score: "RAF Score" will include the Risk Adjustment Factor score on the e-list. Managing your member's RAF scores will enable delivery of appropriate, quality care.
- LIS Level: The column "LIS Level" will indicate the Low Income Subsidy level copayment, with a 0, 1, 2, 3, or 4 to indicate the different levels of copays. The column "LIS Date" will identify the effective date with the level of LIS.
- Info Method: Is the accessible format the member is requesting to received their materials. Methods provided are Audio, Braille, Large print, E-mail, Website, and blank if no information is provided.

8. QUALIFIED MEDICARE BENEFICIARY (QMB)

Federal law prohibits all Medicare providers from billing dual-eligible Qualified Medicare Beneficiary (QMB) members for Medicare deductibles, copayment and coinsurance. The QMB program assists low-income Medicare beneficiaries with their Medicare Part A and Part B premiums and cost-sharing. All Medicare and Medicaid payments received by providers for furnishing services to a QMB are considered payment in full. IPAs/medical groups or participating providers may request payment for these premiums and cost-sharing amounts from the state.

Providers are responsible for educating their staff on the importance of checking a patient's QMB status before billing for any deductibles, copayment and coinsurance. Use **AVA®** to verify QMB status or call Alignment Eligibility (see **Exhibit 1.1: Eligibility**). As an additional resource, the IPAs/medical groups will receive, via SFTP, the aforementioned 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**.

Your QMB report contains beneficiaries with dual status for the current calendar month. The file consists of:

NAME	DESCRIPTION	FORMAT	MAX LENGTH
MEMBER_ID	Member ID	Text	25
LAST_NAME	Member last name	Text	30
FIRST_NAME	Member first name	Text	30
MI	Member middle initial	Text	3
SEX	Member gender code where "M" is for Male, and "F" is for Female	Text	1
DOB	Member date of birth	Date (YYYYMMDD)	8
MEDICARE_ID	Member Medicare ID (HIC/MBI)	Text	12
REPORTING_CATEGORY	Name of the reporting category. See section 4.0 for the definition	Text	60
REPORTING_CODE	Name of the reporting code. See section 5.0 for the definition	Text	50
START_DATE	Effective start date of the reporting code	Date (YYYYMMDD)	8
END_DATE	Effective end date of the reporting code	Date (YYYYMMDD)	8

9. NO BALANCE BILLING

Payments made by Alignment to provider, less copayment, coinsurance, or deductibles, which are the member's financial responsibility, are considered payment in full. Providers may not seek additional payments from members and shall hold members harmless for the difference between the billed charges and the rate paid by Alignment and for any unpaid balance remaining after coordination of benefits.

Providers shall not deny services to a member based on the member's inability to pay a coinsurance or copayment amount.

Additionally, providers must follow applicable agency regulations regarding cost-share protection for members. Providers shall not hold any member responsible for a cost share if that member is cost-share protected.

10. PRIMARY CARE PROVIDER (PCP) SELECTION

At the time of enrollment, HMO Plan members will be required to select a PCP who will provide services described in the member's Evidence of Coverage (EOC) booklet. If the member does not select a PCP, or selects a PCP and the panel is closed, the Health Plan will assist the member with their PCP selection or assign a PCP near the member's residence.

PPO Plan members are not required, but are strongly encouraged, to select a PCP. PPO Plan members can see any doctor or specialist in the network without a referral. Prior authorization is not required for covered services received out-of-network. However, it is recommended that the member and/or doctor ask for a pre-visit coverage decision to confirm that the services are covered and medically necessary by calling Member Services (see **Exhibit 1.1**). The physician most likely to serve as a member's PCP will be contacted by Alignment regarding care coordination and quality.

11. MEMBER TRANSFERS BETWEEN PCPS

CMS guidelines allow transfers between PCPs without any annual limitation. These transfer requests may be made by the member at any time. The effective date of transfer shall be the first day of the month following the transfer request.

Members requesting a transfer should contact the Health Plan's Member Services Department. The transfer request procedure is as follows:

- Affected PCPs and/or the IPAs/medical groups are notified of the transfer via the eligibility report.
- Once the request is completed, the member is sent an updated Health Plan member ID card.

12. MEMBER INELIGIBILITY

Member disenrollment occurs only on the last day of the month. A Medicare-entitled member becomes ineligible for coverage under the Health Plan when any of the following situations occur:

1. 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.)
2. The member is not a United States citizen or lawfully present in the United States. (Termination is effective the first day of the month following the notification by CMS.)
3. 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 out of the service area for a maximum of six months per coverage period.
4. The member becomes incarcerated. (The effective date of disenrollment will be the first of the month after the incarceration start date.)
5. The member commits fraud or allows another person to use their Health Plan ID card to obtain services. Such terminations must be approved by CMS.
6. The member is disruptive, abusive, unruly and/or uncooperative to the extent that this behavior jeopardizes the well-being of any provider, member or employee, and this information is documented by the Health Plan. Such terminations must be approved by CMS.
7. The member knowingly omits or misrepresents a material fact on the application for membership. Such terminations must be approved by CMS.
8. The Health Plan's contract with CMS is not renewed.
9. 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.

13. VOLUNTARY DISENROLLMENT

A member may not always be able switch plans until the appropriate election periods apply. If a specific election period applies and the member wishes to make a change, they must submit a written request to the Health Plan's Member Services Department.

The member may also request that a disenrollment form be 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 be accepted, but calls will be documented within the Health Plan's system and a preprinted 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 by phone and shall document the contact and process the request rather than return the written request as incomplete.

If a member enrolls in another Medicare Advantage Plan, they will automatically be disenrolled from their existing health plan when their new membership becomes effective. The effective date of disenrollment is the first day of the month following the month in which CMS receives the member's request.

14. MEMBER NOTIFICATION OF PARTICIPATING PROVIDER TERMINATIONS

Pursuant to the Code of Federal Regulations 88 FR 22120, when a contracted provider terminates from Alignment Health's network, Alignment Health, or Alignment's delegated IPAs/MGs/Providers as set forth herein, must provide members with notice of such contracted provider termination, irrespective of whether the termination was for cause or without cause. Alignment Health will make a good faith effort to provide members with notice of a for-cause termination of a contracted provider within the timeframes below. A summary of the time frames and requirements for notifying members when a contracted provider terminates, pursuant to the Code of Federal Regulations 88 FR 22120, is as follows:

1. For terminations that involve a primary care or behavioral health provider, the following member notification is required:
   - At least 45 calendar days before the termination effective date, provide written notice to members and
   - At least 45 calendar days before the termination effective date, make one attempt at a telephonic notice to members who have not opted out of calls regarding plan business.

   Notice is required to all members who are currently assigned to the terminating primary care provider and to members who have been patients of the terminating primary care or behavioral health provider within the last three years.
2. For terminations that involve specialty types other than primary care or behavioral health, written notice to the member is required at least 30 calendar days before the termination effective date.

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

For non-delegated IPAs/MGs/Providers, Alignment Health will facilitate the member notifications when a contracted provider terminates.

For IPAs/MGs/Providers who are delegated for utilization management, Alignment Health will facilitate the member notifications when a primary care provider terminates. For all other provider terminations, the delegated IPA/MG/Provider will be responsible for the member notifications.

15. MEMBER NOTIFICATION OF PROVIDER TERMINATION DUE TO PARTICIPATING PROVIDERS' BEING ON THE PRECLUSION LIST

The delegated provider will notify members (who have received care in the last 12 months from a specialist, ancillary provider, hospital or other practitioner) whose provider is on the CMS Preclusion List and thus no longer available.

The Health Plan will notify members (who have received care in the last 12 months from a PCP) whose PCP is included on the CMS Preclusion List and thus no longer available to them.

Members will be notified within 30 days of the Health Plan receiving the Preclusion List.

16. PROVIDER-INITIATED DISENROLLMENT OF A MEMBER

The provider can request that a member be involuntarily disenrolled from the provider's practice if the member does not comply with recommended patterns of treatment or exhibits repeated abusive behavior. Examples include:

- Assault
- Serious threats
- Disruption to IPA/medical group operations or the provider's office
- Inappropriate use of Out-of-Network services
- Inappropriate use of medical services
- Inappropriate use of medical services

In all such instances, providers recognize their responsibility for making 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. Provider offices must document all occurrences in the member's medical record. The provider and/or the IPA/medical group acting on behalf of the provider must send a certified letter to the Health Plan's Member Services Department stating the reasons for the disenrollment request. This letter must be directed to the respective addresses in **Exhibit 1.1**.

The Health Plan's Member Services Department will evaluate the request and determine the conditions that would warrant the request. Until the effective date of an approved disenrollment, the provider shall continue to be responsible for the member's healthcare. Based on the outcome of the review, the member may be transferred and notified according to policy or given a corrective action plan (CAP) to follow. If the member does not comply with the CAP, an immediate transfer to another physician within the network shall be made. If the matter was due to noncompliant or disruptive behavior, a request for an involuntary disenrollment may be made to CMS.

If a member's disruptive behavior is of a serious nature, a single occurrence may warrant an involuntary provider-to- provider transfer or involuntary disenrollment. Examples of this behavior include threatened or actual bodily harm to the provider or the 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 CAP, provider transfer or involuntary disenrollment is justified.

SECTION 4 | COMPLIANCE

OVERVIEW

Providers are required to comply with the terms of their agreement with Alignment, this manual (which is an extension of the Provider's agreement with Alignment), federal law, including CMS regulatory requirements, and applicable state law, except where federal law preempts state law. These requirements, including the Medicare Advantage Regulatory requirements, are included in your agreement with Alignment. Refer to **Exhibit 1.1** for Compliance Department contact information.

Alignment will conduct oversight, monitoring and auditing to ensure that providers follow all applicable laws and regulations and that providers implement corrective action plans when these requirements are not met.

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

Provider's failure to comply with the CMS regulatory requirements, the Provider's agreement with Alignment or this manual is subject to disciplinary action, including, but not limited to a corrective action plan, penalty or payment withhold set forth by Alignment.

1. OFFSHORE ATTESTATION

No IPAs/medical groups or providers may employ or contract with a person or entity to which Medicare beneficiary Protected Health Information (PHI) will be sent or accessed offshore without prior written consent of the Health Plan. "Offshore" refers to countries outside the 50 United States and its territories (American Samoa, Guam, Northern Marianas, Puerto Rico and the U.S. Virgin Islands). Examples of countries that meet the definition of "offshore" include, but are not limited to, Mexico, Canada, India, Germany and Japan.

Subcontractors that are considered offshore can either be American-owned companies with certain portions of their operations performed outside of the United States, or foreign-owned companies with operations performed outside of the United States. Offshore subcontractors provide administrative or health benefit services that are performed by employees or contractors located in offshore countries, regardless of whether those workers are employed or contracted by American or foreign companies.

CMS must be informed if the offshore employee or subcontractor is receiving, processing, transferring, handling, storing, or accessing beneficiary PHI in oral, written, or electronic form. Examples of PHI include name, birth date, address, Social Security number, Medicare identifier, health insurance claim number, patient identifiers, treatment records, payment information, or any information that could reasonably lead to the identification of a beneficiary.

Providers must submit an offshore subcontractor attestation to Alignment's Compliance Department to obtain approval before entering into or amending any agreement with an offshore subcontractor or employing workers who are located offshore (see **Exhibit 1.1: Compliance**). Alignment's Offshore Subcontractor Information and Attestation Form is accessible to FDRs in the Providers tab on the **Alignment Website**.

2. OBLIGATION FOR REPORTING SUSPECTED NONCOMPLIANCE, FRAUD, WASTE, AND ABUSE OR HIPAA PRIVACY/SECURITY VIOLATIONS

Providers play a vital role in protecting the integrity of the Health Plan and the Medicare program. Alignment maintains an open-door policy to encourage providers to report compliance-related concerns, ensure that reports are handled as confidentially as possible, and escalate issues that cannot be resolved to a higher level of management.

The methods available for reporting noncompliance or fraud, waste, and abuse (FWA) concerns, along with a non retaliation policy, must be publicized throughout the provider's facilities. Providers should train their employees on their own reporting processes, including emphasizing that reports may be made directly to the Health Plan when applicable. Alignment has adopted and enforces a zero-tolerance policy for retaliation or retribution against any provider or their employees who, in good faith, report suspected noncompliance, FWA or HIPAA violations.

To this end, providers must ensure that 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 Participating Provider, Health Plan management, or the Health Plan's Compliance and Regulatory Affairs Department
- May report compliance-related issues anonymously and without fear of retaliation

Providers should ensure that their employees know how to report suspected noncompliance, FWA and HIPAA violations either through the appropriate provider management or directly to Alignment (see **Exhibit 1.1: Compliance**). For FirstMedicare Direct, please refer to **Compliance section of its website**. Also, see **Health Insurance Portability and Accountability Act of 1996** (HIPAA) for more information.

3. ALIGNMENT CODE OF CONDUCT AND MEDICARE COMPLIANCE AND FRAUD, WASTE, AND ABUSE PLAN

CMS requires Alignment to distribute our Code of Conduct and Compliance Policies and Procedures within the Medicare Compliance and Fraud, Waste, and Abuse Plan ("Compliance Plan") to our employees and all first-tier, downstream, and related (FDR) entities. Alignment's Code of Conduct and Compliance Plan are accessible to FDRs in the Providers tab on the **Alignment website**. FirstMedicare Direct's compliance page can be accessed via its website.

FDR temporary and permanent employees, board members, volunteers, interns, consultants, contractors and subcontractors must receive a copy of Alignment's Code of Conduct and Compliance Policies and Procedures or the FDR's own comparable materials. These must be provided during orientation (or upon contracting, in the case of subcontractors) and upon revision and annually thereafter. Evidence of distribution and receipt of this information must be retained for 10 years to meet CMS's retention requirement, and it may be requested by Alignment upon audit.

4. OIG-GSA EXCLUSION LIST SCREENINGS

Per CMS guidance, Medicare payment may not be made for items or services furnished or prescribed by an excluded provider or entity. Sponsors shall not use federal funds to procure services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR entity excluded by the DHHS Office of the Inspector General or General Services Administration.

Providers must review the DHHS OIG's List of Excluded Individuals and Entities (LEIE) and the GSA's System for Award Management (SAM) before hiring or contracting with any new employee, volunteer, consultant, governing body member or downstream entity. They must also review these resources monthly thereafter to ensure that none of these people or entities have become excluded from participation in federal programs. Monthly screening is essential to prevent inappropriate payments. After

entities are initially screened against the entire LEIE and SAM prior to hire or contracting, only the LEIE supplement file and SAM updates provided each month must be reviewed.

The LEIE includes all healthcare providers and suppliers that are excluded from participation in federal healthcare programs, including healthcare providers and suppliers that might also be on the SAM. In addition to healthcare providers (that are also included on the LEIE) the SAM includes non-healthcare contractors.

Evidence of initial and monthly screenings must be retained for 10 years to meet CMS's 10-year retention requirement, and it may be requested by Alignment upon audit.

Website links are below:

- **OIG LISTSERV** via the OIG website
- **General Services Administration (GSA) database** via the SAM website

5. NONDISCRIMINATION

Providers must follow laws that protect members from discrimination or unfair treatment. Providers shall not deny, limit or condition the provision of covered services to members on the basis of any factor related to health status. These factors include but are not limited to: medical history (including mental and physical conditions), claims experience, receipt of healthcare, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

Further, providers shall not discriminate against members in the delivery of healthcare services based on: race, ethnicity, national origin, religion, sex, creed (beliefs), age, sexual orientation, gender identity, geographic location within the service area, or source of payment (i.e., providers cannot refuse to provide covered services to members because the member receives assistance with Medicare cost-sharing from a State Medicaid program).

In providing covered services to members, providers must comply with federal laws against discrimination. These include but are not limited to: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and the Genetic Information Nondiscrimination Act of 2008, any other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

Additional information is available at HHS.gov (**Civil Rights for Providers of Health Care and Human Services** and **Section 1557 of the Patient Protection and Affordable Care Act**)

6. MEMBER RIGHTS AND RESPONSIBILITIES

Members have the right to:

1. Receive information in a way that works for them and is consistent with their cultural sensitivities (in languages other than English, in Braille, in large print, alternate formats, etc.)
2. Fair and respectful treatment, free from discrimination based on race, ethnicity, national origin, religion, sex, creed (beliefs), sexual orientation, gender identity, age, disability, health status, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, source of payment, or location within the service area.
3. Timely access to covered services, including the right to:
   - Choose a Participating Care Provider in the Health Plan's HMO network to provide and arrange for covered services.
   - Choose a provider in the Health Plan's PPO network.
   - For HMO plans, go to a women's health specialist (e.g., a gynecologist) without a referral and, for PPO plans, to do so while paying in-network cost-sharing amounts.
   - Get appointments and covered services from the Health Plan's HMO network of providers within a reasonable amount of time.
   - Get appointments and covered services from providers within a reasonable amount of time for PPO plans.
   - Get timely services from specialists when care is needed.
4. Privacy of their medical records and personal health information.
5. Confidentiality of personal and health information, including the release of medical records, regardless of the format of that information (e.g., spoken communications, written materials, electronic records, facsimiles).
6. Access personal medical records in accordance with the law.
7. See the information in their medical records and know how it has been shared with others.
8. Participate in decisions about their healthcare and be educated on all available treatment options and associated risks (including the option of no treatment), regardless of cost or coverage by the Health Plan. Members must be told about any risks involved with their care, and informed in advance if any proposed medical care or treatment is part of a research experiment. Members always have the choice to refuse any experimental treatments.
9. Utilize an advance directive, such as a living will or a durable healthcare power of attorney.
10. Appoint a representative to make healthcare decisions, including the decision to withhold resuscitative services or to withdraw life-sustaining treatment, if requested.
11. File complaints and obtain a prompt resolution of issues, including grievances or appeals relating to the authorization, coverage or payment of services. When members exercise this right, they must be treated fairly.
12. Obtain information regarding healthcare coverage and costs, and the rules that members must follow when using coverage.
13. Obtain information about participating providers, including their qualifications and how they are paid by the Health Plan.
14. Obtain a written explanation for why a medical service is not covered or is restricted in some way and how to appeal the decision.

Members have certain responsibilities. These include the responsibility to:

1. Have a general understanding of their healthcare coverage, the rules that must be followed to receive care, and what they must pay out of pocket.
2. Inform the Health Plan of any other health insurance coverage or prescription drug coverage in addition to our plan, so benefits can be appropriately coordinated.
3. Show their Health Plan membership card whenever they get medical care or Part D prescription drugs.
4. Provide their physicians and other healthcare providers with complete and accurate information necessary for appropriate healthcare – ask questions and follow through on their care.
5. Pay any applicable co-payment, deductible, co-insurance, or charge for noncovered services when requested by their Alignment participating providers.
6. Be considerate, respectful of the rights of other patients, and act in a way that helps the smooth running of their doctor's office, hospitals and other facilities.
7. Tell the Health Plan if they move outside or within the Health Plan service area, so that we can assist with their options to keep their membership record up to date.

Inform the Health Plan of any questions, concerns or suggestions. For more information about Medicare beneficiary rights and protections, visit the Medicare website (**https://www.medicare.gov/basics/your-medicare-rights**). Please also refer to the member's Evidence of Coverage (EOC) for the plan they are enrolled in.

SECTION 5 | DELEGATION OVERSIGHT

OVERVIEW

Alignment's Delegation Oversight (DO) Department is responsible for the oversight of claims, credentialing, utilization management, and case management delegated functions, as applicable, according to the participating provider service agreement.

Instructions for submitting all required reports and documents will be provided to providers during onboarding with Alignment and annually thereafter. Reporting instructions and templates are also available in **AVA®** (login needed).

Reporting and monitoring activities in this section are subject to change based on regulatory requirements and will be communicated to delegated entities by DO.

1. DELEGATED ENTITIES

Those IPAs/medical groups, hospitals or vendors that have been delegated to conduct specific functions and/or activities on behalf of Alignment will have the delegated requirements included in their participating provider service agreements. Delegated entities must receive Alignment's prior approval before any of the delegated responsibilities are sub-delegated to another entity.

Adherence to these requirements is vital to ensure that functions and activities meet the standards of CMS, the National Committee for Quality Assurance (NCQA), state regulations, other governing agencies and Alignment.

As a delegated entity, compliance with regulatory requirements and Alignment standards will be evaluated through oversight audits, periodic monitoring, or other assessments as required. All staff members who have accountability for compliance with these standards must receive training to ensure comprehensive understanding of these standards. Delegated entities are responsible for maintaining records of training programs, including, at a minimum, dates, attendees and a summary of the training provided.

2. DELEGATION OVERSIGHT AUDIT AND MONITORING PROGRAMS

DO conducts an annual risk assessment of all delegated entities to determine whether an annual audit is warranted for the upcoming calendar year. Qualifying risks that may be considered include past performance of audits and/or monitoring, membership or other criteria as defined by Alignment.

The audit type will be determined during the risk assessment.

ROUTINE AUDITS

A routine audit consists of a review of sample cases applicable to the function being audited, such as claims, pre-service, case management, credentialing, and policies and procedures. Supporting documentation associated with the function being audited is included in the review.

FOCUSED AUDITS

Focused audits may be performed in lieu of routine audits. This audit type focuses on specific categories of sample cases, policies and procedures, and supporting documentation.

VALIDATION AUDITS

Validation audits are conducted to test the remediation of corrective action plans implemented in response to an audit or monitoring finding of noncompliance. Validation audits are scheduled after the clean period has passed. The timing of the validation audit is dependent on the reported clean period. Adjustments to audit scheduling and clean periods may be considered. Please reference the Corrective Action Time Frames section for more details.

AD HOC AUDITS

Ad hoc audits may be performed in response to reports of noncompliance by CMS made via Complaint Tracking Modules (provider or member complaints filed directly with Medicare), state or federal regulatory agencies, or Alignment departments. The manner in which this review will be conducted is dependent on the nature of the complaint and the risk level identified (e.g., potential beneficiary harm).

CORRECTIVE ACTION REQUESTS AND CORRECTIVE ACTION PLANS

A corrective action plan (CAP) is a method of documenting an issue of noncompliance, identifying the root causes, and clearly outlining the strategy to correct the issue and ensure it will not recur.

A corrective action request (CAR) will be issued as a result of findings during an oversight audit or through the monitoring process.

The CAP response must include, at a minimum:

- Root cause analysis: What is the problem? Why did it occur? What needs to be done to prevent it from happening again? There are three basic causes of a problem: (1) Physical/technical issues or hardware or software failure. (2) Human cause – process was not followed. (3) Organizational causes – incorrect processes or policies in place, insufficient monitoring of the process, or inadequate staffing.
- An explanation of how the issue was immediately resolved and what initial fixes were implemented
- A review of the effectiveness of the corrective action(s) taken: provide a description of the monitoring and/or auditing process to be implemented (provide copies of reports showing results)
- Identification of a “clean period” – the date the issue has been or will be remediated and can be tested to measure compliance
- Corrective Action Plans must be complete and include all key elements as specified

3. CORRECTIVE ACTION TIME FRAMES

DO will schedule an exit conference to discuss preliminary findings once all samples and supporting documentation have been reviewed. The delegated entity will have 2 business days to submit any additional supporting documentation that may address these preliminary findings. However, a final report will be issued regardless of whether the additional documentation is received.

Delegated entities will have fifteen (15) business days to review the final report and submit a CAP from the date the audit report was issued. Delegated entities will have thirty (30) calendar days to fully remediate the issues identified. Requests for extensions may be considered on a case-by-case basis. Extension requests must be submitted in writing to the assigned DO auditor to be reviewed and approved/rejected by DO management.

DO will review the CAP response and either accept as written or reject approximately ten (10) business days after receipt of the CAP. If rejected, DO will work with the delegated entity to ensure complete understanding of why the CAP was rejected and assist with CAP revisions.

Once the CAP is accepted, DO will monitor progress and remain in contact throughout the remediation period. Approximately 90 calendar days after the clean period, DO will schedule a validation audit to ensure correction of all conditions of noncompliance have been remediated.

Upon passing of the validation audit, the CAP will be considered closed. However, if acceptable remediation has not been demonstrated, the CAP will remain open. A second validation audit may be scheduled, or further monitoring may continue until remediation can be demonstrated. Escalation to Alignment's senior leadership may be warranted when a determination of further action is decided.

4. REGULATORY REQUIREMENTS – CLAIMS

CLAIMS - TIMELINESS REQUIREMENTS

If delegated for processing claims on behalf of Alignment, the IPAs/medical groups, provider groups or supplemental benefit providers must adhere to CMS (Medicare Advantage) processing standards and timeliness requirements in accordance with 42 CFR 422.520:

- Pay 95% of clean claims within 30 days of receipt, if they are submitted by or on behalf of an enrollee of an MA private fee-for-service plan, or are claims for services that are not furnished under a written agreement between the organization and the provider.
- Pay interest on clean claims that are not paid within 30 days, in accordance with sections 1816(c)(B) and 1842(c)(2)(B).
- Pay or deny within 60 calendar days all other claims from non-contracted providers from the date of the request. (Alignment's compliance threshold is 95%.)

CLAIMS MONITORING OF MONTHLY TIMELINESS

The DO claims staff monitors claims processing timeliness performance to ensure compliance with all requirements.

Use **AVA®** to submit a monthly timeliness report (MTR) to DO no later than the 15th of each month (see **Exhibit 1.1: Delegation Oversight)**.

If 30-day or 60-day timeliness scores fall below the 95% threshold, a corrective action plan will be required, along with the MTR submission.

The Health Industry Collaboration Effort (HICE) approved MA MTR template is mandatory for monthly submissions. Please use the most recently updated version of the **ICE MTR template**.

CMS PART C REPORTING REQUIREMENTS

CMS Part C Reporting Requirements – Organization Determinations and Reconsiderations (ODR) Claims Report is a required quarterly submission. Part C ODR reports must be submitted through **AVA®** for review and validation by DO. (see **Exhibit 1.1: Delegation Oversight**).

Quarterly reports are due on the following dates each year: April 15, July 15, October 15, January 10.

PROVIDER DISPUTE RESOLUTION REPORTS (PDRS)

Quarterly PDR reports must be submitted through **AVA®** to Alignment for review and validation by DO (see **Exhibit 1.1: Delegation Oversight**).

Quarterly reports are always due on the following dates each year: April 15, July 15, October 15, January 15.

ORGANIZATION DETERMINATION, APPEALS, AND GRIEVANCE (ODAG) UNIVERSE TABLE 3 (CLAIMS)

Monthly ODAG Universe Table 3 must be submitted to Alignment for review and validation by DO. The ODAG Universe Table 3 is due on the 15th of each month.

ODAG Universe Tables are used by CMS to conduct Medicare Advantage Health Plan program audits. In the event that Alignment is selected for a program audit, IPA/medical group or participating provider group universe data may be tested by CMS. Failure to pass the data validation may require corrective actions. Therefore, Alignment must validate data to ensure that reports are audit-ready and can pass a CMS review.

MEDICARE PART C APPEALS AND PAYMENT DISPUTE RESOLUTION REQUESTS

Alignment Health does not delegate the processing of Medicare Part C appeal/reconsideration requests, including post-service (claim) appeals from non-contracted providers.

Once requests for post-service appeals from non-contracted providers (or pre-service appeal requests from members, contracted providers and/or non-contracted providers) are identified, the request must be forwarded to the Alignment Provider Appeals and Dispute Team immediately (see **Exhibit 1.1 Claims**).

The following table describes how to identify a Medicare Part C appeal from a non-contracted provider and a provider dispute resolution request, as well as what type of requests are delegated or non-delegated.

Failure to forward the appropriate appeal and/or second-level PDR information under the responsibility of Alignment Health is subject to disciplinary action, including, but not limited to a CAP or penalty set forth by Alignment.

REQUEST TYPE	REQUESTED BY	DELEGATED	PROCESS	NOTES
APPEAL REQUEST ALL LEVELS	Non-contracted provider (NCP) – Contracted provider (CP) (pre-service denials) – Member	**No**	Once you have mailed an IDN (Notice of denial of payment) to the member, any response or request received after the denial notice was mailed must be forwarded to Alignment immediately. **IMPORTANT: This includes all non-contracted provider denials when medical records were requested and not received. If you receive the requested documentation after the IDN was mailed, do not reprocess the claim. This is considered an appeal and must be processed by Alignment Health Plan.**	Other determinations that would qualify as a request for an appeal: • Diagnosis code/DRG payment denials • Down-coding • Bundling issues and disputed rate of payment • Level of care or rate of payment denials • Payment denials by payers that result in zero payments being made to a non-contracted provider. • Partially approved decisions* • Local and national coverage Determinations • Medical necessity determinations • Denials due to lack of medical records or authorization *An NCP does not need to receive zero payment to request an appeal or otherwise access the Subpart M appeals process. *Source: CMS Memo 9/23/2020* *Medical records received after the claim has been denied and after the Integrated Denial Notice (of payment) has been mailed to member, must be forwarded to Alignment along with the information below. DO NOT process the appeal as they must be processed by Alignment. Submit the following supporting documentation when forwarding the appeal request: • Copy of claim • Evidence that the provider is non-contracted (e.g. provider screenshot with contract information) • Evidence of Payment (EOP) or Remittance Advice (RA) for initial claim payment. • EOP/RA copy must include the instructions for your Provider Payment Dispute and/or Medicare Part C Non-contracted Provider Appeal Rights reference • Member Denial Notice (IDN), all pages

REQUEST TYPE	REQUESTED BY	DELEGATED	PROCESS	NOTES
PROVIDER DISPUTE RESOLUTION (PDR) 1ST LEVEL	Non-contracted provider	**Yes**	The CMS PDR process applies only to non-contracted providers. Each delegated entity must process the first request of a PDR from a non-contracted provider.	PDRs include decisions where a non-contracted provider contends that the amount paid by the payer for a covered service is less than the amount that would have been paid under Original Medicare. Source: CMS Memo 9/23/2020 and HICE PDR Guide.
PROVIDER DISPUTE RESOLUTION (PDR) 2ND LEVEL	Non-contracted provider	**No**	Delegated entities must forward all second- level PDR requests to Alignment for review.	
PROVIDER DISPUTE RESOLUTION (PDR)	Contracted provider (post-service/claim)	**Yes**	Contracted provider post-service/claim disputes must be processed by the entity that contracts directly with the provider. Alignment Health does not process delegated entity contracted provider payment dispute requests.	

FORWARDING NON-CONTRACTED PROVIDER APPEALS AND SECOND-LEVEL PDRS TO ALIGNMENT'S PROVIDER APPEALS AND DISPUTE TEAM:

If your organization is in receipt of an Appeal, do not reprocess, reopen, or adjust the claim in any manner.

Complete the Alignment NCP Appeals IPA Forwarding Form (**Exhibit 5.1**), and immediately forward the form and complete claim documentation to:

Fax: 1-562-261-8385

Or by mail to:

Alignment Health Plan
Attn: Provider Claim Appeals
PO Box 14012
Orange, CA 92863

RESPONDING TO REQUESTS FROM ALIGNMENT'S PROVIDER APPEALS AND DISPUTE TEAM:

If the Alignment Provider Dispute and Appeals Team has received a non-contracted provider appeal or a second-level PDR directly from the provider:

- The team will reach out to you and request additional documentation related to the appeal or PDR when needed.
- A response is required by the third business day from the date the request was sent to you.
- The request will include the Alignment NCP Appeals IPA Forwarding Form (Exhibit 5.1), which must be completed and included with your response.

5. REGULATORY REQUIREMENTS – CREDENTIALING

Alignment Health participates in the Health Industry Collaboration Effort (HICE) Credentialing Shared Audit Policy Team program. Results of the HICE credentialing audits will be reviewed and communicated to those delegated entities that participate in the program.

For those delegated entities that do not participate in the HICE program, the DO credentialing staff will conduct an audit based on the results of the annual risk assessment. Refer to Section 2, Delegation Oversight Audit and Monitoring Programs, above.

Regardless of participation in the HICE program, the corrective action request and plan process will be followed, as with all other audits conducted by DO.

CREDENTIALING REPORTING

Submitting a quarterly credentialing report to Alignment for review and validation by DO is required. The report must be submitted through **AVA®** (see **Exhibit 1.1: Delegation Oversight**).

Each report submission includes the HICE Credentialing Quarterly Template and Provider Roster (initial, recredentials, suspensions and terms). Quarter 1 submission also includes the prior year's credentialing policies and procedures and program. Copies of the required templates and an attestation will be provided with each quarterly report reminder.

Quarterly reports are due on the following dates each year:

- Q1 data (including P&Ps and program): May 15
- Q2 data: August 15
- Q3 data: November 15
- Q4 data: February 15

A summary of credentialing regulatory requirements that must be met to maintain delegation status is provided during onboarding and quarterly thereafter.

PROVIDER UPDATES:

ALL provider updates (new, suspensions, terminations, panel status and address changes) MUST be submitted to the Provider Data Management Department at ProvData@ahcusa.com. **Do not send provider updates to the DO Department – DO collects quarterly rosters for monitoring only and does not process provider updates.**

6. REGULATORY REQUIREMENTS – UTILIZATION MANAGEMENT

Timeliness Requirements

If delegated for processing and issuing notices in response to pre-service authorization requests, CMS (Medicare Advantage) notification and timeliness requirements must be followed.

Alignment's compliance threshold: Delegated entities must meet all timeliness requirements with a score of at least 95% or higher.

Please reference **Medicare Managed Care Manual; Parts C & D Enrollee Grievance, Organization/ Coverage Determinations and Appeals Guidance** for additional details.

CMS NOTIFICATION TIMELINESS REQUIREMENTS

TYPE	PROCESSING TIME FRAME	WITH EXTENSION
Standard Pre-Service	14 calendar days	28 days
Standard Part B Drug Request	72 hours	N/A
Expedited: Pre-Service	72 hours	17 days
Expedited: Part B Drug Request	24 hours	N/A

*14-day extension if the member requests the extension or if the MA plan (or delegated entity) justifies a need for additional information and documents how the delay is in the member's best interest. MA plan (and their delegated entities) must notify the member in writing if extension is going to be taken and explain the reason for the delay.

Note: Part B drug authorization and payment time frames cannot be extended. See 42 CFR 422.568(b)(1) and (2).

NOTIFICATION REQUIREMENTS: PRE-SERVICE APPROVALS

For favorable decisions on a pre-service request, notice to the requesting party may be provided verbally or in writing and must explain any conditions of the approval, such as the duration of the approval.

Alignment recommends providing written notice of favorable decisions (including any applicable conditions/ parameters of the approval). If a provider submits the request on behalf of the member, the MA plan (or delegated entity) must notify the member as well as the provider of its determination.

NOTIFICATION REQUIREMENTS: PRE-SERVICE DENIALS

A written denial notice must be sent to the member (and the physician involved, as appropriate) whenever an MA plan's (or their delegated entity's) determination is partially or fully adverse to the member.

Approved notice language must be used when issuing written denial notices to members. The standardized denial notice is the Notice of Denial of Medical Coverage or Payment (Form CMS-10003-NDMCP), also known as the Integrated Denial Notice (IDN). DO will provide Alignment's approval and denial templates and training during onboarding. New IDN templates are only provided when CMS issues updates. Draft templates are reviewed during onboarding or when CMS issues new templates.

A specific and detailed explanation must be provided as to why medical services, items or Part B drugs were denied. This must include a description of the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based and, if applicable, a specific explanation about what information is needed to approve coverage.

MONTHLY TIMELINESS REPORTS

Pre-service authorization timeliness performance is monitored by DO staff to ensure compliance with all notification requirements. The ODAG Table 1 is used to calculate pre-service timeliness. Table 1 must be submitted no later than the 15th of each month through **AVA®** (see **Exhibit 1.1: Delegation Oversight**).

CMS PART C REPORTING REQUIREMENTS

Organization Determinations and Reconsiderations (ODR) (Pre-Service Organization Determinations) Report:

Submitting a quarterly ODR Pre-Service Organization Determinations report to Alignment for review and validation by DO is required. The report must be submitted through **AVA®** (see **Exhibit 1.1: Delegation Oversight**).

Quarterly reports are due on the following dates each year: April 15, July 15, October 15, January 10.

7. REPORTING AND MONITORING

To monitor the delegated functions performed by Alignment's delegated entities, Alignment requires that either reports or documentation be submitted in the manner and frequency noted below.

All reports and/or documentation requests must be submitted through **AVA®** (see **Exhibit 1.1: Delegation Oversight**).

REQUIRED REPORTS AND DOCUMENTS

FUNCTION	REPORT OR DOCUMENT	METHOD OF EVALUATION	FREQUENCY OF REPORT
Claims	Monthly Timeliness Report (MTR)	• Monitoring of timeliness performance • Monitoring of timeliness corrective actions	Monthly
Claims & Pre-Service/UM	CMS Organization Determination, Appeals and Grievance ODAG Universe: Tables 1 (Pre-Service/UM) Table 3 (Claims)	• Data validation of UM and claims • Sample testing conducted via live system review	Monthly
Claims & Pre-Service/UM	CMS Part C Reporting Requirements: Organization Determinations and Reconsiderations (ODR), for Claims and Pre-Service/UM	• Data validation for UM and claims • Sample testing conducted via live system review	Quarterly
Claims & Pre-Service/UM	Member notices include, but not limited to: • Integrated Denial Notices (IDN) (Claims & Pre- Service/UM) • Notice of Medicare Non-Coverage (NOMNC) (Pre- Service/UM) • Detailed Explanation of Non-Coverage (DENC) (Pre-Service/UM) • Pre-Service Approval Notices (Pre-Service/UM) • Multi-Language Insert (MLI) and Notice of Availability	Sample review: • During annual or focused audits • If not selected for an annual audit, Alignment will conduct annual or biannual sample testing of all notices. Testing may be completed either via live system or desktop top review.	Annually or Biannually
Credentialing	Provider and OP/HDO Credentialing: • HICE Quarterly Credentialing Submission Form • AHP Provider and OP/HDO	Desktop review and monitoring	Quarterly
Credentialing	Ongoing Monitoring Log	Desktop review and monitoring	Quarterly
Credentialing	CMS Preclusion List: • DO distributes a monthly Preclusion List to all Delegated Entities	Track and review responses from delegated entities Delegated entities must confirm if any Precluded providers are contracted	Alignment distributes monthly Delegated entity responds monthly

EXHIBIT 5.1
ALIGNMENT NCP APPEALS – REQUEST FOR IPA CLAIMS INFORMATION

URGENT REQUEST FOR CLAIMS INFORMATION			
DATE OF REQUEST	[DATE]	**DUE DATE**	[DUEDATE]
Delegated Entity Name	[ENTITYNAME]	**Member Name**	[MEMBNAME]
MSO Name (if applicable)	[MSONAME]	**Patient Account #**	[PATACCTNUM]
Delegated Entity or MSO Address	[ENTITYADDRESS1] [ENTITYADDRESS2]	**Member DOB**	[DOB]
Alignment PDR Specialist	[SPECIALISTNAME]	**Member Health Plan ID**	[MEMBID]
Alignment PDR Specialist Email	[SPECIALISTEMAIL]	**Date of Service**	[DOS]
Specialist Phone #	1-657-213-7679 (TTY: 711)	**Total Billed Amount**	[BILLED]
Fax #	1-562-261-8385	**Provider Name**	[PROVNAME]
Alignment Claim #	[CLAIMNO]	**Provider Appeal/ Dispute Received Date**	[RECEIPT_DATE]

Alignment's Provider Dispute Resolution Department has received a provider payment dispute and/or appeal for the claim(s) referenced above.

To ensure that the request is processed within the CMS required time frame, we require the following information and/or supporting documentation listed below.

PLEASE SUBMIT RESPONSE VIA EMAIL OR FAX BY DUE DATE NOTED ABOVE

INSTRUCTIONS

- Respond to each request listed.
- If a request is not applicable, respond with "N/A"; do not leave blank.
- If supporting documentation is not included with your response, provide the reason.
- If missing documentation will be submitted later, provide expected received date.

SUPPORTING DOCUMENTATION REQUEST		DELEGATED ENTITY RESPONSE	SUPPORTING DOCUMENTATION INCLUDED IN RESPONSE? YES OR NO	DATE PROVIDED
Provider Contract Status	Provide screenshot that clearly indicates whether the provider was contracted or non-contracted for the date of service in question.	☐ Contracted ☐ Non-contracted		

IF PROVIDER IS CONTRACTED

You will only need to provide a screenshot of provider contract status as requested above. Alignment will notify the contracted provider that they will need to submit their payment dispute to your office.

IF PROVIDER IS NON-CONTRACTED

You will only need to provide the following information:

1. Copy of claim
2. Evidence of payment (EOP) or remittance advice (RA) for initial claim payment
   - EOP/RA copy must include the instructions for your provider payment dispute and/or Medicare Part C Non-contracted Provider Appeal Rights reference
3. Member Denial Notice (IDN), all pages

HAS THE PROVIDER SUBMITTED A FIRST-LEVEL PAYMENT DISPUTE FOR THIS CLAIM?

If yes, in addition to the documentation noted above, please submit the following:

1. Copy of provider's first-level dispute letter and all supporting documentation
2. Copy of your first-level provider dispute decision letter

HAS THE PROVIDER SUBMITTED A MEDICARE PART C NON-CONTRACTED PROVIDER APPEAL REQUEST TO YOU?

If yes, did you process the appeal request? (See Corrective Action Request below)

IF YES, IN ADDITION TO THE DOCUMENTATION LISTED ABOVE, SUBMIT THE FOLLOWING:

1. Provider's appeal request letter and supporting documentation
2. If you made an appeal decision, provide a copy of your decision letter

IF YOU DID NOT PROCESS THE APPEAL AND FORWARDED THE NON-CONTRACTED PROVIDER APPEAL REQUEST TO ALIGNMENT:

Provide a copy of the notification, including the date it was forwarded to Alignment.

CORRECTIVE ACTION REQUEST

Inappropriate Processing of Medicare Advantage Part C Non-contracted Provider Appeals:

Alignment Healthcare does not delegate the processing of Medicare Advantage Part C non-contracted provider appeals. According to your response above, it appears that a non-contracted provider appeal was processed by your organization in error. We require that you provide a corrective action plan.

Please provide your CAP by responding to each section below:

	INSTRUCTIONS	DELEGATED ENTITY RESPONSE
Root Cause	Describe the reason appeals are being processed by your organization.	
Corrective Action Plan	Describe the steps required to remediate this issue. Provide both immediate (short-term) corrective action implementation and long-term implementation, if needed.	
Expected Remediation Date	Provide the date you expect the issue to be remediated. If short-term and long-term corrective actions will occur, provide both dates.	
Person(s)/Staff Responsible for Training and/or Implementation of Corrective Actions	Provide the name and title of staff responsible for updates to policies & procedures, training, system updates, etc.	

SECTION 6 | PROVIDER NETWORK

OVERVIEW

Alignment's Network Management Department negotiates and maintains all contracts in support of Alignment's provider network, research contract inquiries from providers, collaborates with providers to improve performance, and monitors the provider network to ensure compliance with CMS requirements. Network Management ensures that members are not balance-billed on services beyond their cost share and that providers are trained on Alignment benefit plans and policies. To best serve members, Network Management tracks and communicates provider performance standards.

1. ACCESS TO CARE

Providers are responsible for meeting all access and availability standards as required by CMS and reflected in "Access to Care" (see **Section 14: Quality Management**). If member care is impacted by the provider not meeting these standards, the provider is expected to work with Alignment to become compliant. If an appointment with an authorized specialist cannot be made within time frames stipulated in the Access to Care standards, the provider should work with Alignment to have the member seen by an alternative specialist. If the delegated entity is unable to provide Covered Services in the time frames required by CMS or applicable law as needed for the appropriate coordination of care for members, then Alignment may authorize such needed covered services with another provider and the delegated entity may be financially responsible for the cost of such covered services.

2. PROVIDER NETWORK CHANGES

Providers are to immediately notify Alignment of all adverse actions, which include, but are not limited to:

- Providers listed on the Office of Inspector General (OIG)
- Preclusion List or having a revoked, suspended, or expired license
- Participating providers who are opting out of Medicare

Such providers will not be permitted to provide, prescribe, order, or arrange for services to Alignment members and must be terminated from the Alignment network.

Alignment will monitor Preclusion List activity and notify the providers of any provider identified on the Preclusion List published by CMS at the delegated IPA and MSO organization level. For non-delegated providers, our Credentialing Department conducts searches as part of the credentialing approval process. The provider must monitor OIG and SGA sanction activity for all participants within 30 days of release of the report by the reporting entity or within 30 days of receiving a new alert. Appropriate reports and/or queries include, but are not limited to, the following:

- Medicare Opt-Out Physicians
- Medicare/Medi-Cal Provider Suspension and Ineligible List
- Medical Board, Osteopathic Medical Board
- Board of Behavioral Sciences
- Board of Psychology
- Board of Chiropractic Examiners
- Board of Registered Nursing
- Board of Occupational Therapy
- Physical Therapy Board or the License Facility Information System

In addition, the provider must monitor license, board, and malpractice expirations on an ongoing basis to ensure that all licensure, certification, and malpractice information remains current and in good standing at all times.

3. SUBMISSION OF PROVIDER DATA CHANGES

Alignment has enhanced the process for the submission of provider adds, terminations, and changes. Providers that are delegated for credentialing should utilize the Alignment proprietary roster template that is designed to capture the group's provider network and changes. The roster should be submitted by SFTP utilizing a similar process as with other data file submissions. This helps minimize the number of secure/encrypted emails between organizations and allows for the provider data to be enriched into valid, standardized data that will display in the provider directories. Non-delegated providers should submit their provider demographic data updates to Alignment as follows:

1. Utilize the adds/terms/changes notification process as agreed upon during implementation, or
2. Forward to the provider's Network Management/Provider Relations contact

Additionally, Alignment is in the process of enhancing the provider portal to be able to accept provider data updates and attestation of quarterly provider roster data. If any of the options above cannot be utilized, the roster can be emailed to Provider Data (see **Exhibit 1.1: Network Management/Provider Relations**) for processing.

4. TERMINATIONS

CMS requires prompt outreach to members when a provider is terminated. As such, Alignment requests that the provider make best efforts to notify Alignment in writing at least 90 days prior to the effective date of the termination. In the event that a provider is terminated with less than 90 days' notice, the provider is to provide Alignment with written notice within five days of becoming aware of the termination.

For PCP terminations, the IPA/medical group or provider must also provide the following:

- Alternate Primary Care Provider to whom members can be transferred*
- Termination reason (e.g., left service area, Medicare opt- out, deceased)
- Termination effective date

*Although an alternate PCP is required to be disclosed, members have the ultimate authority in their choice of PCP.

5. ADDITIONS

Providers should provide Alignment with at least 30 days written notice of the addition of any new providers. Required information includes group and individual tax IDs, NPI, name, degree(s), gender, language(s), specialty(ies), panel status (open or closed),

whether to display the provider in directories, practice address(es), phone, fax, and OSCAR ID (if a facility). Alignment will not process additions if the required information is not included. Incomplete requests will be returned to the IPA/medical group.

Non-delegated providers must be credentialed by Alignment prior to providing care or services to members. Refer to **Section 15** for the credentialing process and required forms. Upon completion of the credentialing process, the provider will be added to Alignment's network of participating providers.

6. PANEL CLOSURES

Unless otherwise directed by Alignment, providers shall not close their respective patient panels to any new Alignment members if those panels remain open for any other patients or members of any other health plan. Providers should provide at least 90 calendar days' written notice to Alignment upon their knowledge of any significant changes in capacity or ability to arrange covered services to members.

7. DEMOGRAPHIC AND ADMINISTRATIVE CHANGES

The provider must notify Alignment of demographic or administrative changes at least 30 days before the change takes effect. Examples of these types of changes include, but are not limited to, provider's name, practice location, telephone number, fax number, billing address, tax identification number, key contact person, etc. Alignment displays provider cultural and linguistic capabilities in the directory, as required by CMS, including non-English languages and American Sign Language. Providers will need to include this information on all roster submissions. These additional data elements have been included in the Alignment proprietary roster templates. Alignment will update its provider database and directories accordingly.

8. PROVIDER DIRECTORY ACCURACY

CMS requires that Alignment maintain accurate provider directories. As such, Alignment requires its providers to provide accurate roster information and to promptly notify Alignment of any changes to their roster including, but not limited to the addition of new providers, the termination of any providers (including term date), and changes to any provider's name, practice location, practice name, telephone number, specialty, and/or panel status (i.e., accepting new patients).

Practice locations are defined as addresses where a member can make an appointment to see a provider in person. Practice name represents the unique description or name of the physical office or facility, if applicable, that should be made accessible to the member.

Additionally, Alignment will proactively reach out to providers on a quarterly basis to validate the provider demographic information mentioned above. Providers must submit accurate and current provider roster information, provide timely notification of changes, respond to directory validation requests from Alignment or Alignment's designee, or regularly attest to their NPPES data. For those providers who do not comply with this requirement, Alignment may suppress the provider from directories, cease to refer members to the provider, discontinue accepting new providers from the IPA/medical group or the provider's practice, and/or terminate the provider from the Alignment network.

Providers will have 30 calendar days to respond to Alignment's directory validation requests, or other such time frame as requested by Alignment.

CMS considers inaccurate provider data and directories a potential violation of its access and availability requirement, pursuant to 42 CFR 422.111(b)(3) and (h)(2)(ii), 422.112, 423.128(d)(2).

9. NPPES INFORMATION MAINTENANCE

Contracted healthcare providers are encouraged to review, update, and attest to their provider information in the National Plan & Provider Enumeration System (NPPES). Updating provider information in NPPES will provide organizations with access to a current database that can be used as a resource to improve provider directory reliability and accuracy. Refer to the CMS issued memo with the subject "Reminder to Update and Certify Provider Information in the Centers for Medicare & Medicaid Services' National

Plan & Provider Enumeration System" For additional information on maintaining NPPES data. For additional questions, see the **NPPES Frequently Asked Questions** document.

10. USE OF ALIGNMENT-CONTRACTED PROVIDERS WHEN ALIGNMENT IS FINANCIALLY RESPONSIBLE FOR SERVICES AND PRIOR AUTHORIZATION

For delegated participating providers, when Alignment is financially responsible for a service as per the IPA/medical group's division of financial responsibility or as per the delegated provider's agreement with Alignment (when delegated for utilization management), the IPA/medical group and delegated provider group will be required to direct such services to providers that are contracted with Alignment, except as otherwise set forth below.

Both delegated and non-delegated providers will be required to comply with Alignment's prior authorization policy for those services requiring prior authorization (see **Section 13: Medical Management/Utilization Management**.) Referrals to non-contracted providers require prior authorization from Alignment.

Failure to comply with Alignment's prior-authorization policy or to obtain prior authorization from Alignment may result in the provider being held financially responsible for such services, up to and including offsets from future payments.

PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance by choosing to do so. All services, procedures and medications on the prior authorization list still require clinical review for final determination.

11. PHYSICIAN INCENTIVE PLANS

Physician incentive plans are regulated by CMS, which prohibits direct or indirect payments to a physician or physician group that might create an inducement to reduce or limit medically necessary services furnished to Health Plan members. If an incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, they may be required to obtain stop-loss coverage. (See 42 CFR 422.208.)

12. PARTICIPATING PROVIDER-BASED ACTIVITIES

Alignment is responsible for any comparative/descriptive material developed and distributed on our behalf by our providers. As such, we must ensure that any providers (and their subcontractors) comply with CMS marketing rules. (See 42 CFR 422.2260 and 422.2262.) 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 provider
- Offer inducements to persuade beneficiaries to enroll in a particular health plan
- Conduct health screenings as a marketing activity
- Accept compensation, directly or indirectly, from a health plan for enrollment activities
- Use Alignment's logo or engage in co-branding without Alignment's prior written consent

Providers should remain neutral when assisting health plan sponsors with marketing to beneficiaries or when assisting with enrollment decisions. Providers may provide the names of health plans with which they contract and objective information on all benefits based on a patient's healthcare needs.

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.

13. PROVIDER TRAINING

Alignment's Network Management Department is responsible for educating providers on Alignment and for providing access to provider educational materials, this manual, newsletters, and reports. If providers have training needs or questions, they should contact the appropriate Network Management/Provider Relations Representative (see **Exhibit 1.1: Network Management/ Provider Relations**).

SECTION 7 | CAPITATION PAYMENTS AND REPORTING

OVERVIEW

Capitation payments and associated reporting is meant to communicate and deliver information regarding payments to capitated providers. Payments typically occur at regular intervals and are based upon the specifications outlined in the contract with the IPA/medical group and/or provider.

1. CAPITATION PAYMENTS

Alignment pays fixed monthly payments (capitation or other payment methodologies) to IPAs/medical groups and certain other providers for the provision of healthcare services provided or arranged by an IPA/medical group or provider groups. The payment schedule, unless otherwise stated in the Alignment agreement, is as follows:

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

MARKET/STATE	PAYMENT AND CAPITATION DETAIL REPORT DUE DATES
California, Nevada, Arizona, and Texas	15th calendar day of the month
North Carolina	27th calendar day of the month

2. CAPITATION ADJUSTMENTS

Alignment may apply adjustments to the capitation payments, which includes but are not limited to the examples below:

- Retroactive adjustments either upward or downward due to retroactive changes in the number of members that are assigned to IPAs/medical groups or provider groups
- Recoupment of claims paid by Alignment, which are the financial responsibility of the provider
- Deductions to fund the Shared Risk Withhold Pool as stated in the provider services agreement (applies to delegated providers)
- 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 that the provider refers to providers that are not contracted with Alignment without Alignment's prior authorization, where such services are Alignment's financial responsibility
- Other adjustments as stated in the provider's agreement with Alignment

3. CAPITATION REMITTANCE REPORT

The capitation remittance report provides a summary of the payments and any adjustments for each member assigned to the provider group. The report will be placed in the IPA/medical group's and provider's SFTP site each month for download on or before the capitation payment due dates included in the Alignment agreement.

If you have any questions, please email or call the appropriate Network Management/Provider Relations representative (see **Exhibit 1.1**).

SECTION 8 CLAIMS

OVERVIEW

This section describes the requirements for submitting claims and processing fee-for-service claims. Alignment processes claims for reimbursement of services rendered to its members in accordance with the CMS requirements and all applicable regulatory requirements.

Alignment may delegate a provider for claims payment if the provider meets the CMS and Alignment requirements for claims delegation. For information about claims that are processed by Alignment's contracted IPAs/medical groups, refer to **Section 5: Delegation Oversight, Regulatory Requirements – Claims**.

1. DEFINITION OF CLEAN CLAIM

Unless otherwise specified in your contract with Alignment, a "clean claim" means a claim that has no defect or impropriety, including lack of any required substantiating information or documentation or any other circumstance requiring special treatment that prevents timely payment of the claim.

All electronic and paper claims must conform to CMS clean claims requirements and claims billing and submission guidelines, including those set forth in the Medicare Claims Processing Manual and the prevailing Correct Coding Initiative (CCI) edits.

2. CLAIMS SUBMISSION

SUBMISSION FORMATS

Alignment strongly encourages providers to submit claims electronically. Benefits of electronic claims submission include faster disposition, improved claims control, and standardized industry format. There is no charge for the submission of electronic claims.

Alignment applies the appropriate Strategic National Implementation Process (SNIP) edits for all claims received. Providers must bill the appropriate HIPAA-compliant billing codes. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services.

Alignment will not reimburse any claims submitted using noncompliant billing codes.

ELECTRONIC CLAIMS

Providers can submit all professional and institutional claims including attachments (such as medical/emergency records, invoices, and explanation of benefits from other health insurance or payers) electronically through Office Ally at no cost. Providers may use a different clearinghouse, if preapproved by Alignment. Please note that some vendors and/or clearinghouses may charge a service fee. To enroll with or to contact Office Ally, please see the information in **Exhibit 1.1: General Resources**.

When submitting fee-for-service claims through a clearinghouse, providers must supply the following Electronic Payer ID: CCHPC

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

PAPER CLAIMS

Paper claims must be submitted using current CMS standard forms:

- Hospital, skilled nursing facility (SNF), home health, inpatient mental health, inpatient psych and ESRD dialysis claims must be billed on UB-04
- Physician and all other claims (DME, lab/X-ray, transportation and ancillary services), except pharmacy, must be billed on CMS-1500

Paper claims submissions may be mailed to Alignment for processing. Providers can mail claims to the Claims Department (see **Exhibit 1.1: Claims**).

INCOMPLETE CLAIMS

Claims submitted without all the required information will be returned (paper claims) or rejected (electronic claims). Providers are expected to promptly respond to requests for additional information and/or records to facilitate prompt payment and resolution of claims.

SUBMISSION TIME FRAMES

Providers are encouraged to submit all claims as soon as possible to facilitate prompt payment. Unless otherwise stated in the provider's agreement with Alignment, claims are to be submitted within 90 days from the date services are rendered. Failure to submit claims within the defined time frame may result in denied claims.

3. REJECTED VERSUS DENIED CLAIMS

Providers must ensure that paper claims submitted to Alignment are clean, accurate and legible. Alignment may reject claims that are not processable due to missing or invalid required information. Rejected claims do not have appeals rights. Providers must correct and resubmit claims for further processing or adjudication.

Alignment will deny claims determined to be non-payable. Claims considered non-payable include but are not limited to services, medical equipment, or supplies that are identified as noncovered benefits and claims for non authorized services.

4. BILLING FOR DRUG-RELATED CLAIMS AND NATIONAL DRUG CODE (NDC) REPORTING

When submitting drug-related claims and encounters, each claim line with a drug-related Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code must include the following additional information:

REQUIRED INFORMATION	FORMAT DETAILS (IF APPLICABLE)	OTHER REQUIREMENTS (IF APPLICABLE)
11-digit NDC number on the container from which the medication was administered	No spaces or hyphens	• If the NDC on the prescription label is fewer than 11 digits, it will be necessary to add leading zeros (0) • If there is more than one NDC for the HCPCS/ CPT code (e.g., compounded drugs, drugs with different strengths), each NDC and associated information must be submitted as a separate line item • If billing multiple lines for the same injectable medication due to different NDC numbers, a modifier 59 is required • Professional: Enter on field 24D of the CMS-1500 or Loop 2410 LIN03 segment of the HIPAA 837p electronic form • Institutional: Enter on field 43 of the UB-04 or Loop 2410 LIN03 segment of the HIPAA 837i electronic form • Due to the implementation of the HIPAA X12 version 5010, only one LIN03 segment is used to report supplemental NDC information along with the HCPCS/CPT code
Unit price	EDI only	
Two-digit unit of measure code	E.g., GM (gram), ML (milliliter), UN (unit)	
Number of NDC units dispensed		
Prescription numbers		For electronic and direct data entry claims, the prescription number must be reported to link multiple service lines together for the same procedure code

5. UNLISTED/UNCLASSIFIED CODES

Alignment requires that providers submit the appropriate documentation on all claims for services or procedures that are not otherwise specified.

Alignment may send providers a request for documentation that supports the need to bill for unlisted/unclassified procedure codes. Because unlisted/unclassified procedure codes do not describe a specific procedure or service, it is necessary for the providers to submit supporting documentation when filing the claim. (See the table below.) Claims billed with unlisted/unclassified procedure codes will be subject to denial if the provider fails to provide the supporting documentation. The provider will need to rebill with appropriate documentation.

TYPE OF CODES/PROCEDURES	REQUIRED DOCUMENTATION
All unlisted/unclassified codes billed	Clear description of the procedure or service
Laboratory and pathology procedures	All unlisted codes within the range of 80048–89356: Laboratory and pathology report
Medical procedures	All unlisted codes within the range of 90281–99602: Office notes and reports
Radiology/imaging procedures	Imaging report
Surgical procedures	All unlisted codes within the range of 10021–69990: Operative or procedure report attached to the claim stating what the procedure was and how the procedure was performed
Unclassified drug "J" codes	Unlisted J code and NDC number in appropriate fields
Unlisted DME HCPCS codes	Invoice along with narrative on the claim

6. CORRECTED CLAIMS

Providers resubmitting claims for corrections must clearly mark them as "corrected claim(s)." Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the original claim.

7. NO BALANCE-BILLING

Under CMS regulations, providers cannot balance-bill the member. Members cannot be billed for covered services beyond their normal cost-sharing amounts (copayment, deductible or coinsurance). Providers shall not collect payments from members for services, unless the member has been advised in advance and in writing that such services may not be covered, and Alignment confirms such services are not covered.

8. COLLECTION OF COPAYMENTS, COINSURANCE, AND/OR DEDUCTIBLES

Providers shall be responsible for the collection of copayments, coinsurance and/or deductibles upon rendering covered services to members. Providers shall not refuse to provide covered services in the event a member is unable to pay the member's copayments, coinsurance and/or deductibles unless otherwise specifically approved in advance by Alignment.

9. COORDINATION OF BENEFITS – MEDICARE SECONDARY PAYER AND THIRD-PARTY LIABILITY

Medicare Secondary Payer is the term generally used when the member has other primary insurance, such as group health plan. The decision as to who is responsible for paying first on a claim and who pays second is known as coordination of benefits.

Alignment does not pay for services to the extent that there is a third party which is required to be the primary payer. Providers must bill the primary insurers first. Alignment pays up to the member's cost-sharing amount with Alignment. Alignment may make secondary payments if both of the following apply:

- The primary-carrier payment is less than the gross amount payable by Medicare
- The provider does not accept and is not obligated to accept the primary carrier's payment as payment in full

In the presence of third-party liability (e.g., workers' compensation, no-fault and liability insurance), Alignment makes conditional payments if the other insurance does not pay promptly. These conditional payments are subject to recovery if and when the other insurance makes payment.

All claims payments to providers are subject to retrospective review to determine whether any third-party liability exists, and to recovery where such liability is determined to exist. Alignment may use a vendor to conduct a retrospective review on its behalf for third-party liability and recovery purposes.

10. MAXIMUM OUT-OF-POCKET LIMIT

Alignment members under certain benefits plans have limits on their cost-sharing amounts during a benefit year. Once these limits are reached, Alignment will no longer deduct cost-sharing amounts from the providers' payments until the following benefit year or when the member changes benefits plans.

11. CLAIMS PAYMENT

CLAIMS PROCESSING TIMELINESS

Unless otherwise stated in the provider's agreement with Alignment, or unless a longer period is allowed by law, claims are processed within 60 calendar days of receipt of claims.

ELECTRONIC FUNDS TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICE

Alignment contracts with Zelis to provide providers access to remittance advice electronically and give them the option to receive payment via EFTs. Providers may register through Zelis to receive electronic services. To contact Zelis, see the information in **Exhibit 1.1: Electronic Fund Transfer (EFT) & Electronic Explanation of Benefits (EOB)**.

12. OVERPAYMENT RECOVERY

By law, providers are required to report and return overpayments to Alignment within 60 calendar days after the date the overpayment was first identified. Alignment processes overpayment recoveries in accordance with CMS regulations or contractual agreements.

OVERPAYMENTS COMMONLY OCCUR DUE TO THE FOLLOWING:

- Duplicate submission of the same service or claim
- Billing for excessive services or noncovered services
- Payment for excluded or medically unnecessary services
- Payment to the incorrect payee
- Claims system configuration issues
- Pricing errors
- Incorrect adjustments
- Primary payment when Alignment Health is the secondary payer

Alignment's look-back period for overpayments will be done in accordance with the time frames permitted by CMS, unless otherwise stated in the provider's agreement with Alignment. A prior written notification regarding the overpayment amount, along with the reason and time frame for returning overpaid amounts, is provided to the provider. If the provider does not submit a full refund within the time frame indicated on the written notification, Alignment will process recoupments against future claims payments.

Providers must mail refund checks, along with a copy of the notification or other supporting documentation, to the address in **Exhibit 1.1: Claims**.

13. CLINICAL TRIAL CLAIMS

Claims for Medicare-qualified clinical trials must be billed to the correct entity and with the appropriate coding per CMS guidelines, including but not limited to the National Clinical Trial (NCT) and Investigational Device Exemption (IDE) numbers.

Authorization is required for the services being rendered (if required per the member's Explanation of Benefits) but is not required for a Medicare-qualified clinical trial performed as part of the service (e.g., a member who is seeking a heart transplant must obtain authorization for the transplant but is not required to obtain authorization for a specific clinical trial associated with the transplant).

COVERAGE/ RESPONSIBILITY	INVESTIGATIONAL ITEM/SERVICE (Q0)	ROUTINE SERVICES (Q1)	FINANCIAL RESPONSIBILITY
Clinical Trial Policy	Covered, if otherwise coverable by Medicare in qualified study	Covered, if otherwise coverable by Medicare in qualified study	Primary responsibility: Original Medicare Secondary responsibility: Alignment (the difference between the member's Original Medicare cost-sharing and the Plan's in-network cost-sharing) Submit Medicare Explanation of Benefits (EOB) to Alignment as proof of primary payment
Coverage With Evidence Development	Covered, if CMS approves study	Covered, if study is approved by CMS and otherwise coverable by Medicare	Alignment, unless Medicare determines the significant cost threshold has been exceeded
Investigational Device Exemption (IDE)	Category A: Not covered Category B: Covered, if CMS approves study	Categories A and B: Covered, if study is approved by CMS and otherwise coverable by Medicare	Categories A and B: Alignment

Refer to the following CMS resources for additional information:

- **CMS Clinical Trial Policy**
- **CMS Coverage With Evidence Development**
- **CMS Approved IDE Studies**

14. PAYMENT DISPUTES

Participating Providers must submit disputed claims to Alignment within 90 days from the receipt of the applicable claims determination from Alignment, unless otherwise stated in the participating provider services agreement.

CLAIMS PAYMENT RECONSIDERATION AND DISPUTE SUBMISSION

Claims payment reconsideration and disputes must be submitted, in writing, to the Payment Dispute address shown in **Exhibit 1.1: Claims**.

Information that must be submitted:

- Provider's name and address
- TIN, NPI that billed for the services
- Health Plan claim number
- Copy of approved authorization (if applicable)
- Member's first and last names
- Member date of birth
- Health Plan member ID number
- Dates of service (from/to)
- Billed amount
- Paid amount
- Expected paid amount
- Detailed reasoning for the payment appeal or dispute
- Any other supporting documentation

Multiple disputes that are similar may be submitted in a batch. Batch similar issues together, and include a table that lists all required information, such as the items listed above.

15. ARBITRATION

A contracted provider who is unable to resolve a payment issue with Alignment via the dispute process may initiate arbitration per the contract.

16. CHECKING CLAIMS STATUS

Providers can use **AVA®** to check claims statuses and to submit inquiries (see **Exhibit 1.1: Claims**).

17. MISDIRECTED CLAIMS

Triage and sorting processes are established for claims that are identified as being the IPA/medical group's responsibility to pay. Alignment works with the IPA/medical group in ensuring that claims are forwarded to the appropriate payer in a timely fashion. Claims are either mailed or electronically transmitted to the IPA/medical group via Office Ally. To avoid delays in processing your claims, please submit your claim to the appropriate payor. In general, Part B services shall be billed to the IPA/medical group and Part A claims shall be billed to Alignment.

18. DIVISION OF FINANCIAL RESPONSIBILITY (DOFR) – RELATED ISSUES/ QUESTIONS

For any DOFR-related issues or questions, please contact your Alignment Network Management representative (see **Exhibit 1.1**).

SECTION 9 | ENCOUNTER DATA

OVERVIEW

Encounter data submissions are meant to support the full breadth of data associated with a member's care. Encounter Data submissions directly impact both Quality and Risk Adjustment. In conjunction with the efforts of providers, encounter data also delivers insight into diagnoses and past services rendered, allowing for augmentations to the care plans for members. Encounter data is further used as part of Alignment's insight development on improvements and streamlining of various reporting and regulatory materials. **Accurate and timely encounter data** submissions **are a requirement from CMS for all Medicare Advantage Health Plans**.

1. ENCOUNTER DATA SUBMISSION REQUIREMENTS

Information regarding electronic billing and electronic data interchange (EDI) transactions can be obtained by contacting Electronic Data Interchange (EDI) (see **Exhibit 1.1: Electronic Data Interchange**).

2. ALIGNMENT'S CLEARINGHOUSE

SUBMISSION

Providers can submit all professional and institutional claims electronically through Office Ally at no cost to the provider. Providers may use a different clearinghouse, if preapproved by Alignment. Please note that some vendors and/or clearinghouses may charge a service fee. To enroll or contact Office Ally, please see the information in **Exhibit 1.1: General Resources**.

When submitting encounters through a clearinghouse, providers must supply the following Electronic Payer ID: **CCHP2**
When submitting claims through a clearinghouse, providers must supply the following Electronic Payer ID: **CCHPC**

3. ENCOUNTER DATA

Encounter data must be submitted electronically (using the ASC X12 837 format or successor formats) to Alignment or Alignment's claims clearinghouse vendor, as determined by Alignment, via the following:

- HIPAA-compliant ASC X12 Standards for Electronic Data Interchange Technical Report Type 3-Healthcare Claim (Professional (837P) format, version 5010)
- Or successor version for the submission of professional healthcare claims
- Institutional (837I) format, version 5010
- Or successor version for institutional claims, if applicable

Additional submission requirements (e.g., timeliness and specific claims header/line level data elements) required for encounter completeness are provided in **Exhibit 9.1: Enterprise EDI Data Exchange Guidelines**.

All electronic and paper claims submissions must meet the **CMS billing guidelines** for required information. This includes encounter data for an IPA/medical group's affiliated PCP, specialists, laboratories and imaging providers, and encounter data for all participating providers' affiliated providers.

The billing guidelines can be found at CMS.gov by accessing the following links:

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

The provider's responsibilities include:

- Submitting all claims details for adjudicated claims only, including all applicable billed, paid, adjusted and denied information.
- Submitting encounter claims electronically directly to Alignment's designated clearinghouse.
- Ensuring that encounter data reflects all procedures performed by the provider during a single healthcare encounter and documented in the member's medical record.
- Ensuring that all fee-for-service encounters include the total billed amount, the total allowed amount (i.e., the total contracted amount), the member's cost share, and Alignment's/the Health Plan's share.[1]
- Ensuring that all capitated encounters include the total billed amount, the Medicare Allowable amount, the member's cost share, and Alignment's/the Health Plan's share.[2]
- Ensuring that encounter data includes standard and current CMS code sets only, including Claims Adjustment Reason Codes, and Anesthesia Modifiers applicable for Medicare line of business.
- Submitting encounter data for capitated services and fee-for-service claims the week following the date such claim or encounter is finalized or adjudicated. It should be received by the health plan within 90 days of the DOS.
- Submitting lab encounter data, including all laboratory results data, on a weekly basis in a standard HL7 format. If there is an inability to submit in HL7 format, submissions can be done via QSI format.

In addition to any contractual quality covenants, the expected encounter-data thresholds Per Member Per Year (PMPY) that providers are expected to submit are as follows:

Encounter category	PMPY benchmark
Encounter submission	Within ninety (90) days of service
Facility encounters – total	2.30
Radiology/imaging procedures	Imaging report
Professional encounters – total	12.00
Provider visit **Lab and radiology** **Other professional**	6.00 4.00 2.00

Alignment will measure the IPA/medical group's and 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 time frames, as outlined throughout this manual.

1 Requirements in accordance with CMS guidelines
2 Marketing Models Standard Documents and Educational Material

EXHIBIT 9.1 | ENTERPRISE EDI DATA EXCHANGE GUIDELINES

Use of electronic EDI transactions allows providers and IPA/vendors to submit a variety of transactions in support of a timely, data-driven healthcare delivery system. Electronic transactions facilitate a more accurate way to be paid for claims faster, and to accomplish this at a lower cost than is generally the case for paper or manual transactions. Submitting transactions electronically in compliance with Health Insurance Portability and Accountability Act – Administrative Simplification (HIPAA-AS) regulations is easy. We accept standard electronic ASC X12N 5010 and HL7 clinical transactions through either direct submissions or commercial clearinghouses identified by simply using our Payer ID.

SUMMARY OF ELECTRONIC TRANSACTIONS:

Depending on the specifics of a provider and/or IPAs contract relationship, additional data transaction requirements may be necessary. A summary of the typical inbound standard electronic transactions is listed below.

#	TYPE	TRANSACTIONS SUPPORTED	REQUIRED FREQUENCY	PROTOCOL
1	IPA Claim Encounters	837(I/P) ASC X12N 5010 Payer ID: CCHP2	Daily	Clearinghouse (Office Ally, TransUnion/ FinThrive)
2	Claims	837(I/P) ASC X12N 5010 Payer ID: CCHPC	Daily	Clearinghouse (Office Ally)
3	Authorizations	Proprietary Format	Daily	Direct sftp.ahcusa.com
4	Lab Results	HL7	Daily / Real-time	Direct sftp.ahcusa.com
5	ADT	HL7	Daily / Real-time	Direct sftp.ahcusa.com
6	Pharmacy Claims	MCEF (PBM format) Custom format	Daily	Direct sftp.ahcusa.com
7	Vision Claims	837(P) ASC X12N 5010	Daily/Monthly	Direct sftp.ahcusa.com
8	HEDIS Supplemental Data	Custom format (IPA Standard) Custom format (Cozeva layout)	Monthly	Direct sftp.ahcusa.com
9	CRR Supplemental Data	ASM Supplemental format	Weekly	Direct sftp.ahcusa.com
10	Enrollment	834 ASC X12N 5010 Custom Format	Daily	Direct sftp.ahcusa.com
11	Dental	837(D) ASC X12N 5010	Daily/Monthly	Direct sftp.ahcusa.com
12	Encounter Reconciliation	Proprietary Format	Quarterly	Direct sftp.ahcusa.com
13	Provider Roster	Proprietary Format	Monthly	Direct sftp.ahcusa.com

For questions regarding companion guides or specific requirements for each transaction, 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.

The EDI Support team will return your inquiry within one business day. If your request is urgent, please make sure your request is identified as “URGENT” on email and voicemail correspondence.

ELECTRONIC SUBMISSIONS OF CLAIMS AND ENCOUNTERS THROUGH COMMERCIAL CLEARINGHOUSES

#	TYPE	TRANSACTIONS SUPPORTED	REQUIRED FREQUENCY	PROTOCOL
1	IPA Claim Encounters	837(I/P) ASC X12N 5010 Payer ID: CCHP2	Daily	Clearinghouse (Office Ally, TransUnion/ FinThrive)
2	Claims	837(I/P) ASC X12N 5010 Payer ID: CCHPC	Daily	Clearinghouse (Office Ally)

When submitting claims and/or encounters through your clearinghouse, providers and IPAs must supply the following payer ID for Alignment Health Plans:

FOR ALIGNMENT HEALTH PLAN INDEPENDENT PRACTICE ASSOCIATIONS (IPA S)	
Office Ally Clearinghouse:	Contact: **Charmagne Williams** Senior Payer Account Manager Office Ally, Inc. **PayerSupport@OfficeAlly.com** Direct: 1-360-975-7000 Ext. 7503 Fax: 1-360-896-2151
IPA Electronic Claim Encounters Payer ID:	CCHP2
TransUnion/FinThrive Clearinghouse	Contact: **Ariana Huezo** Sr. Analyst, Business Operations Email **ariana.huezo@finthrive.com** Office: 1-310-337-8513 Mobile: 1-760-213-1890 **Transunion/FinThrive** 200 Corporate Pointe Suite 350 Culver City, CA 90230 **https://finthrive.com/markets/payers**
IPA Electronic Claim Encounters Payer ID:	CCHP2
FOR PROVIDERS	
Office Ally Clearinghouse:	
Electronic Claims Payer ID:	CCHPC

ADDITIONAL CLEARINGHOUSE INFORMATION:

For providers and IPAs that do not currently participate in electronic claims submission, there are many options for vendors and/or clearinghouses that offer electronic claims submission programs. Providers can file claims electronically through a clearinghouse of their choice or partner with Office Ally (**https://www.officeally.com**).

Please note that some vendors and/or clearinghouses charge a service fee. Contact the clearinghouse of choice for more information.

OFFICE ALLY CONTACT INFORMATION	
Customer Service	1-360-975-7000 Option 1 or **info@officeally.com**
Business Hours:	Mon-Fri, 6 a.m. to 5 p.m. PT
	After Hours Support is also available 24/7

HELPFUL HINTS FOR ELECTRONIC SUBMISSIONS:

- Ensure that you are an authorized representative of the designated provider.
- Have your contact, organization and financial account information available.
- Supply your NPI in the Provider ID field.

Alignment Health Plan offers and supports SFTP (SSH) and HTTP/S (Browser) connections via any modern web browser (Internet Explorer, Chrome, Firefox, etc.).

SFTP INFORMATION	
FTP Application:	**sftp.ahcusa.com**
Support Contact	**https://sftp.ahcusa.com**

Username = (AHC supplied FTP User Account)
Password = (AHC supplied FTP User Account)

For general questions regarding account setup, test transaction scheduling, and production support, please use the contact information in Exhibit 1. Please note that your inquiry will be handled during normal business hours.

The EDI Support team will return your inquiry within one business day. If your request is urgent, please make sure your request is identified as "URGENT" on email and voicemail correspondence.

SECTION 10 | APPEALS AND GRIEVANCES

OVERVIEW

Reconsiderations and redeterminations are appeal procedures that apply when a member disagrees with a decision regarding payment or provision of services (a pre-authorization denial, claims denial, or prescription drug denial, in whole or in part). Federal regulations require special appeals process procedures for Medicare members who are enrolled in a Medicare program. The Explanation of Coverage (EOC) details the appeals and grievance process and procedures. Please review the EOC for the member's respective Health Plan located on the company websites (see **Exhibit 1.1**).

1. INITIAL ORGANIZATION DETERMINATION

An initial determination is made when either Alignment, the Health Plan, an IPA/medical group or a delegated provider group approves or denies payment on a service rendered or has failed to authorize or provide a service. For Alignment's process on Initial Organization Determinations, refer to **Section 13: Medical Management/Utilization Management**.

2. REDETERMINATION – PART D APPEALS

A Member who is dissatisfied with the initial determination of their Part D drug coverage request may ask for a redetermination within 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 delegated by Alignment or the Health Plan.

3. RECONSIDERATION – PARTS A AND B SERVICES AND ITEMS, AND PART B DRUGS APPEALS

A member who is dissatisfied with the initial determination of their request for service (including a Part B drug) or claims payment of services (post-service) may request a reconsideration within 60 days of the initial determination. A request for reconsideration may be initiated orally or in writing.

If Alignment, an IPA/medical group or a delegated 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. This must be no longer than 30 days (standard request for pre-service), seven days (standard Part B drug request), or 72 hours (expedited service or expedited Part B drug request) after receipt of the appeal.

The Health Plan is required to take the following actions:

- Review the initial determination.
- Ensure that the reconsideration/redetermination decision is not made by the same person or persons who were involved in making the initial determination, if denied for medical necessity.
- Send a written notification of the appeal decision. For reconsiderations (medical services or claims-payment appeals), if the decision upholds the initial determination, the appellant will be informed that the case has been forwarded to CMS's independent review entity (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 the service in question as quickly as the member's health requires. This will be no later than 72 hours for expedited appeals, 24 hours for expedited Part B, 30 days for standard pre-service, and 60 days for payment requests from the date that Alignment reverses its determination.

4. MAXIMUS FEDERAL SERVICES

If the original determination is upheld in whole or in part, Alignment is required to send a new notification to the member stating this information. At that point, the case file is forwarded to CMS's 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 CMS will make the final determination. If the decision is overturned by MAXIMUS, Alignment must authorize, within 72 hours, expedited service or provide the service in question as quickly as the member's health requires, but no later than 14 days. Payment requests will be authorized within 30 days of the date of the MAXIMUS letter informing Alignment of the decision. Alignment reserves the right to request a reopening of the MAXIMUS decision.

5. ADMINISTRATIVE LAW JUDGE (ALJ)

A member who is dissatisfied with the CMS reconsideration may request a hearing before an Administrative Law Judge (ALJ). The member may file this request with the Office of Medicare Hearings and Appeals (OMHA), as noted in the MAXIMUS Federal Services decision notice. To qualify, the dispute must involve an amount predetermined by CMS. The request for this type of hearing must be filed in writing within 60 calendar days of the date of the reconsideration notice. Although Alignment may not appeal a MAXIMUS reconsideration decision, it is party to any ALJ hearing.

After the third appeal level (ALJ), the appeal process may continue through the fourth (Medicare Appeals Council) and fifth (District Court) levels if Alignment or the member requests it and the amount meets the CMS-defined threshold. Additionally, any decision may be reopened by any entity that rendered a decision: within 12 months of the notice of initial or reconsidered determination, after such a 12-month period but within four years for just cause, or at any time for a clerical correction or suspected fraud or to consider new evidence that was not available earlier.

6. EXPEDITED APPEALS PROCESS

Members are notified of the appeals processes, including the right to an expedited review, at initial enrollment and upon notification of an adverse determination. The member, or physician on behalf of the member, can file an expedited appeal if the member does not agree with the healthcare decisions made by Alignment.

Health plans routinely have 30 days to process a standard appeal and 72 hours for an appeal regarding medication. However, in certain cases, the member has a right to an expedited, 72-hour appeal (including Part B drugs) and 24 hours for an appeal regarding part D 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 appeal, which might take up to 30 days. If the member requests an expedited appeal, the Health Plan will evaluate the request and determine whether it qualifies for an expedited appeal. If it does not meet the requirements, the 30-day processing time will be invoked.

The member may request a 72-hour appeal if they have missed the deadline for requesting a Quality Improvement Organization (QIO) review from Health Services Advisory Group (HSAG). This would follow a termination of services from a skilled nursing facility (SNF), home health services, or comprehensive outpatient rehabilitation facility services. The member must specifically state that an expedited appeal is being requested and that the member believes that their health could be harmed by waiting the standard appeal 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 pre-authorization and appeals. These regulations apply to Medicare-contracted providers.

7. 14-DAY EXTENSION

If an extension will benefit the member, an extension of up to 14 calendar days is permitted for both a standard appeal and an expedited appeal (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 decide on an expedited appeal and notify the member within 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's contractor, MAXIMUS Federal Services, for an independent review. MAXIMUS will send the member a letter with its decision within 10 working days of receipt of the member's case from Alignment.

8. 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. CMS requires that Medicare Advantage health plans, delegated IPAs/ medical groups, and delegated participating provider groups have a process in place to record and respond to all 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 the delegated participating provider group must:

- Document the member's information, the provider's information, the appeal issue, the date and time that the request was received.
- Obtain all pertinent information, including medical records.
- Ensure that the review of denied service or claim is conducted by an individual who is not involved in the original review and denial.
- Notify the member of the appeal decision in writing within 30 calendar days for service appeals and within 60 calendar days for standard appeals.

9. FAX REQUEST FOR STANDARD OR EXPEDITED APPEALS

Faxed requests should be directed to the Member Services Department (see **Exhibit 1.1: Member Services**). If a member is in a hospital or a skilled nursing facility, they can request assistance in having a written appeal faxed to Alignment or to the Health Plan. The time limit for the review of the appeal will not begin until the request for the appeal has been received.

Providers should direct members to call Alignment's or the Health Plan's Member Services Department using the contact information in **Exhibit 1.1: Member Services,** which includes phone and fax numbers for initial determinations, reviews or appeals.

10. GRIEVANCE OVERVIEW

A grievance is any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with how the Health Plan or provider provides healthcare services, regardless of whether any remedial action can be taken.

A member may make a complaint or initiate a dispute, either orally or in writing, to Alignment, the Health Plan, the provider or the 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 about a covered health service procedure or item during a course of treatment not meeting acceptable standards for the delivery of healthcare (quality-of-care complaint). A quality-of-care complaint is an event, or sequence of events, which has negatively impacted a member's medical outcome. All complaints of this nature require submission at the time they are identified but no later than within 24 hours.

11. HOW TO FILE A GRIEVANCE

A member who is dissatisfied or has a grievance may call the Health Plan's Member Services Department (see **Exhibit 1.1: Member Services**).

When submitting a written complaint or dispute, the member must include all pertinent information from the member ID card and the details of their concern. Alignment will acknowledge receipt of the request within five days and will review the grievance and respond to the member in writing within 30 days (plus 14 days, if an extension is taken).

The written response will state if additional time is necessary to complete the review or it will 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 **Exhibit 1.1: Member Services**). For online complaints, members may visit Medicare.

12. INTEGRATED DENIAL NOTICE (IDN)

Alignment, IPAs/medical groups and delegated provider groups are responsible for sending Integrated Denial Notice (IDN) letters to members for initial determination. Alignment and its IPA's/medical groups will issue the IDN to inform the enrollees of their appeal rights upon denial of coverage items and services, and for discontinuation or reduction of a previously authorized course of treatment.

In compliance with the CMS guidelines, an acute care hospital must furnish each Medicare member with an Important Message from Medicare (IM) upon admission. The IM explains appeals rights, should the member disagree with the discharge, and must be reissued by at least the day of discharge.

If the member appeals the discharge, Alignment, the delegated IPA/medical group/provider group or the hospital may be financially responsible for the inpatient stay until a decision has been made by the Quality Improvement Organization (QIO) as to whether the discharge is appropriate. Prior to the issuance of the written IM, Alignment, the delegated IPA/medical group/provider group or the hospital must obtain the approval of the physician responsible for the inpatient care. The IM must include the member's appeals rights. Failure to follow the above protocol may result in the delegated IPA/medical group/provider group being responsible for the charges of the continued hospital stay until a valid IM is presented to the member.

If the member appeals to the QIO or the Health Plan, Alignment or the delegated IPA/medical group/provider group must ensure that the hospital provides a copy of the IM (or certified letter with proof of delivery) and issue the Detailed Notice of Discharge (DND). 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. The DND explains the specific reason for the discharge.

Copies of the Notice of Medicare Non-Coverage (NOMNC) are appended to this section as exhibits.

Copies of the IM, NOMNC, Detailed Notice of Discharge (DND), and Detailed Explanation of Non-Coverage (DENC) letters should be faxed to Alignment or the Health Plan (see **Exhibit 1.1: Member Services**). For CMS-approved versions of these letters and for complete information regarding organization determinations, appeals and grievances, refer to the **Appeals & Grievances** processes described in the Medicare Managed Care Manual at **CMS.gov**.

13. DETAILED EXPLANATION OF NON-COVERAGE (DENC)

A Detailed Explanation of Non-Coverage (DENC) is a notice that is issued to a member by a home health agency (HHA), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), or hospice agency when the member appeals a decision to end care to the Quality Improvement Organization (QIO).

Effective January 2025, CMS has proposed an enhancement to an enrollee's rights to appeal an MA's plan to terminate coverage for non-hospital provider services. Enrollees who submit their fast-track appeal after the deadline, will still have their appeal considered by the QIO, even if the enrollee leaves the provider or stops receiving services prior to meeting the deadline.

EXHIBIT 10.1 | NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

NOTICE OF MEDICARE NON-COVERAGE

Patient Name: xxxxxxxxxxxxxxxxx

Patient Number: xxxxxxxxxxxxxxxxx

The Effective Date Coverage of Your Current: xxxxxxxxxxxxx

Services Will End: xxxxxxxxxxxxxxx

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal and the independent reviewer agrees services should no longer be covered after the effective date indicated above.
- Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability

How to Ask for an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two (2) days after the effective date of this notice, if you are in Original Medicare. If you are in a Medicare health plan, the QIO, generally, will notify you of its decision by the effective date of this notice.
- Call your QIO (see QIO information below) to appeal or if you have questions.
- If you miss the deadline to request an immediate appeal, you may have other appeal rights. If you have Original Medicare, call the QIO listed below.
- If you belong to a Medicare health plan, call your plan (see **Exhibit 1.1**).
- Plan contact information:

  _____

- Additional information (optional):

  _____

Please sign below to indicate that you have received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date

QIO	MARKET	CONTACT	WEBSITE
KEPRO	NC & TX	Toll-Free Phone 1-888-317-0751 North Carolina 1-888-315-0636 Texas Toll-Free Fax 1-844-878-7921 North Carolina 1-844-878-7921 Texas	**https://www.keproqio.com**
Livanta	AZ, CA & NV	1-877-588-1123 Toll-Free Fax 1-844-420-6672	**https://livantaqio.com/en**

EXHIBIT 10.2 | DETAILED EXPLANATION OF NON-COVERAGE (DENC)

1100 W. Town and Country Road Suite 300
Orange, CA 92868
1-866-634-2247 (TTY: 711)

DETAILED EXPLANATION OF NON-COVERAGE

Date: [Month, DD, YYYY]

_____

Patient Name: [Member Name]

Patient Number: [Member ID]

_____

_____

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined that Medicare coverage for your current services should end. This notice is not the decision on your appeal. The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current skilled nursing services should end.

- The facts used to make this decision
    - Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision
- Plan policy, provision or rationale used in making the decision (health plans only)

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to your QIO, please call us at 1-866-634-2247 (TTY: 711).

Form CMS-10124-DENC (Approved 12/31/2011.) OMB Approval No. 0938–0953 Y0040_CMS_10124_DENC

File & Use 04072012

EXHIBIT 10.3 | IM NOTICE

{Insert contact information here}

IMPORTANT MESSAGE FROM MEDICARE

Patient name: **Patient number:**

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at: {insert QIO name and toll-free number of QIO} The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Right to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

See page 2 of this notice for more information.

How to Ask For an Appeal of your Hospital Discharge

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the QIO listed on Page 1 to appeal, or if you have questions.

If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on Page 1.
- If you belong to a Medicare health plan: Call your plan at {insert plan name and toll-free number of plan}

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.

Signature of Patient or Representative

Date / Time

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS 10065-IM (Exp. 12/31/2025)

OMB approval 0938-1019

EXHIBIT 10.4 | DND NOTICE

{Insert contact information here}

DETAILED NOTICE OF DISCHARGE

Date: **Patient name:** **Patient number:**

This notice gives a detailed explanation of why your hospital or Medicare health plan has determined Medicare coverage for your hospital stay should end. This notice is not the decision on your appeal. The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your hospital stay should end.

- The facts used to make this decision:

- Detailed explanation of why your hospital stay is no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

- Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: {insert hospital/Medicare health plan name and toll-free telephone number}

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS 10066-DND (Exp. 12/31/2025) OMB approval 0938-1019

SECTION 11 | CLINICAL PROGRAMS AND MEMBER RESOURCES

OVERVIEW

Alignment provides a range of clinical programs and member resources to supplement the care that members receive through their network providers. Alignment providers work alongside the member's PCP to develop a care plan that puts member's needs first. To refer a member to an Alignment clinical program, a referral is required (see **Exhibit 11.1**).

1. COMPREHENSIVE ANNUAL HEALTH ASSESSMENT

The Comprehensive Annual Health Assessment (also known as a Jump Start 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 PCP, the Comprehensive Annual Health Assessment provides a holistic approach to caring for our members to ensure that all acute, chronic and preventive care needs are addressed. This enables Alignment to collect comprehensive psychosocial and health status information for medical record integration through **AVA®**, develop a plan of care for the year in collaboration with the member's PCP, and initiate appropriate follow-up services and visits. Depending on the specific contractual agreement, Alignment may conduct this assessment in the member's home, in an Alignment care center, or via telehealth (virtual video visit). It may also delegate the function to the IPA/ medical group or PCP to complete as an Annual Wellness Visit, compliant with CMS requirements. This service applies only to PCPs and does not include services provided in any other settings.

2. CARE ANYWHERE HIGH-RISK MEMBER MANAGEMENT PROGRAM

The Care Anywhere program is a physician-led, advanced practice clinician (APC)-driven model of care designed to support patients that have been deemed frail or chronically ill.

It serves those who would benefit from a comprehensive medical, functional and social-needs assessment and ongoing care to address immediate, chronic, and social healthcare needs. The program aims to reduce preventable emergency room utilization, hospitalizations, undesired or unnecessary treatments, and overall cost of care while providing patient-centered care aimed at addressing short-and long-term needs. The Care Anywhere program targets the top 10% of frail or chronically ill members who account for a disproportionate amount of health expenses, primarily through the utilization of emergency rooms and inpatient hospital services. The program delivers an extra layer of care for targeted members to improve health outcomes and restore humanity in advanced-care planning.

During the initial face-to-face or CMS-compliant telehealth visit, the APC assesses the member's comprehensive health and psychosocial needs 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 that the member's care is coordinated, and that the member is receiving treatments as prescribed.

Once enrolled, members have access to an interdisciplinary care team, which includes an Alignment physician, nurse practitioners, physician assistants, registered nurses, social workers, behavioral health specialists, pharmacists and health coaches. They will address any care needs the member may have, including any potential acute health needs, provider referrals, open care gaps or medication compliance.

For 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.

Depending on the specific contractual agreement, Alignment may conduct this assessment in a patient's home, via a telehealth appointment or in an Alignment Health Center or may delegate the function to the provider.

3. VIRTUAL CARE CENTER:

Alignment's 24/7 Virtual Care Center (VCC) offers access to a clinician or other healthcare professional for urgent or acute healthcare needs. This service is available to all members regardless of the PCP or IPA affiliation 24 hours a day, seven days a week including holidays. VCC clinicians use **AVA®** to support clinical decision-making for any member calling, and all clinical notes are faxed to the primary care provider office within 72 hours of the visit. Members can utilize VCC for acute symptoms, medical advice, medication refills for routine chronic medications, social work needs or to help with care coordination activities. Members may access this service using Alignment's ACCESS On-Demand phone number and visits are available via telephone or video.

EXHIBIT 11.1 | CLINICAL PROGRAMS REFERRAL FORM

PATIENT LAST NAME	PATIENT FIRST NAME	PATIENT MIDDLE NAME
PATIENT DOB	PATIENT PLAN ID	PATIENT HOME OR CELL PHONE
PATIENT PROVIDER NAME	PATIENT TYPE	PATIENT PHONE
PROVIDER EMAIL		PROVIDER FAX

PLEASE CHECK ALL THAT APPLY TO THIS MEMBER:

- ☐ 15 prescription medications identified in HAV visit
- ☐ Active cancer/chemotherapy
- ☐ Advanced care planning discussion needed
- ☐ Advanced wound care assessment/planning needed
- ☐ CHF (NYHA stage III and IV)
- ☐ CKD stage IV or greater
- ☐ CKD>4 and not interested in pursuing dialysis
- ☐ Complex psychosocial or symptom management need
- ☐ COPD (Gold stage III, IV)
- ☐ Dementia with functional decline, Parkinson's, CVA with inability to maintain caloric intake or hydration, ALS, or MS
- ☐ Dialysis
- ☐ DM2 (HbA1c>9.0, hypoglycemic episodes, or new to insulin) resulting in an admission
- ☐ Evaluation for referral to hospice needed
- ☐ Feeding tubes
- ☐ Frequent ER utilization (2 or more visits in last 6 months)
- ☐ High risk for readmission
- ☐ Hoyer lift
- ☐ Hypertension (uncontrolled, >160 systolic)
- ☐ Liver disease with ascites
- ☐ Member is homebound/bedbound or institutionalized, or at risk of either
- ☐ Paraplegic/quadriplegia
- ☐ Progression of cancer or metastasis
- ☐ Two falls in the last 6 months

*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

You may refer members by phone or secure email: 1-833-902-1665 (TTY: 711) or **careanywherecoordination@ahcusa.com**

SECTION 12 | SPECIAL NEEDS PLAN

OVERVIEW

Alignment identifies, supports and engages with our most vulnerable members at any point in their healthcare continuum, striving to assist in achieving an improved health status. Alignment provides services in a member-centric fashion by offering both a Chronic Special Needs Plan (C-SNP) and a Dual-Eligible Special Needs Plan (D-SNP) to eligible members in California, Nevada, North Carolina, Arizona and Texas.

Alignment's objectives for serving members with complex and special needs include but are not limited to:

- Completion of an annual population assessment to identify the needs of the population and subpopulations, so that Care Management processes and resources can be updated to address members' needs.
- Promotion of preventive health services and the management of chronic diseases through disease management programs that encourage the use of services to decrease future morbidity and mortality in members.
- Conducting comprehensive assessments that identify members' needs and barriers to care.
- Coordination of transitions of care for members with complex and special needs to assist in navigating the complex healthcare system and accessing provider, public and private community- based resources.
- Improvement of access to primary and specialty care for members with complex health conditions, so they receive appropriate services.
- Consultation with appropriate specialized healthcare personnel when needed, such as with medical directors, pharmacists, social workers and behavioral health professionals.
- Ensuring that members' socioeconomic barriers are addressed.

The Special Needs Plan (SNP) Model of Care Program's effectiveness is evaluated by Alignment through the identification of objective, measurable, and population-specific quality indicators. Performance outcomes for each special needs plan have been established to evaluate and measure quality of care, quality outcomes, service, and access for members. For each metric, benchmarks have been established using evidence-based medicine found in current literature, standards and guidelines. Root-cause analysis is conducted, and interventions are identified for each indicator that falls below the desired value. The analysis, process improvement plan, and implementation of interventions and improvements will be reported to the Quality Improvement Committee (QIC) for review, feedback and approval.

1. SPECIAL NEEDS PLAN SUMMARIES

CHRONIC SPECIAL NEEDS PLAN (C-SNP)

- For the Heart and/or Diabetes C-SNP, Members with confirmed chronic heart failure, cardiovascular diagnosis of cardiac arrhythmias, coronary artery disease, peripheral vascular disease, diabetes mellitus, and/or chronic venous thromboembolic disorder and who live in a qualifying county may enroll in this plan.
- For the Alignment Health Plan ESRD Balance (HMO C-SNP), members with confirmed end-stage renal disease on dialysis and living in a qualifying state and county may enroll in this plan.
- For the Chronic Disabling Mental Health C-SNP, Members with confirmed bipolar disorder, major depressive disorder, paranoid disorder, schizophrenia or schizoaffective disorder and who live in a qualifying county may enroll in this plan.
- For the Chronic Lung Disorder C-SNP, Members with confirmed Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and who live in a qualifying county may enroll in this plan.

PCPs are required to verify the chronic condition upon the member's enrollment into the C-SNP.

DUAL-ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)

Beneficiaries eligible for both Medicare and Medicaid and living in a qualifying state and county may enroll in the Alignment Health Plan D-SNP. A member is required to maintain dual eligibility in order to remain enrolled in this plan. Alignment's plan is a coordinated care D-SNP, so Alignment does not provide Medicaid services but rather coordinates such services with the member's Medicaid plan or the state in all markets. To assist dual eligible members in obtaining access to providers and covered services, Alignment identifies Medicare providers that accept Medicaid on the Alignment online provider search portal.

Refer to **Exhibit 2.1: Alignment Health Plan 2025 Product Offerings** for the list of qualifying states and counties.

2. SNP PROGRAM REQUIREMENTS

Providers are expected to help manage and improve members' health outcomes in the SNP program. Requirements include, but are not limited to:

- Completing the credentialing and recredentialing process
- Completing the Initial SNP Model of Care Training as part of the onboarding process for new providers
- Completing the Alignment Annual SNP Model of Care Training
- Completing the Dementia Assessment Training course if required by the state
- Providing attentive Responses to Alignment's requests for information related to member complaints, quality concerns, and medical record review
- Assessing and reassessing the member to identify health status changes and updating their Individualized Care Plan (ICP) as needed
- Reviewing and discussing the Individualized Care Plan (ICP) with our members
- Communicating with the Alignment Interdisciplinary Care Team (ICT) to ensure coordination of care and transition of care for our members
- Referring members to Alignment Care Management for care coordination

3. SNP CHRONIC CONDITION IMPROVEMENT PROJECTS (CCIPS)

As required by regulation, each Medicare Advantage organization must develop and implement a CCIP as part of its required Quality Program and SNP program. A CCIP is a clinically focused initiative designed to improve the health of a specific group of members with chronic conditions.

The CCIP initiative requires a focus on promoting effective management of chronic disease for a three-year cycle. The Quality Management staff may contact providers regarding various CCIP initiatives.

4. MODEL OF CARE

Every Special Needs Plan is required to have a model of care (MOC) approved by the National Committee for Quality Assurance (NCQA). The SNP MOC provides the basic framework under which a SNP will meet the needs of each of SNP members. The MOC is a vital quality improvement tool and an integral component for ensuring that the unique needs of each member enrolled in a SNP are identified and addressed. The MOC adheres to the CMS clinical and nonclinical standards and elements.

The MOC identifies a target population and identifies specific specialties needs so resources and services are available to those who need them. The effectiveness of the MOC is evaluated through specific measurable goals and population specific quality indicators. Indicator data is collected on a routine and ad hoc basis, outcomes analyzed, interventions implemented for goal attainment and reports generated. Data collection follows protocols established in approved polices on program design.

The MOC document outlines the specific program requirements and process that is approved and implemented for Alignment SNP members.

5. SNP MODEL OF CARE TRAINING

All providers who provide care to Alignment SNP members are required to complete Alignment's Special Needs Program (SNP) Model of Care (MOC) Provider Training upon onboarding and annually thereafter. This helps Alignment ensure that SNP members are managed in accordance with Alignment's Model of Care.

Providers can complete the required training by visiting Alignment Health Plan's **Provider Resources** page (see **Exhibit 1.1: General Resources**) and following instructions for electronically signing the required attestation, providing a list of providers who completed the training and for submitting evidence of training completion to the Quality Management Department.

6. CARE TRANSITIONS

When a member has a care transition, the PCP is responsible for responding to requests for information from Alignment. The PCP must ensure that Alignment receives admission and discharge notification in the electronic medical record system, works with the Alignment Care Manager and members of the Interdisciplinary Care Team to facilitate needed services. In addition, the PCP is responsible for evaluating the member as soon as possible after an inpatient discharge; completing the medication reconciliation, and reviewing, updating and discussing the Individualized Care Plan with the member.

7. OVERSIGHT RESPONSIBILITY

Oversight of the Special Needs Models of Care programs is retained by Alignment and is not a delegated function. While providers are expected to cooperate with C-SNP and D-SNP improvement initiatives, the overall management and outcome of the Models of Care will be the responsibility of Alignment.

8. NONDISCRIMINATION

Providers shall not unlawfully discriminate against members eligible for D-SNP enrollment. Discrimination may include, but is not limited to, the following:

- Denying any member any covered services.
- Providing to a member any covered service that is different or provided in a different manner or at a different time from that provided to other members within the Health Plan, except where medically indicated.
- Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service.
- Restricting a member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any covered service. This includes treating a member or beneficiary eligible for D-SNP differently from others in determining whether the member satisfies any admission, enrollment, quota, eligibility, membership, or other requirement to receive any covered service.
- The assignment of times or places for the provision of services on the basis of race, religion, ancestry, national origin, creed, ethnic group identification, age, disability, medical condition, genetic information, marital status, gender, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.
- Failing to make auxiliary aids available or failing to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of a disability.
- Failing to ensure meaningful access to programs and activities for limited English proficient (LEP) members and potential enrollees.

Providers must take affirmative action to ensure that members are provided services without regard to items aforementioned, except as needed to provide equal access to members with limited English proficiency or disabilities, or when medically indicated.

For these purposes, a physical handicap includes the carrying of a gene that may, under some circumstances, be associated with a disability in that person's offspring but cause no adverse effects to the carrier. Such genes include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait and X-linked hemophilia.

9. QUALIFIED MEDICARE BENEFICIARY (QMB) – D-SNP ONLY

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 Part B premiums and cost-sharing. All Medicare and Medicaid payments received by providers for furnishing services to a QMB are considered payment in full. IPAs/medical groups or providers may request payment for these premiums and cost-sharing amounts from the state.

Providers are responsible for educating their staff on the importance of checking a patient's QMB status before billing for any deductibles, copayments and coinsurance. Use **AVA®** to verify QMB status or call Alignment Eligibility (see **Exhibit 1.1: Eligibility**). As an additional resource, the IPAs/medical groups will receive, via SFTP, the aforementioned 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**.

SECTION 13 | MEDICAL MANAGEMENT/ UTILIZATION MANAGEMENT

OVERVIEW

The purpose of the UM program is to ensure consistent delivery of quality inpatient and outpatient healthcare services with optimal member outcomes. It promotes the provision and management of coordinated, comprehensive, and quality healthcare within the service area, without discrimination toward any individual and in a culturally competent manner. The UM program operates in accordance with CMS, state and accreditation agency requirements.

1. SEPARATION OF MEDICAL DECISIONS AND FINANCIAL CONCERNS

The UM program for IPAs/medical groups and delegated provider groups must include provisions to ensure that financial and administrative concerns do not impact UM decisions. Utilization management (UM) decisions are, therefore, made by medical staff and based solely on medical necessity and evidence of coverage. Alignment and our delegates do not offer incentives for underutilization of care/services or for barriers to care/service. We do not hire, promote or terminate employees or contractors based on whether they deny benefits. Alignment utilizes CMS guidelines as well as health plan policies to assist in making UM determinations. Alignment also monitors compliance with this requirement. Failure to comply may result in the withdrawal of the delegated UM from an IPA/medical group/delegated provider group and, ultimately, termination of its Alignment agreements.

2. FINANCIAL INCENTIVE

During the course of utilization review activities, there may be incidents in which a UM decision is made that results in a denial or a recommendation of denial of services. The utilization review team, which is supported by physician reviewers are not incentivized or reimbursed for adverse decisions relating to UM decisions. The UM decision is independent and impartial and is solely based on appropriateness of care and service and existence of coverage.

3. UTILIZATION MANAGEMENT GOAL

Providers must have the designated items set forth below in place when UM is delegated. When not delegated, Alignment manages the responsibility of these items:

UM COMMITTEE

Delegated or risk-bearing providers are required to have a UM Committee that meets no less than quarterly, and more frequently if necessary. The UM 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 presence of diagnosis or other medical criteria and to ensure the medical necessity of elective referrals to specialty or ancillary care, inpatient admissions and/or outpatient procedures. Requests for pre-authorization of elective referrals, admissions or procedures are received by the provider from either the PCP or specialist and will be approved or denied based on medical necessity. The delegated provider determines medical necessity using standardized criteria.

CHEMOTHERAPY DRUGS, RADIATION THERAPY AND GENETIC MOLECULAR TESTING

OncoHealth will be utilized as a delegated entity for utilization management for clinical determinations when Alignment Health holds financial responsibility for chemotherapy drugs, radiation therapy and genetic molecular testing. Approval may be obtained through the prior authorization process and will be valid as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history and the treating provider's recommendation.

BEHAVIORAL HEALTH

Optum Behavioral Health Solutions will be delegated for utilization management when Alignment Health holds financial responsibility for behavioral health, including both outpatient and inpatient services. Optum Behavioral Health Solutions will be fully delegated to manage all behavioral health requests.

Alignment Health members do not need to obtain authorizations for routine office visits. For other behavioral health services that require authorization, those authorizations will go directly to Optum Behavioral Health Solutions. Optum Behavioral Health Solutions will maintain a network of contracted behavioral health providers, which are available to view on the Alignment Health Provider Search. Requesting providers are expected to utilize these contracted behavioral health providers whenever possible. Referral to non-contracted providers and hospital-based services will require pre-service approval from Optum Behavioral Health Solutions. Failure to obtain a pre-service approval could result in services being denied.

For all new enrollees to Alignment that have a continuity of care need, Optum Behavioral Health Solutions will provide a minimum of a 90-day transition coverage period when an enrollee who is currently undergoing active treatment switches from a previous plan.

For any UM related questions or concerns, reach out to Optum Behavioral Health Solutions at 1-866-505-6370 (TTY: 711).

CONCURRENT REVIEW PROCESS

The objective of concurrent review is to evaluate clinical information during a member's hospitalization, perform discharge planning, and assist in determining medical necessity at an appropriate level-of-care setting, along with Quality Improvement screening. The hospital is required to notify Alignment UM staff within 24 hours of admission whenever a member is admitted. Providers may call the number in **Exhibit 1.1: Utilization Management, All Admission Notifications**. A completed admission cover sheet should be faxed as soon as possible to the fax number in **Exhibit 1.1: Utilization Management**.

Appropriately licensed professionals will conduct concurrent reviews on all hospitalized members. Reviews will include hospital clinical documentation, physician's communication, telephonic review, and ongoing communication with other healthcare professionals involved in the member's care. Approved criteria for justifying medically appropriate services and length of stay will be applied and documented. Care will not be discontinued until the member's treating provider has been notified of the decision and a care plan that is appropriate for the member's medical needs has been agreed upon by the provider. The discharge-planning process will be initiated at the time of the member's admission and will be an integral part of managing their care. The member's progress will be closely monitored and evaluated to plan for a timely discharge from the hospital.

The UM staff (physician and nonphysician reviewers) use standardized review criteria to ensure consistency of decision- making. This includes determining the appropriate level of care and initiating discharge planning. Concurrent review is required on an ongoing basis. Once an acute level of care is determined to no longer be medically necessary, the Alignment or delegated UM staff will review the clinical information with the Medical Director. The hospital UM staff will also be notified that the continued stay is under review.

For delegated providers, the Medical Director or Alignment staff may call the attending physician to discuss alternatives. If the physician agrees with the determination, the member will be either discharged home or transferred to a lower level-of- care setting. The Alignment staff or delegated group will coordinate the transfer and arrange for discharge services.

Members who are discharged from any inpatient hospital unit or skilled nursing facility are to be seen seven days following such discharge. Such interaction between the provider and member must be documented in the member's medical record and submitted to Alignment via the encounter or claim.

RETROSPECTIVE REVIEW PROCESS

Alignment's UM Department conducts retrospective reviews with respect to medical necessity for all initial requests for authorization of care or services that have been rendered without prior authorization. The Claims Department is responsible for initial receipt and handling of retrospective authorizations/claims payment requests. Upon receipt of a claim requesting payment for services already rendered, the Claims Department staff determines whether adequate supporting documentation is available.

Not all services require prior authorization. However, if a circumstance exists in which a retrospective review is warranted, retrospective review includes two components: retro-authorization request review and retrospective utilization review.

Retro-authorization request reviews are performed when medical services were provided without obtaining prior authorization. Retro-authorization requests will be considered for authorization only under certain circumstances.

Retrospective utilization reviews include the review of a provider's referral patterns, appropriateness of referrals, and procedures. The information is collected and analyzed on a regular basis, at least annually. After conducting the retrospective utilization review, the provider may be placed on focus review on a prospective basis to determine the future appropriateness and medical necessity of requested services.

The delegated provider shall conduct retrospective reviews on individual cases and on aggregate decision data. Individual case reviews help identify specific issues arising from an episode of care. For example, ER claims are reviewed for medical necessity and covered benefits.

4. 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 provider group. Alignment's UM program requires that delegated IPAs/medical groups and delegated providers have a UM program in place to monitor and evaluate the care and services provided to its members. The IPA/medical group's and delegated provider group's UM program must meet Alignment, state and federal requirements. Alignment will perform systematic monitoring and oversight of all IPAs/medical groups and delegated provider groups and the oversight of their respective provider networks to ensure compliance with contractual and regulatory requirements.

Oversight of utilization practices is conducted through Alignment's Delegation Oversight Department (refer to **Section 5: Delegation Oversight** for details).

5. DELEGATED PARTICIPATING PROVIDER GROUP'S UTILIZATION MANAGEMENT PROGRAM

In addition to the key components listed above, provider groups with delegated responsibilities for utilization management are required to have a written UM program that documents all facets of delegated authority. All decisions regarding the approval or denial of healthcare services under delegation are made in accordance with the IPA/medical group/delegated provider group UM program, which includes a UM committee review process. The UM program should specify the medical criteria and process used to determine medical necessity.

The IPA/medical group/delegated provider group's UM program and work plan are evaluated during routine audits conducted by Alignment's Delegation Oversight Department to determine compliance with Alignment standards. (Refer to **Section 5: Delegation Oversight** for details). The IPA/medical group/delegated provider group UM program and work plan must also be approved by their governing body on an annual basis, with such approval documented and signed in the minutes. The UM program should provide evidence that internal procedures for UM are operational and include but are not limited to the following:

- A specific person/position designated to ensure necessary authorization procedures are performed – minimum experience required for this designee is that of a licensed vocational nurse.
- Authorization for elective and urgent healthcare services meet established standards.
- Physician involvement and collaboration for medical necessity determinations occur daily.
- A summary of utilization activities to be reviewed by the IPA/medical group/delegated provider group UM Committee.
- Documentation of UM that includes the decision and member notification. In the case of a denial, an alternative treatment plan and information on the member's right to appeal must be included.
- Timely, documented referral determination and member notification outcomes.
- Daily logs of hospital admissions and denials/appeals, which must be maintained and available upon request to Alignment staff for review purposes.
- Cooperation with Alignment's UM Department for all out-of-area admissions.
- In accordance with CMS requirements, the IPA/medical group/delegated provider group shall provide valid and reliable encounter data in a timely manner and comply with the Alignment UM 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 which includes approvals, partial approvals and denials (submitted weekly)
- Bed days/1,000, admits, length of stay, level of care which includes final determination (submitted weekly)
- 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 UM indicator
- Specific written procedures for precertification, 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 UM committee composed of providers that make determinations regarding the approval or denial of healthcare services to members.
- A UM program and policies and procedures that specifically outline member/provider notifications of medically necessary determinations, including approvals and denials. The denial process must be clearly outlined and include: a process for appeals, denial and/or appeals policy, and member letters that 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 appeals process, so IPAs/medical groups/delegated provider groups need to define their role in an appropriate and timely notification to Alignment.) Only a licensed physician can deny services based on medical necessity.
- Utilization of evidence-based clinical criteria for UM medical review criteria (e.g., CMS National and Local Coverage Determinations, 2 midnight rule and other applicable CMS guidelines or health plan rules). These criteria ensure reliable and consistent medical-necessity determinations for all individuals involved in the utilization process. All criteria and guidelines are to be clearly documented and accessible to providers and members.
- Case management instances that are reported to Alignment staff at the point of identification.
- Assistance with the identification of coordination of benefits and third-party payer information.
- Participation with Alignment in Joint Operations Meetings annually, or more frequently as indicated.

- Administration of member benefits based on the member's individual benefits schedule.
- IPA/medical group/delegated provider group representatives that participate in Alignment medical management committees, as requested.

Failure of the IPA/medical group/delegated provider group to meet UM delegation requirements will result in the development of a CAP that is submitted to Alignment for review and approval.

The IPA/medical group/delegated provider group is responsible for the timely submission of monthly, quarterly and annual reporting, as listed in **Section 5: Delegation Oversight**.

6. TIMELINESS REQUIREMENTS FOR UTILIZATION REVIEW DECISIONS

Alignment and Alignment's participating providers who have been delegated by Alignment for UM are required to comply with utilization management decisions (refer to **Section 5: Delegation Oversight** for details).

Alignment's Healthcare Services Department, the Medical Director, and Utilization Management Committee shall provide decisions within the time frames required by Alignment, accreditation, and state and federal legislation. Alignment has adopted the Health Industry Collaborative Effort (HICE) recommendations as its decision-timeliness standard.

INITIAL ORGANIZATION DETERMINATION

An initial determination is made when either Alignment or the delegated provider approves or denies payment on a service rendered or has failed to authorize or provide a service. For Part C service requests, Alignment must make an initial decision on a request for a service as quickly as the member's health permits. This must be no later than 14 days from the date of receipt of the request, or 72 hours from the 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.

Requests for Part B drugs, including Part B drugs subject to step therapy, must be processed under the same time frames as used in the Part D drug program. This includes time frames for standard organization determinations 72 hours from the date and time of receipt and 24 hours for expedited organization determinations from the date and time of receipt when an urgent situation exists. Standard Part B drug reconsiderations determinations will be made within seven days and expedited reconsiderations within 72 hours.

If the reviewer is unable to make a determination using the clinical criteria and treatment guidelines, the reviewer will forward the request to the designated physician reviewer or to the Medical Director for a determination. Only licensed physicians may make adverse medical necessity determinations and apply the status of denial to the referral or request.

If the delegated IPA/medical group/provider group is unable to provide covered services in the time frames required by CMS for the appropriate coordination of care, Alignment may arrange for such needed covered services with another provider. In such cases, the delegated IPA/medical group/provider group may be responsible for reimbursing Alignment for any costs it has incurred as a result. Alignment may have the right to recoup such costs from the IPA/medical group/ provider group's capitation payments or other compensation.

For information regarding oversight and monitoring of the delegated IPA/medical group/provider group operations, refer to **Section 5: Delegation Oversight.**

Alignment will ensure appropriate utilization of covered services and benefits; establish a process to track, trend and analyze utilization activity; and implement appropriate interventions upon identification of under and overutilization patterns. CMS requires that every MA Prescription Drug plan have a utilization management program with mechanisms to detect both underutilization and overutilization of services. Such a program must not structure utilization management activities so that they provide inappropriate incentives for denial, limitation or discontinuation of authorized services.

7. AUTHORIZATION AND DENIAL LOG SUBMISSIONS

All delegated providers, regardless of contractual risk arrangements, must submit weekly authorization and denial logs for all services when an authorization is required for such services by either the IPA/medical group/delegated provider group or Alignment. The logs will be submitted by SFTP at **https://sftp.ahcusa.com/** and supported by Alignment's Data Technology Support (DTS) team.

8. CLINICAL CRITERIA FOR UTILIZATION MANAGEMENT AND CASE MANAGEMENT DECISIONS

Evidence-based clinical criteria for UM and case management are used to determine medical appropriateness. In addition to utilizing CMS National and Local Coverage Determinations, other examples of criteria that should be used include the CMS 2 Midnight rule and health plan guidelines. Proprietary guidelines can be used as reference but must meet CMS criteria for decision-making. All decision guidelines must be clearly documented and accessible to providers and members.

9. HOSPITAL ADMISSION NOTIFICATION

Alignment requires notification within 24 hours of all elective, urgent, and emergency admissions, regardless of whether the services are in or out of the service area, whenever Alignment may be at risk for hospital services. Providers can notify Alignment by calling the number in **Exhibit 1.1: Utilization Management**.

Hospital-based treatment due to an emergent condition does not require authorization prior to the service(s) being rendered.

For HMO Plans members, unless otherwise authorized by Alignment, elective hospital, and hospital services are required to be provided by participating hospitals that are contracted with Alignment when such services are Alignment's financial responsibility. Should this not occur, the provider may be held responsible. Lack of notification will prevent proper evaluation of medical necessity and may result in authorization and/or claims payment discrepancy.

10. OUTPATIENT HOSPITAL OBSERVATION

Alignment requires notification within 24 hours of all elective, urgent, and emergency observation stays, regardless of whether the services are in or out of the service area, whenever Alignment may be at risk for hospital services. Should this not occur, the provider may be held responsible.

Alignment Health follows the Centers for Medicare & Medicaid Services ("CMS") Two-Midnight Rule as noted in the Code of Federal Regulations, § 412.3(d)(1), to determine the appropriateness of inpatient admissions for Medicare beneficiaries. This rule is part of an effort to reduce improper inpatient admissions and standardize hospital stay decisions.

KEY POINTS OF THE POLICY

1. Inpatient Admission Criteria:
   - Expectation of Two-Midnight Stay: A patient is generally considered an inpatient if the admitting physician expects the patient to require hospital care spanning at least two midnights.
   - Medical Necessity: The decision for inpatient admission must be supported by the patient's medical condition and the necessity for hospital-level care.
2. Observation Services:
   - Less Than Two Midnights: Patients expected to need hospital care for less than two midnights are usually classified under observation status rather than inpatient.
   - Role of Physician Judgment: The admitting physician's clinical judgment plays a crucial role, particularly in cases where unforeseen circumstances (e.g., rapid recovery or transfer) alter the expected length of stay.
3. Documentation Requirements:
   - Physician Orders: The physician must formally document the order for inpatient admission and provide a rationale based on the patient's condition and expected length of stay.

- Clinical Records: Supporting documentation should include detailed clinical notes that justify the necessity of an inpatient stay according to the Two-Midnight expectation.

4. Review and Compliance:
   - Claims Review: Alignment Health conducts reviews to ensure that inpatient admissions meet the Two-Midnight criteria.
   - Compliance Audits: Periodic audits are performed to ensure hospitals and physicians adhere to the policy and to prevent improper billing.
5. Exceptions and Special Cases:
   - Unforeseen Circumstances: Cases where a patient's condition changes unexpectedly (either improving or worsening) are taken into account, and the physician's judgment in these scenarios is respected.
   - Procedures on Medicare's Inpatient-Only List: Certain procedures that Medicare designates as inpatient-only are exempt from the Two-Midnight Rule.

Providers and delegated IPAs should make note of the following as it pertains to training on behalf of Alignment Health as a delegated entity:

1. Accurate Billing: Proper classification of patient status (inpatient vs. observation) is crucial for correct billing and reimbursement.
2. Training and Education: Continuous education for hospital staff and physicians on the documentation and criteria requirements of the Two-Midnight Rule is essential to maintain compliance.
3. Coordination of Care: Enhanced communication and documentation between the admitting physician and hospital administration to ensure the Two-Midnight expectation is accurately reflected in patient records.

By adhering to these guidelines, Alignment Health aims to ensure that inpatient admissions are medically necessary and appropriately classified, promoting efficient use of hospital resources and accurate payment for services rendered.

11. MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

CMS requires that hospitals, including critical access hospitals (CAHs), deliver the Medicare Outpatient Observation Notice (MOON) to members who receive observation-related services for more than 24 hours. The purpose of the MOON is to inform Medicare beneficiaries of the reason(s) they are an outpatient receiving observation services for more than 24 hours and are not inpatients of the hospital or CAH. The MOON must also contain the implications of receiving outpatient services regarding Medicare cost-sharing and coverage for post-hospitalization services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services begin.

12. CONTINUITY OF CARE

Alignment expects that all contracted specialists, PCPs and providers cooperate with continuity of care efforts that promote high-quality, effective medical care. Behavioral health specialists, with the member's written consent, will collaborate with PCPs to provide safe, appropriate and coordinated healthcare.

Alignment and its delegated IPAs, MSO, or medical groups will also coordinate with the previous insurance carrier to provide continuing healthcare to members with specific conditions who have been receiving care from a terminated provider. Care will be continued for an appropriate period of time or until a safe transfer to new providers can be arranged.

13. ANNUAL WELLNESS VISIT

An Annual Wellness Visit (AWV) is an annual health assessment performed by providers with the member through a face- to-face encounter or an audiovisual telehealth visit. Completing a comprehensive evaluation entails that all the member's health conditions that are assessed at the visit are documented in the medical record accurately, completely and compliantly to ensure appropriate coding is reported to CMS. To qualify as an AWV, the visit must meet, at a minimum, all the criteria and elements required by CMS.

Providers must follow Alignment's coding guidelines in assigning ICD-10-CM diagnosis codes based on medical chart documentation. These guidelines are based on the current International Classification of Diseases Tenth Revision – Clinical Modification (ICD-10-CM), CMS HCC coding guidelines, and the American Hospital Association (AHA) coding clinic for ICD- 10 references.

Alignment will work with its providers to develop specified recommendations for treatment of care to all its assigned members who receive a completed AWV. The PCP will ensure that the treatment of care plan is implemented and refer members to Alignment's chronic disease management programs.

14. 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 the provider's service area. Alignment is responsible for managing out-of-area services, unless otherwise specified in the IPA/medical group's provider services agreement. Medical services that are provided outside the defined service area and that are arranged, referred directly or indirectly, and/or authorized by a provider may be the provider's financial responsibility and are not considered out-of-area services.

HMO members, IPAs/medical groups and providers are requested to notify Alignment within one business day of becoming aware of any known out-of-area cases and when Alignment is, or may be, at risk for such services. Once deemed stable for transfer to an in-area facility, the provider must work actively and collaboratively with Alignment to return the member to a contracted provider in a timely fashion. If the provider does not cooperate with Alignment, or delays the transfer of a member considered medically stable for transfer, Alignment may hold the provider responsible for any additional out-of-area charges incurred due to the delay.

15. TRAVEL DIALYSIS

Travel dialysis services are dialysis services required by a member who is temporarily outside the IPA/medical group's or Alignment'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 included in the IPA/medical group's Division of Financial Responsibility. Travel dialysis services do not require prior authorization, but delegated IPAs/medical groups are responsible for the medical management of members who require travel dialysis services. In addition, providers are requested to notify Alignment within one business day upon becoming aware of a member utilizing travel dialysis services.

16. OUT-OF-NETWORK SERVICES

Out-of-network services are provided or arranged by providers who are not contracted with Alignment. With some exceptions as set forth in the member's Evidence of Coverage, Alignment covers services only provided by providers who are in the Alignment contracted network. Providers are responsible for obtaining prior authorization from Alignment prior to referring, authorizing, or directing services out of network when such services are Alignment's financial responsibility. This is determined in accordance with the IPA/medical group's Division of Financial Responsibility and the provider group's agreement with Alignment. A provider who fails to obtain prior authorization from Alignment may be financially responsible for such out-of-network services.

PPO members can elect to use out-of-network providers but may be subjected to higher copays or co-insurance by choosing to do so. Out-of-network services for PPO members do not require plan notification or authorization. However, they can be requested and are encouraged for some services to ensure there is no delay in claims processing as out-of-network services are subject to a medical necessity review upon claims submission. Services deemed to be not covered will result in the claim being denied and the responsibility of the member. Out-of-network services for PPO members are subject to the member's out-of-network cost share. Alignment PPO members will have less out-of-pocket expense if they select a provider in the network.

17. DIRECT ACCESS SERVICES

To ensure that female members have direct access to obstetrical and gynecological providers, CMS requires that managed care organizations, IPAs and medical groups provide or arrange for necessary specialty care. This includes in-network women's health specialist(s) for routine and preventive services. Members have the option to seek obstetrical and preventive gynecological care directly from a specialist or family practice without prior approval from another physician, another provider, or the healthcare plan, on an unlimited basis.

18. TRANSPLANTS

Unless stated otherwise in your agreement with Alignment, providers must receive prior authorization from Alignment's UM Department for all transplant services. This includes pre-transplant evaluations and post-transplant services in any situations where Alignment is financially responsible. The PCP or referred specialist is responsible for the initial diagnostic workup prior to a referral to an approved transplant center. The Alignment Case Manager will work with the member's PCP and other specialists to complete an assessment of the member's healthcare needs to develop, implement, and monitor a care plan, coordinate services, and reevaluate the plan. Scheduled admissions or referrals to a tertiary or general acute hospital must be authorized by Alignment. If a member needs an organ transplant, Alignment will arrange to have the case reviewed by an approved Medicare Transplant Center.

19. SECOND OR THIRD OPINIONS

Members may seek a medically necessary second medical opinion from an appropriately qualified healthcare professional not previously involved in the member's treatment plan. A second opinion will serve to evaluate and determine the medical necessity for any proposed or continued treatment or medical options for the member's condition. CMS requires that every Medicare Advantage Prescription Drug organization have procedures in place for utilization management, including the availability to members of a second and, in some cases, a third opinion.

20. INTERPRETER SERVICES

Providers are expected to have mechanisms in place to ensure that interpreter services for non-English languages and American Sign Language are available to members in order to access healthcare services. In addition:

- Alignment will provide interpreter services at no cost to the member.
- Members are encouraged to use interpreter services instead of relying on family and friends.
- Providers are to ensure the availability of trained staff members for medical interpreting.
- Providers must record the member's primary spoken language and any request for or refusal of interpreter services.

To access interpreter services:

- For Alignment Health Plan members, please contact Member Services (see **Exhibit 1.1: Member Services**) at least seven days prior to when the service will be needed.
- For FirstMedicare Direct members, please contact FirstMedicare Direct's Member Services (see **Exhibit 1.1: Member Services**).

21. REFERRALS

The PCP is responsible for the management and coordination of a member's complete medical care, including initial and primary care, maintaining continuity of care, and initiating specialist referrals. The PCP refers for specialty care when additional knowledge or skills are required. Non-delegated providers may use **AVA®** to initiate referrals (see **Exhibit 1.1: Utilization Management)**.

The IPA/medical group/delegated provider group shall refer members to its contracted providers and to Alignment- contracted providers when such referral services are Alignment's financial responsibility. In the event the use of a non-contracted provider is necessary, the IPA/medical group shall obtain prior authorization from Alignment when Alignment is at risk for such services. IPAs/medical groups/delegated provider groups are responsible for the following:

- Monitoring referrals that have been authorized for medically appropriate care to ensure that Alignment members have access to and follow up with the PCP. In turn, the PCP is responsible for maintaining continuity of care for the members during the referral process.
- Monitoring the quality of care and the cost associated with outside referrals.
- Ensuring timely payment to the referred providers for covered services.
- Ensuring that the member can get an appointment for routine visits and urgent visits within the time frames described in the Access to Care Standards (see **Section 14 Quality Management Program**).
- Notifying Alignment upon a member's permanent relocation outside the Alignment service area or when a member resides outside the Alignment service area for more than six months. Notification should be called in to Alignment Member Services (see **Exhibit 1.1: Member Services**).

If the IPA/medical group receives a request for services for which it is not delegated, it is responsible for redirecting the requesting member and/or provider to the Health Plan and notifying Alignment.

Generally, referrals in which Alignment is or may be at risk require prior authorization from the IPA/medical group/delegated provider group or Alignment. Exceptions include Emergency Services, Direct Access services, and services specifically excluded from prior authorization in accordance with CMS or other regulatory agencies and referenced in the Prior Authorization Guidelines. (See **Exhibit 1.1: General Resources**.)

Alignment HMO members must obtain all routine services within the Alignment provider network, unless such services are urgent, emergent, needed for travel dialysis or when prior approval has been provided by the plan. Alignment

HMO-POS members have limited out-of-network coverage for routine services. All services not covered under the POS benefit must be obtained within the Alignment provider network, unless such services are urgent, emergent, or needed for travel dialysis, or when prior approval has been provided.

Alignment PPO members can utilize providers both in and out of the network.

22. REVOCATION OF DELEGATED MEDICAL MANAGEMENT

Alignment reserves the right to revoke delegated status when the IPA/medical group/delegated provider group has failed to meet and maintain established standards.

23. PRIOR AUTHORIZATIONS

Providers are required to comply with Alignment's prior authorization policy. These guidelines provide information about the services that require prior authorization, which services are automatically approved, and how to submit requests for authorization. Failure to comply with Alignment's prior authorization policy or to obtain prior authorization from Alignment may result in providers being held financially responsible for such services, up to and including offsets from future payments. Medicare Advantage health plans must follow CMS regulations. All services and procedures, regardless of place of service, must be covered by CMS or added to as a supplemental benefit offered by the health plan.

For all Alignment members, non-delegated providers are required to obtain a prior authorization for the procedures listed in the Prior Authorization Guidelines (see **Exhibit 1.1: General Resources**). Failure to do so may result in the member and/or provider being held financially responsible for the procedure.

HOW TO REQUEST A PRIOR AUTHORIZATION

Non-delegated providers can request a prior authorization through any of the following methods:

- Use **AVA®** to initiate/request prior authorizations, to view statuses of existing authorizations and claims, and to submit inquiries (see Exhibit 1.1: Utilization Management and Claims).
- Fax
- Phone

(Refer to **Exhibit 1.1: Utilization Management** for detailed contact information the AVA UM provider section for all prior authorization submissions (https://avaprovidertools.alignmenthealth.com/authorizations)

INFORMATION REQUIRED

Information required for a prior authorization request may include, but is not limited, to:

- IPA/Medical Group name*
- Member name and member ID number
- IPA/Medical Group/delegated participating provider group authorization number, if appropriate*
- Referring provider name
- Requested facility or provider name
- Description of service (inpatient admission, outpatient surgery, SNF, DME, hospice, etc.) – if home health service, treatment plan should be included
- Admissions 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 name
- Procedure (description and CPT code/s)
- Clinical rationale for service
- Description of treatment related to diagnosis and requested service/s 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

*Applies to Delegated Providers

Alignment's UM staff, or Alignment's designee, will review the request, and the authorization will be either approved or denied. Only a licensed physician can deny services. All determinations will be communicated in writing to the requesting provider. The member will be notified orally and in writing for all expedited requests.

24. AUTHORIZATION FOR SKILLED NURSING FACILITY (SNF)

For delegated providers, the IPA/medical group shall follow the procedures set forth in this section for referral to and authorization of skilled nursing facility (SNF) services. In addition, the 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, SNF admissions are required to be directed to SNFs that are in-network with Alignment when such services are Alignment's financial responsibility. Please refer to the Concurrent Review Process outlined in this section of the manual for guidance on inpatient acute concurrent reviews.

For non-delegated providers, to request prior authorization with an in-network SNF, call or fax Alignment (**Exhibit 1.1: Utilization Management**).

25. UTILIZATION OF AMBULATORY SURGERY CENTERS

Members who require an outpatient surgical procedure should be referred to an Alignment-contracted freestanding ambulatory surgery center (ASC) when medically appropriate and in accordance with national clinical guidelines. All services that can be rendered at an ASC must be directed appropriately.

For delegated providers, failure to direct care to the appropriate setting may result in financial responsibility for the IPA/ medical group/delegated provider group for any incremental costs incurred by Alignment.

26. AUTHORIZATION OF OTHER ANCILLARY & SUPPLEMENTAL SERVICES

For HMO members, providers are required to use Alignment's in-network ancillary and supplemental providers, which are contracted with Alignment when Alignment is or may be at risk for such services. Referring members to a non-designated ancillary or supplemental vendor could result in a deduction in payment for services incurred to such a provider.

PPO members using in-network providers pay zero or lower copays and co-insurance. PPO members can elect to use out- of-network providers but may be subjected to higher copays or co-insurance by choosing to do so. All services, procedures, and medications listed on the prior authorization list still require clinical review for final determination.

Refer to **Section 16: Prescription Drug Benefits and Pharmacy Services** for prescription drug benefits and pharmacy services related to diabetic supplies. For a complete listing of Alignment's designated ancillary and supplemental providers for these services, please see Alignment's website and the Provider Resource Guide noted in **Exhibit 1.1: General Resources**.

27. UTILIZATION MANAGEMENT CARVED-OUT SERVICES

Some agreements with delegated providers may include select services where the responsibility for utilization management will remain with Alignment, and where Alignment will provide authorization for such services ("Carved-Out Services"). Please refer to the Utilization Management delegation section of your agreement with Alignment. Carved-Out procedures/specialty referrals must be sent to Alignment for authorization and include the applicable CPT code(s) for the Carved-Out procedures/specialty referral.

Urgent requests must be submitted to Alignment within four hours of receipt by the provider, and routine requests must be submitted to Alignment within one business day. The provider must also notify members that Alignment is responsible for determining medical necessity.

28. HOSPICE AUTHORIZATIONS

For hospice authorizations, the member must sign the provider's designated authorization form indicating that the member has elected hospice care. (See **Medicare Hospice Benefits** at **CMS.gov** for further details.) The physician is required to sign a certification of terminal illness. If the member is unable to sign, an Appointment of Representative form must be completed. This form can be found at **CMS.gov**.

29. ADMISSION, DISCHARGE AND TRANSFER ("ADT") EVENT NOTIFICATIONS

ADT event notifications are transactions provided by hospitals to health plans in order to improve coordination of care and the timeliness of appropriate care delivery.

In accordance with the CMS Interoperability Rules dated April 30, 2021, ADT event notifications must be provided to receiving practitioners, patient care team members, and post-acute care services providers and suppliers with whom they have established patient care relationships and agreements for patient health information exchange as allowed by law and in a timely manner. The CMS Interoperability Rules also state that all patient care team members, and post- acute care services providers and suppliers are entitled to the ADT event notifications to assess clinical quality and care coordination and ensure that patients are receiving the most appropriate care.

Such coordination is beneficial for the members, Alignment, and hospitals. Alignment requires ADT event notifications, as the clinical teams depend on these notifications to engage with other clinical leaders, patients and patients' families. Alignment's technology team will work with hospitals to develop and integrate the real-time ADT feeds between the hospitals and our **AVA®** platform. Alignment will enrich the ADT with its AVA Patient 360 (P360) document that contains all of the Alignment patient clinical, pharmacy and sociodemographic data that can improve our joint member/patient outcomes.

30. CASE MANAGEMENT

IPAs/medical groups or provider groups that are delegated for General, Post-Discharge/Transitions, Complex, and/or Disease Management programs will be monitored for their compliance to the criteria below and the Care quality measures outlined below.

Alignment and/or its delegates offer the following telephonic case management programs for members at risk of poor health outcomes:

- General Case Management
- Post-Discharge/Transitions of Care Case Management
- Complex Case Management
- Disease Management

General Case Management is a collaborative, member-centered process of assessment, care planning, care coordination, health education and advocacy to reduce or eliminate barriers to care. Case Managers work directly with the member and the family/caregiver(s) to develop an individualized care plan (ICP) that is focused on increasing access to resources and services that support the member's health needs. The Case Manager is responsible for coordinating benefits and services with other agencies/providers, monitoring progress, and ensuring interventions are in place to support the member's ICP.

Post-Discharge and Transitions of Care Case Management is a subset of the General Case Management program. This program focuses on members discharged from a facility (inpatient/emergency/post-acute care) and provides timely education and assistance with access to care and services, with the goal of preventing unnecessary readmissions. The Case Manager will complete a transitions of care assessment that includes completion of the HEDIS quality-of-care measures. These measures include but are not limited to:

- Medication review and medication reconciliation (MRP)
- Transitions of Care measures (TRC)
- Follow-up after emergency department visits for people with multiple high-risk chronic conditions (FMC)
- Access to care – Facilitating a transitions/post-discharge visit with a provider or specialist

- Verify that ordered services are in place (e.g., home healthcare, durable medical equipment and prescriptions)
- Readmission prevention
- Reinforce understanding of discharge instructions
- Member education on symptom management
- Education regarding a PCP visit
- Ensure family/caregiver support is in place
- Identify any ongoing coordination-of-care needs for referral to Telephonic Disease Management, General Case Management or Complex Case Management

IPAs/medical groups or provider groups delegated for Post-Discharge/Transitions of Care must ensure that members who are discharged from inpatient hospital units, skilled nursing facilities or ERs are contacted by a provider within 168 hours of discharge. Such interaction between provider and member must be supported by the provider member's medical records and associated Encounter Data to include completion of the TRC and FMC required measures.

Complex Case Management (CCM) is provided to members who 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 are severe and need an intense level of management beyond that of General Case Management.

Disease Management (DM) is a system of coordinated heath care interventions and communications for defined patient populations with conditions where self-care efforts can be implemented to manage the conditions and to prevent complications. DM is designed to help members and practitioners manage chronic conditions, including diabetes, chronic kidney disease (CKD)/ end-stage renal disease (ESRD), coronary artery disease (CAD), heart failure (HF), chronic obstructive pulmonary disease (COPD) and hypertension (HTN).

31. CASE MANAGEMENT REPORTING

IPAs/medical groups that are delegated for care management functions are required to provide monthly /weekly monitoring reports to include:

- Monthly Case Management logs:
  - Member ID
  - Member First Name
  - Member last Name
  - Member Date of Birth
  - DX- Reason for CM
  - Program (General CM/CCM/DM/TOC)
  - Start Date of CM
- Discharge Date of CM
- Case Status (Open or Closed)
  - Weekly Transitions of Care logs:
  - Number of inpatient/skilled nursing/rehabilitation admissions
  - Number of members attempted within 168 hours of discharge
  - % of attempted members who agree to participate in TOC program
  - % of members with successfully completed TOC HEDIS measures
  - Number of ED visits
  - % of ED discharges with FMC measure completed timely

EXHIBIT 13. 1 | COMPLEX CASE MANAGEMENT AND TELEPHONIC DISEASE MANAGEMENT CRITERIA

Any member identified with a diagnosis listed below should be referred to Alignment for review and consideration to be included in the Complex Case Management or Telephonic Disease Management program if the program is not delegated.

COMPLEX CASE MANAGEMENT (CCM) CRITERIA:

- Members followed in General Case Management for more than 60 days
- Special Needs Plan (SNP)
- Traumatic brain injury
- Major organ transplant
- Spinal injuries
- Four or more chronic conditions
- Cancer – active treatment
- Complex behavioral health issues
- Complex social issues
- Neurological impairments (ALS, Parkinson's disease, etc.)
- Other

TELEPHONIC DISEASE MANAGEMENT (TDM) CRITERIA:

- Diabetes
- Chronic kidney disease (CKD)/End-stage renal disease (ESRD)
- Coronary artery disease (CAD)
- Hypertension (HTN)
- Heart failure (HF)
- Chronic obstructive pulmonary disease (COPD)

SECTION 14 | QUALITY MANAGEMENT PROGRAM

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 (QI) initiatives.

The program provides the foundation for fulfilling regulatory and statutory requirements of CMS and NCQA® , as well as other regulatory requirements.

Alignment and IPAs/medical groups and providers are required to engage in specific reviews and tasks applicable to state and federal regulatory guidelines that are geared toward improving care for members enrolled in an Alignment plan. However, most QM activities are not delegated functions and are the responsibility of Alignment.

1. PARTICIPATION IN THE QUALITY MANAGEMENT (QM) PROGRAM

Providers play an integral role in the implementation of the QM Program and are expected to understand and acknowledge the policies and procedures described by Alignment. IPAs/medical groups and providers are required to cooperate with our QM Department program requests.

The QM Program focus includes but is not limited to:

- Medical Records Review
- Focus Studies

- Member Satisfaction Surveys
- Potential Quality of Care Complaint Investigations
- Peer-Review Investigations
- Chronic Condition Improvement Projects
- SNP Model of Care Outcome Requirements
- Access to Care and Appointment Availability Studies (may be a delegated function)
- Provider Satisfaction Surveys (may be a delegated function)

When documentation is presented and there is an opportunity to improve a member's care, IPAs/medical groups and providers may be asked to participate in formulating the care plan.

2. DATA COLLECTION PROCESS

Monitoring activities are designed for a broad range of healthcare issues, with a focus on identifying areas of needed improvement in clinical and administrative areas. The ongoing monitoring of these activities may include reviews of compliance with clinical and administrative standards, as well as with accrediting or regulatory 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
- Evaluation of member outcomes
- Trending of administrative data
- Review of target diagnoses and sentinel events
- Trending of member and provider complaints, grievances and appeals
- Evaluation of care and disease management outcomes

3. QUALITY IMPROVEMENT COMMITTEE (QIC)

The purpose of Alignment's Quality Improvement Committee (QIC) and subcommittees is to provide oversight of the QM Program, policies, and procedures as it reviews, approves and makes recommendations for the program on at least an annual basis. In addition, the QIC ensures that the implementation of the QM Program is responsive to and supports improving health outcomes, improving member satisfaction. It also ensures that the collection, analysis and reporting of quality data is 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. CHRONIC CARE IMPROVEMENT PROGRAM (CCIP)

As required by regulation, each Medicare Advantage Organization must develop and implement a Chronic Care Improvement Program (CCIP) as part of its required QM Program. A CCIP is a clinically focused initiative designed to improve the health of a specific group of members with chronic conditions.

The CCIP initiative requires a focus on promoting effective management of chronic disease for a three-year cycle.

5. PROVIDER SATISFACTION

The monitoring, evaluation and improvement of provider satisfaction are key components of Alignment's QM Program. Provider surveys may be conducted to gain an understanding of the level of satisfaction with the quality of services provided by various Alignment departments. Feedback is provided to providers and shared with stakeholders through the QIC and the Annual QM Program evaluation.

6. MEMBER SATISFACTION

Alignment participates in regulatory member satisfaction surveys, as well as monitors member satisfaction with certain clinical programs. Member satisfaction data and surveys are used to track and trend member satisfaction and to identify opportunities for improvement by using the continual QI process. Clinical Program member satisfaction surveys are shared with stakeholders through the QIC and the Annual QM Program Evaluation.

7. MEDICAL RECORD DOCUMENTATION

Providers are required to maintain a complete medical record for every Alignment member they provide care for. Providers shall maintain standards set forth by, but not limited to, accrediting agencies, Alignment, and state and federal regulatory requirements and guidelines that apply to medical records documentation and standards.

Complete and current documentation in the medical record is essential for quality patient care. Annually, Alignment performs a clinical quality review of provider medical records to ensure compliance to commonly accepted standards. From charts selected for the Ambulatory Medical Record Review (AMRR), the following elements will be reviewed for compliance:

- Each page of the medical record contains the patient's name or ID number.
- Personal biographical data includes the address, phone numbers, marital status and preferred name.
- Document date of birth and gender.
- The record is legible to someone other than the writer.
- All entries are signed by the author and dated.
- Significant illnesses and medical conditions are indicated on the problem list.
- Medication allergies and adverse reactions are prominently noted in the record. If there are no known allergies or history of adverse reactions, this is appropriately noted in the record.
- Past medical history is easily identified and includes serious accidents, operations and illnesses.
- Record contains a current medication list or medications are listed in progress notes.
- History and physical exam identify appropriate subjective and objective findings are documented, including appropriate vital signs-height, weight, blood pressure and temperature.
- Problems from previous visits addressed.
- Appropriate notation concerning the use of cigarettes, alcohol and drugs.
- Inquiry/referrals regarding domestic violence documented.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- Lab and/or diagnostic studies ordered as appropriate.
- If a consultation was requested, there is a note from the consultant in the record.
- Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow up plans.
- Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review.
- Life Planning (AD, POLST, MOLST) status noted, education given if not present (at 18 years and older).
- Documentation that preventive screening and services are offered in accordance with practice guidelines.
- There is evidence patient was provided information regarding the risks, benefits, consequences, harm of a potential medical treatment (e.g., informed consent form, decision aids, educational materials).
- Telephone or online messages are documented in the record, appropriately dated/signed/initialed.

The criteria utilized for medical records and quality-of-care standards are based upon regulatory requirements outlined by regulatory agencies, accreditation guidelines, and accepted national organizations and are subject to change based upon nationally recognized practice guidelines.

Providers are given the results of the AMRR and, if warranted, a corrective action plan (CAP) addressing any deficiencies. Any area that is not compliant with regulatory or Alignment standards will require a CAP.

The provider will be required to implement actions for improvement and provide them to Alignment by fax or email within 30

business days of receiving the results (see **Exhibit 1.1: Quality Management**). Should a provider not acknowledge by signing and returning the CAP in the allotted time, a final request will be sent to the provider. Any member assignments or referrals may be deferred until the signed plan is received by Alignment. Recredentialing may not occur if the provider has an outstanding CAP. A follow-up audit will be scheduled and conducted within a reasonable timeframe to ensure that all deficiencies are corrected and meet regulatory compliance.

8. APPOINTMENT AVAILABILITY AND ACCESS TO CARE

All IPAs/medical groups and providers are responsible for meeting the access standards outlined in this section. Alignment monitors the ability of its members to access each service type according to the specified Access to Care Standards.

Alignment has provided the following appointment availability and after-hours standards set by CMS, NCQA® and the Departments of Health Services. When a state has standards that are different than CMS, Alignment adheres to the applicable standard that is most restrictive.

PRIMARY CARE PHYSICIAN (PCP)

APPOINTMENT	ACCESS STANDARD
Routine PCP Visit	Within 10 Business Days of the Request for an Appointment
Urgent Care PCP (does not require prior authorization)	Within 48 hours of the Request for an Appointment
Urgent Care PCP (requires prior authorization)	Within 96 hours of the Request for an Appointment
Annual Wellness Exam	Within 30 Business Days of the Request for an Appointment
Ancillary Provider (e.g., Lab, X-Rays, PT)	Within 15 Business Days of the Request for an Appointment

SPECIALIST PROVIDER

APPOINTMENT	ACCESS STANDARD
Routine Specialist Visit	Within 15 Days of the Request for an Appointment
Urgent Care Specialist (does not require prior authorization)	Within 48 Hours of the Request for an Appointment
Urgent Care Specialist (requires prior authorization)	Within 96 Hours of the Request for an Appointment

BEHAVIORAL HEALTH PROVIDER

APPOINTMENT	ACCESS STANDARD
Mental Health Provider Visit (non-urgent)	Within 10 Business Days of the Request for an Appointment
Non-Physician Mental Health Provider (incl. counseling professionals, substance abuse professionals and qualified autism service providers)	Within 10 Business Days of the Request for an Appointment
Urgent Care Behavioral Health Provider	Within 48 Hours of the Request for an Appointment
Mental Health/Substance Use Disorder Follow-Up (Non-Physician	Within 10 Business Days From Prior Appointment

EMERGENT OR URGENTLY NEEDED CARE

APPOINTMENT	ACCESS STANDARD
Life-Threatening Emergency Care	Call 911 or Go to the Nearest Emergency Room
Behavioral Health Provider	Call 911 or Go to the Nearest Emergency Room Immediately
Non Life-Threatening Emergency Access to Behavioral Healthcare	Within 6 hours

AFTER-HOURS ACCESS

APPOINTMENT	ACCESS STANDARD
Emergency Care	Call 911 or Go to the Nearest Emergency Room
Urgent Care	Call the Provider's Office 24 hours a Day, 7 Days a Week; A Provider Will Call Back Within 30 Minutes

Alignment Members can reach the ACCESS On-Demand Concierge service 24 hours a day, seven days a week, by calling 1-833-242-2223 (TTY: 711).

ACCESS On-Demand Concierge gives Alignment members access to a national network of U.S. board-certified physicians available 24 hours a day, seven days a week by phone or video. These doctors can diagnose, treat and prescribe medicine for non-emergency general medical, dermatology and behavioral health conditions by phone or video.

9. POTENTIAL QUALITY OF CARE EVENTS

Alignment is committed to improving patient safety and promoting a supportive environment for providers to improve patient safety in their practices. Many of the ongoing Quality Management Program measurement activities include safety components, such as measures for accessibility, availability, adherence to clinical practice guidelines, and medical records documentation. Potential quality of care issues should be reported securely and as soon as identified or no later than 90 days from the time of incident. This helps to ensure that all relevant documentation and/or records can be obtained, and that a thorough review can be conducted (see **Exhibit 1.1: Quality Management**).

Potential Quality of Care investigations are not a delegated function and should be referred to Alignment immediately when identified. IPAs/medical groups, hospitals, vendors and providers are required to provide a timely response to quality inquiries and to implement improvement interventions, should a serious quality event be identified.

10. PREVENTIVE HEALTH SERVICES

Alignment has adopted age-specific preventive healthcare guidelines for the prevention and early detection of illnesses and diseases. The guidelines are based on those from CMS, the U.S. Preventive Task Force Preventive Services and/or applicable accreditation or regulatory organizations. These guidelines are reviewed and revised, as needed, on an annual basis and then presented and approved at the Quality Improvement Committee. Preventive healthcare guidelines are made available to members and providers when requested.

The Medicare Preventive Services Quick Reference Information is available at **CMS.gov**.

11. MEMBER HEALTH EDUCATION AND WELLNESS PROMOTION

IPAs/medical groups and providers are responsible for meeting the health education needs of Alignment members. Appropriate brochures and/or class offerings should be available to distribute to members.

IPA/medical groups and 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.

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

12. BEHAVIORAL HEALTH CARE

The Alignment Quality Management Program's scope incorporates both medical and behavioral healthcare services. Alignment includes a designated behavioral health provider in the Quality Improvement Committee, as needed, to encourage appropriate input on behavioral health issues.

Coordination of care between general medical care and behavioral healthcare is essential to the well-being of members. Processes have been implemented to facilitate the exchange of information in an effective, timely and confidential manner. Alignment collaborates with its providers to assist them and members to access all care required.

13. EQUITABLE ACCESS, CULTURAL AND LINGUISTIC COMPETENCE

Alignment ensures equitable access for all care and services provided by Alignment or any contracted Providers. Care is delivered in a culturally sensitive manner and in the language that the member speaks and can easily understand. Our set of values, principles, policies and structures will enable the Alignment staff, IPAs/ medical groups, and providers to work cross-culturally in an effective manner.

IPAs/medical groups and Providers of Alignment must possess the ability, aptitude and behavior to work cross-culturally in the delivery of healthcare services. IPAs/medical groups and Providers must provide equitable access and services to members:

- Irrespective of a person's culture, ethnic background, race and religion
- Regardless of a person's gender identify or sexual orientation such as nonbinary, transgender, lesbian, gay, bisexual or other diverse gender identities or sexual orientations
- In a manner that is sensitive to people who may live in rural areas and other areas with high levels of deprivation and people otherwise adversely affected by persistent poverty or inequality
- In a manner that recognizes, values, affirms and respects the worth of the individual and that protects and preserves their dignity
- Irrespective of a person's disabilities
- In a manner that removes 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
- In a manner that increases satisfaction with clinical care and services while decreasing healthcare disparities in the minority populations we serve
- In a manner that increases the understanding of health issues, including diagnoses and treatment plans
- Via the development of a provider network that mirrors the cultural and linguistic characteristics of members and that provides for culturally appropriate services to members
- Based on the evaluation of provider offices for oral and written educational material and notices in languages that reflect the membership
- Emphasizing the importance of cultural competency as part of the provider's initial in-service
- With alternative communication methods that Alignment will arrange for providers for members who have potential linguistic barriers

14. PATIENT SAFETY

Alignment promotes a comprehensive strategy to ensure 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 providers' patient safety initiatives.

Providers can develop a culture of patient safety in their practices. Clear communication is key to safe care. Collaboration among members of the interdisciplinary care team, hospitals, care facilities and the patient is 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. This includes suicide threats, spousal abuse, and elder abuse. Any Alignment employee who, during the normal course of performing assigned duties, observes, suspects or has knowledge of a patient's health and safety risk shall immediately report the instance to any manager, director or appropriate agency.

15. CLINICAL PRACTICE GUIDELINES FOR MONITORING AND IMPROVEMENT

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

- American Heart Association
- American Stroke Association
- CMS Approved Drug Compendia
- Federal Drug Administration
- National Comprehensive Cancer Network
- National Institute of Mental Health
- The American College of Cardiology
- The American Diabetes Association
- The American Psychiatric Association
- The Global Initiative for Chronic Obstructive Lung Disease
- The Journal of the American Medical Association
- The National Institutes of Health

16. QUALITY MANAGEMENT REPORTING FOR PARTICIPATING PROVIDERS

Alignment requires its IPAs/medical groups and providers to submit reports to the Quality Management Department, as outlined in the tables below. To submit reports, log in to the Alignment Health Plan **Provider Resources** page (see **Exhibit 1.1: General Resources**) and click on Reports Submission and then Delegation Reporting (unless otherwise directed in the table).

Quality Program Description	Submit via the Alignment Provider Web Portal: Reports Submission **https://ava.alignmenthealth.com**	**Annually**, by February 15th
Case Management/Utilization Management Program Description	Submit via the Alignment Provider Web Portal: Reports Submission **https://ava.alignmenthealth.com**	**Annually**, by February 15th
UM Workplans	Submit via the Alignment Provider Web Portal: Reports Submission **https://ava.alignmenthealth.com**	**Annually**, by February 15th
Potential Quality of Care Issues (not a delegated function)	Submit via Fax: 1-562-207-4617	**Concurrent**, Expedited within 2 hours and Standard 1 business day
Access to Care and Appointment Availability Studies Survey Results for 2024 (routine, urgent appointments, after hours) for PCP, Specialist, Behavioral Health	Submit via the Alignment Provider Web Portal: Reports Submission **https://ava.alignmenthealth.com**	**Annually**, by February 15th (Prior CY Results) **Semi-Annually**, by August 15th (Q1 & Q2 Current Yr. Results)

* Please Note: Annual submissions should be most current study results from previous year, semiannual submissions should be current-year quarterly study results. For IPAs/medical groups not conducting their own studies, Alignment will include IPAs/medical groups in annual studies survey and provide results in corrective action plans when not meeting metric standards.

† See **Exhibit 1: General Resources**

SECTION 15 | CREDENTIALING

OVERVIEW

Alignment, or Alignment's designee, and providers that Alignment has approved to be delegated for the credentialing functions are responsible for collecting, validating and assessing the credentials of healthcare providers to ensure they have the required licenses, certifications and skills to appropriately care for patients. CMS requires all providers/practitioners and facilities who see Medicare members to undergo this formal process.

All providers must meet the criteria, standards, and requirements of NCQA® (National Committee for Quality Assurance) and CMS and be approved by the Alignment Credentialing Committee to participate with Alignment, as described in this section.

1. PROVIDER/PRACTITIONER CREDENTIALING

All providers providing healthcare services to Alignment members are required to complete the credentialing process prior to caring for Alignment members. Providers cannot provide care or services to members until the credentialing process is complete and the provider is approved for participation.

Providers who utilize the services of a physician assistant or advanced registered nurse practitioner and who provide direct patient care to a member under the supervision of a participating provider are also required to undergo credentialing. Scope of practice is limited to the rules and regulations established by the state in which they practice and by the policies and procedures of Alignment.

Credentialing and recredentialing applies to the following types of practitioners/providers:

- Audiologist
- Clinical Nurse Specialist
- Licensed Dietitian/Nutritionist
- Doctor of Addiction Medicine
- Doctor of Chiropractic
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Psychiatry
- Doctor of Psychology
- Clinical Psychologist (PSY)
- Licensed Acupuncturist
- Licensed Clinical Social Worker (LCSW)
- Clinical Social Worker (MSW)
- Licensed Professional Clinical Counselor (LPCC)
- Marriage Family Child Counselor/ Marriage Family Therapist
- Nurse Practitioner
- Occupational Therapist
- Physical Therapist
- Physician Assistant (PA)
- Professional Clinical Counselor
- Speech Language Pathologist
- Registered Dietitian (RD)
- Certified Diabetes Care and Education Specialist (CDCES)

All covering practitioners (locum tenens) or temporary providers with an independent relationship with Alignment and its delegated providers must also be credentialed if they serve in this capacity for more than 90 calendar days.

For non-delegated providers, credentials are submitted to the Alignment Credentialing Committee, which either approves or denies the request for participation. Providers will be notified of their request's outcome by mail or email. However, if a recredentialed provider is denied participation in the network due to a quality-of-care issue, the provider will be notified of the determination by mail or email and will have 30 days to appeal the decision of the committee by requesting reconsideration.

2. RECREDENTIALING

All Alignment providers must undergo recredentialing at least every 36 months, in accordance with regulatory requirements, accreditation, and Alignment's policies and procedures. The provider will need to complete a recredentialing application, along with the requested documentation, or participate with the Council for Affordable and Quality Healthcare (CAQH) to maintain a participating network status with Alignment. The Alignment Credentialing Committee will approve, deny or modify the provider's status according to the established policies. If the provider's recredentialing is denied or modified due to quality-of-care issues, the provider will be notified of the determination by mail and will have 30 days to appeal the decision of the committee by requesting reconsideration.

Delegated provider groups are required to have a similar process in place that requires the providers to undergo recredentialing every 36 months and to complete a recredentialing application, along with the requested documentation. Delegated provider groups must ensure that recredentialing files are reviewed by a Credentialing Committee to approve, deny or modify the provider's status according to the established policies. If denied or modified due to quality-of-care issues, the provider will be notified of the decision in writing.

3. PROVIDER CREDENTIALING REQUIREMENTS

APPLICATIONS

All providers are required to complete a credentialing application. Alignment contracts with the Council for Affordable Quality Healthcare (CAQH®) to collect the credentialing and recredentialing application data. Alignment also contracts with a credentialing verification organization (CVO) to verify required elements of the credentialing application and process.

If a provider is registered with CAQH, the provider must provide permission to Alignment to access their CAQH profile. Providers may sign up with the CAQH at no cost at **https://proview.caqh.org**.

The information provided to Alignment is verified from primary and/or secondary sources. All providers must sign the Attestation and Disclosure Statement, in addition to the Authorization and Release Form. The CVO reviews each credentialing application ensuring that all the following required information is included:

- A current and valid license to practice in the state
- A valid DEA or Controlled Dangerous Substances 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 signed and dated by the applicant. A signature/date stamp is not acceptable to authenticate these documents. An attestation must include:
  - 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 years of work history documented and including the beginning and ending month and year for each work experience within that five-year period. Any gaps of more than six months require an explanation from the applicant (for initial credentialing only).

4. PROFESSIONAL LIABILITY INSURANCE

Providers must carry and maintain professional and general liability insurance of at least $1,000,000 per occurrence and $3,000,000 annual aggregate, or as otherwise stated in their agreement with Alignment.

5. HEALTHCARE DELIVERY ORGANIZATION (HDO) CREDENTIALING REQUIREMENTS (FACILITIES)

All HDO participating providers must meet the credentialing criteria, standards and requirements of NCQA® (the National Committee for Quality Assurance), and CMS and be approved by the Alignment Credentialing Committee to participate with Alignment. All HDOs are assessed initially and at least every 36 months thereafter.

All HDOs providing healthcare services to Alignment members must be credentialed prior to caring for Alignment members. The following is a list of organizations and healthcare professionals who require credentialing, recredentialing and ongoing monitoring by Alignment.

- Behavioral Health Facilities – Inpatient, Residential, or Ambulatory Setting
- Clinical Laboratories
- Comprehensive Outpatient Rehabilitation Facilities

- Durable Medical Equipment
- Federally Qualified Health Centers (FQHC)
- Freestanding Surgical Centers (including family planning clinics performing outpatient surgeries)
- Home Health Agencies
- Home Infusion Care
- Hospitals
- Outpatient Diabetes Self-Management Facilities
- Outpatient Physical Therapy and Speech Pathology Therapy Providers (only applies to institutional facilities that take Medicare Part A)
- Outpatient Rehabilitation Centers
- Portable X-Rays
- Providers for End-Stage Renal Disease Treatment
- Rural Health Clinics
- Skilled Nursing Facilities
- Urgent Care Centers
- Diagnostic Radiology/Advanced Diagnostic Imaging Suppliers (ADI)

An HDO must complete and submit a completed Alignment credentialing application.

The following items are assessed during the HDO credentialing process. The information provided to Alignment is verified from primary and/or secondary sources. All providers must sign the Attestation and Disclosure Statement, in addition to the Authorization and Release form, noting:

- The facility is in good standing with state and federal regulatory bodies.
- The facility has been approved by an accrediting body or completed a recent on-site quality assessment if the facility is not accredited. State or federal quality reviews can be used in lieu of an on-site visit if completed within three years.
- Proof of liability insurance as required by the state or as otherwise stated in your agreement with Alignment.
- State license (if applicable).
- City business or city occupancy license (if applicable).

6. RECREDENTIALING OF HDOS

All participating HDOs must undergo recredentialing at least every 36 months, in accordance with regulatory requirements, accreditation, and Alignment's policies and procedures. HDOs will need to complete a credentialing application, along with the requested documentation to maintain participating-network status with Alignment. The Credentialing Committee will approve, deny or modify the HDO status according to the established policies. If the recredentialing is denied or modified due to quality-of-care issues, the HDO will be notified of the determination by mail or email and will have 30 days to appeal. The HDO will be notified of the decision in writing.

7. THE CREDENTIALING COMMITTEE

The function of the Credentialing Committee includes provider credentialing, recredentialing, and ongoing and periodic performance assessments. The committee is composed of Alignment Medical Directors with a quorum of physician voting members. The committee meets monthly (or as the need arises) to determine the participation status of new providers or those providers who presently participate with Alignment. The committee maintains the confidentiality of information obtained during the credentialing process and follows all policies and procedures implemented by Alignment.

Alignment reserves the right to coordinate, consolidate, and participate in any provider disciplinary hearing. Hearings must be conducted in accordance with CMS and NCQA® along with any applicable state and federal laws.

8. NONDISCRIMINATION POLICY

Alignment does not make credentialing and recredentialing decisions based on the applicant's race, ethnic/national identity, gender, age, sexual orientation, types of procedures, or types of patients in which the provider specializes. IPAs/medical groups and delegated provider groups must also have a policy addressing nondiscrimination with credentialing and recredentialing decisions.

Alignment performs periodic review of provider complaints to determine if there are complaints alleging discrimination. Alignment also requires IPA/medical groups and delegated provider groups to maintain a diverse Credentialing Committee membership. Alignment requires those responsible for credentialing decisions to sign an affirmative statement to make decisions in a nondiscriminatory manner.

9. PROVIDER RIGHTS

Alignment notifies practitioners and providers of their rights to review information submitted to support their credentialing application, correct erroneous information, and receive the status of their credentialing and recredentialing application, upon request (see Exhibit 15.1: Provider's Rights Notification Form).

10. EXCLUDED PROVIDERS

Alignment does not credential or contract with providers/practitioners who are identified on the CMS Preclusion List, those with active exclusions by the Office of the Inspector General (OIG) via the List of Excluded Individuals/Entities and the System for Award Management (SAM), or those that have opted out of Medicare or Medicaid as applicable.

Members are never held responsible for those services that are not covered due to this circumstance, and the providers/practitioners will not bill members.

11. NOTIFICATION OF DISCREPANCY

Providers will be notified in writing, via email, fax or mail when information obtained by primary sources varies substantially from information provided on the provider's application. Examples of information at substantial variance include reports of a provider's malpractice claims history, actions taken against a provider's license/certificate, suspension or termination of hospital privileges, or board-certifying expiration when one or more of these examples have not been self-reported by the provider on their application

form. Providers will be notified of the discrepancy at the time of the primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing or is protected from disclosure by law.

If a provider believes that erroneous information has been supplied to Alignment by primary sources, the provider may correct such information by submitting a written notification to the Credentialing Department. Providers must submit a written notice, along with detailed explanation, to Alignment within 48 hours of Alignment's notification to the provider of a discrepancy or within 24 hours of a provider's review of their credentialing file.

Upon receipt of notification from the provider, Alignment will reverify the primary-source information in dispute. If the primary-source information has changed, correction will be made immediately to the provider's credentials file. The provider will be notified in writing, email, via letter or fax, that the correction has been made to their credentials file. If, after the specified time frame of 10 working days the primary-source verification remains in dispute, the provider will be subject to action under the Fair Hearing Policy in accordance with NCQA® guidelines. This action may include administrative denial or termination. The right to appeal will be provided to providers for suspension, termination or nonrenewal of their contracts with Alignment.

NOTE: Alignment may delegate the primary-source verification process to a Credentials Verification Organization and provide appropriate oversight of that function.

12. ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND QUALITY ISSUES

Alignment monitors 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 our members. Monitoring occurs throughout the credentialing cycle.

In addition, Alignment investigates and monitors member complaints related to a provider and takes this information into consideration during the recredentialing process. Should a quality issue be identified and action taken against a provider, Alignment may report it to the appropriate authorities.

13. APPEALS AND FAIR HEARING

When Alignment's Credentialing Committee makes a decision to deny or modify credentialing or recredentialing of a provider for quality-of-care issues, Alignment must offer the provider a formal appeals process.

EXHIBIT 15.1
PROVIDERS RIGHTS NOTIFICATION FORM

I. RIGHT OF REVIEW

A practitioner has the right to review information obtained by Alignment for the purpose of evaluating that practitioner's initial credentialing or recredentialing application. This includes non privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank) but does not extend to the review of information, references or recommendations protected by law from disclosure.

A practitioner may request to review such information at any time, by sending a written request via letter or fax to the Credentialing Department (see **Exhibit 1.1** for contact information). The Department Representative will notify the practitioner within 72 hours of the date and time when such information will be available for review.

II. NOTIFICATION OF DISCREPANCY

Practitioners will be notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include: reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/ certificate, suspension or termination of hospital privileges, or board certification expiration when one or more of these examples have not been self- reported by the practitioner on their application form. Practitioners will be notified of the discrepancy at the time of primary- source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

III. CORRECTION OF ERRONEOUS INFORMATION

If a practitioner believes that erroneous information has been supplied by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice (via email, letter or fax) along with a detailed explanation to the Credentialing Department (see **Exhibit 1.1** for contact information). Notification to Alignment Health must occur within 48 hours of notification to the practitioner of a discrepancy as provided in Section III or within 24 hours of a practitioner's review of his/her credentials file as provided in Section I.

Upon receipt of notification from the practitioner, the primary-source information in dispute will be rereviewed. If the primary-source information has changed, correction will be made immediately to the practitioner's credentials file and the practitioner will be notified in writing, via letter or fax. If, upon rereview, primary-source information remains inconsistent with the practitioner's notification, the Credentialing Department will notify the practitioner via email, letter or fax. The practitioner may then provide proof of correction by the primary-source body to the Credentialing Department via email, letter or fax within ten working days (see **Exhibit 1.1** for contact information). The Credentialing Department will reverify primary-source information if such documentation is provided. If, after 10 working days, the primary-source information remains in dispute, the practitioner will be subject to action under Alignment's policy, up to administrative denial/termination.

During the verification and credentialing process, practitioners can contact the Credentialing Department to obtain their credentialing or recredentialing application status. Using the email or phone number above, practitioners can contact Alignment and speak directly with the Credentialing Department regarding the status of their credentialing application. At that time, the credentialing department will double check the file to make sure that nothing is pending from the practitioner and request such items if necessary. The Credentialing Department may share with the practitioner the completeness and expected time the file may be reviewed by the Credentialing Committee but may not solicit information regarding a potential decision, references, recommendations, or other peer-review protected information.

SECTION 16 | PRESCRIPTION DRUG BENEFITS AND PHARMACY SERVICES

OVERVIEW

Alignment operates Medicare Advantage Prescription Drug Plans, offering comprehensive pharmacy services, including formulary management, clinical programs and pharmacy network management. Alignment contracts a pharmacy benefits manager (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, which is a list of drugs covered by Alignment. The formulary is reviewed and approved by the Pharmacy and Therapeutics 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 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.

2. PART D RESOURCES

Formulary, prior authorization criteria, coverage-determination forms, pharmacy directory and other resources for the Part D prescription drug plan are available on the Health Plan's website (see **Exhibit 1.1: Pharmacy**).

3. VACCINES

Alignment provides coverage for Part D vaccines, including the shingles and RSV vaccines. Some vaccines such as flu shots, pneumonia vaccines, COVID-19 vaccines, and hepatitis B vaccines (for patients at high or intermediate risk) are considered medical benefits and covered under Medicare Part B. There is no coinsurance, copayment, or deductible for the pneumonia, flu, hepatitis B and COVID-19 vaccines. Vaccines directly related to the treatment of an injury or related to direct exposure to a disease or condition are also covered under Part B.

There is no member cost share for most adult Part D vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC). Members can get vaccines administered by their provider or participating network pharmacy. To improve vaccine access for members and reduce their out-of-pocket costs, providers are encouraged to provide members with prescriptions for Part D vaccines to be dispensed and, if applicable, administered at a network retail pharmacy. Alternatively, if members pay out-of-pocket for the cost of the vaccine in office to providers, members must submit a claim reimbursement request to Alignment and ask the plan to pay our share of the cost.

4. MEDICATION THERAPY MANAGEMENT PROGRAM

Alignment offers a free, voluntary medication therapy management program (MTMP) for eligible members who 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 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' prescribers are also provided with recommendations for drug-therapy changes to resolve medication-related problems or to 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 they are receiving safe and appropriate care. These reviews are especially important for members who have more than one provider prescribing 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 potential problem, we will work with the providers to correct it.

6. OPIOID OVERUTILIZATION POLICIES

Medicare Part D opioid overutilization policies encourage interdisciplinary collaboration, as well as care coordination among Part D plans, pharmacies, prescribers, and patients in preventing opioid misuse, reducing serious adverse risks, and promoting safer prescribing practices. In accordance with CMS policies, Alignment utilizes safety alerts for applicable opioid prescriptions dispensed at pharmacies and drug-management programs for patients determined to be at risk for misuse of opioids or other frequently abused drugs.

DRUG MANAGEMENT PROGRAMS

If a member is identified as being 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. This information will be used to make a decision on whether the member should have their access to frequently abused drugs limited. Prescribers are expected to respond when contacted for information about a member's prescription use history.

OPIOID SAFETY ALERTS

Alignment implements opioid safety alerts (pharmacy claims 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 being rejected at the pharmacy, prescribers may also proactively request a coverage determination, as needed, in advance of prescribing an opioid prescription.

OPIOID SAFETY ALERT	PRESCRIBER'S ROLE
Seven-day supply limit for opioid-naive patients. Medicare Part D patients who have not filled the opioid prescription under the Health Plan will be limited to a supply of seven days or less. Limiting the amount dispensed with the first opioid prescription may reduce the risk of a future dependence or overuse of this drug.	Patients may receive up to a seven-day supply or request a coverage determination for a full-day supply as written. The physician or other prescriber has the right to request a coverage determination on the patient's behalf, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid. The prescriber needs only to attest to the Health Plan that the day's supply is the intended and medically necessary amount. Subsequent prescriptions written by prescribers are not subject to the seven-day supply limit, as the patient will no longer be considered opioid-naive.
Opioid care coordination alert at 90 morphine milligram equivalent (MME). This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative MME per day across all their opioid prescription(s) reaches or exceeds 90 MME and there is utilization from more than two pharmacies and two prescribers. The prescriber will be contacted to resolve the alerts and to be informed of other opioid prescribers or increasing level (MME) of opioids. This is not a prescribing limit. Decisions to taper or discontinue prescription opioids are individualized between the patient and prescriber.	Regardless of whether individual prescription(s) is/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. 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. Once a pharmacist consults with a prescriber on a patient's prescription for a plan year, the prescriber will not be contacted on further opioid prescriptions written for the same patient, unless the plan implements further restrictions. 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.
Concurrent opioid and benzodiazepine use or duplicative long- acting opioid therapy. The alerts will trigger when opioids and benzodiazepines are taken concurrently or if patient is on multiple duplicate long-acting opioids.	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.

7. INSULIN

Member cost-sharing for covered insulin shall cost no more than $35 for a one-month supply regardless of the cost-sharing tier. Covered insulin products are products that are: included on the plan's Part D formulary, treated as being included on the part D formulary as a result of coverage determination or appeal, covered under the transition process, or used in traditional insulin pumps and covered under Part B in accordance with CMS guidelines.

8. DIABETIC SUPPLIES

Alignment covers finger-stick blood glucose monitors, test strips, and lancets, with a prescription, at any network retail or mail-order pharmacy.

FreeStyle is the preferred brand of diabetic supplies. Providers are requested to prescribe FreeStyle brand diabetic supplies to the member's pharmacy of choice. Alignment follows Medicare-defined quantity limits for a maximum testing frequency of three times per day for patients on insulin. Dispensing of test strips is limited to three test strips per day, up to 100 test strips per 30 calendar days, one box at a time. For a brand other than FreeStyle and/or a higher testing frequency, providers are required to submit an authorization request to the Alignment Utilization Management Department for review of coverage, explaining the medical necessity of the request. Providers can submit diabetic supply authorization requests via **AVA®** (see **Exhibit 1.1: Utilization Management**).[3]

9. PRESCRIPTION CLAIMS PAYMENTS

All prescription claims payments are subject to retrospective review to determine whether provider financial liability exists and to pursue recovery, where such liability is determined to exist. In the event a provider orders medication through Medicare Part D, such as intravenous/intramuscular medications that are typically administered by a healthcare professional, Alignment may deduct such costs from the IPA's capitation payments. For medications that are deemed Alignment's risk, and if the medication has a biosimilar available on the market, claims for that medication will be paid at the lowest available biosimilar rate.[3]

3 Applicable to Alignment Health Plan only. Not applicable to FirstMedicare Direct.

SECTION 17 | MEDICARE STAR PROGRAM

OVERVIEW

Alignment's Stars team works with providers toward achieving a five-star rating from the Centers for Medicare & Medicaid Services (CMS). These ratings are based on Healthcare Effectiveness Data and Information Set (HEDIS®) data, Health Outcomes Survey (HOS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, pharmacy data and administrative outcomes. Alignment's program supports CMS's goal to improve the Medicare beneficiary access to quality services through driving a level of accountability in the care provided by physicians, hospitals, IPAs/medical groups other providers, and health plans.

1. HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

HEDIS® is a set of comprehensive standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA) and adopted and used by CMS in connection with the Medicare Five-Star Quality Rating system.

HEDIS® measures are designed to provide a reliable comparison of health plan performance. Examples of HEDIS® measures include preventive screenings, chronic care management, SNP-specific metrics, and other clinically focused measures. Current quality-gap lists for specific members are available in **AVA®** and are sent to individual IPAs and providers via SFTP throughout the year. Quality Performance metrics are also available in **AVA®** . IPAs/medical groups and/or providers will be held accountable to satisfy the Quality Covenants in their agreement. Providers are expected to close care gaps by the end of the measurement year for:

- Colorectal Cancer Screening (1x weighted measure)
- Breast Cancer Screening (1x weighted measure)
- Glycemic Assessment for Patients with Diabetes – HbA1c Control ≤9 (3x weighted measure)
- Eye Exam for Patients With Diabetes (1x weighted measure)
- Kidney Health Evaluation for Patients with Diabetes (1x weighted measure)
- Osteoporosis Management in Women Who Had a Fracture (1x weighted measure)
- Controlling High Blood Pressure (<140/90) (3x weighted measure)
- Statin Therapy for Patients With Cardiovascular Disease – Received Statin Therapy (1x weighted measure)
- Transitions of Care (1x weighted measure)
  - Notification of Inpatient Admission (0.25x weighted measure)
  - Receipt of Discharge Information (0.25x weighted measure)
  - Medication Reconciliation Post-Discharge (0.25x weighted measure)
  - Patient Engagement After Inpatient Discharge (0.25x weighted measure)
- Follow-Up After Emergency Department Visit for People With Multiple Risk Chronic Conditions (1x weighted measure)
- Plan All Cause Readmission (3x weighted measure)
- Care of Older Adults (SNP members)
  - Medication Review (annually) (1x weighted measure)
  - Pain Assessment (annually) (1x weighted measure)

Gaps are closed through administrative data (claims/encounters), hybrid (medical record) data and/or supplemental files provided by IPAs/medical groups and/or providers. As a partner, Alignment requires regular and routine quality data submissions all year long. During HEDIS Audits (January-April), medical record requests will be made, and the expectation is for IPAs/medical groups and/or providers to provide charts as requested.

2. HEALTH OUTCOMES SURVEY (HOS)

The (HOS) is a member-reported outcomes survey used in Medicare managed care. The goal of the HOS is to gather valid, reliable and clinically meaningful health-status data from the Medicare Advantage program to use in quality-improvement activities and program oversight and to improve health outcomes. The HOS survey to members includes questions about their mental and physical health over time, as well as the discussions they have had with their healthcare providers around fall risk, physical activity and urinary incontinence. Discussing these items with Alignment members, your patients, will help ensure a higher quality of life while aging:

- IMPROVE physical health by establishing health interventions when clinically appropriate, such as monthly physical therapy, setting weight-loss, fitness, and mobility goals. Alignment's ACCESS On-Demand Concierge team is available to provide a list of no-cost gym memberships to help members reach these goals as part of their care plan.
- IMPROVE health habits with goal setting and action plans to help members take active roles in improving their health. Set follow-up appointments for goal check-ins.
- IMPROVE emotional health by educating members on staying positive, practicing mindfulness, getting enough sleep, eating healthy, limiting alcohol, and staying connected with loved ones.
- IMPROVE mental health by referring members to behavioral health services when clinically appropriate.
- IMPROVE physical health by setting weight-loss, fitness, and mobility goals. Alignment's ACCESS On-Demand Concierge team is available 24/7 (see Exhibit 1.1: ACCESS On-Demand Concierge) to provide a list of no-cost gym memberships to help members reach these goals.
- IMPROVE self-sufficiency by referring members with limited or decreased mobility to physical therapy to learn safe/ effective exercises.

- IMPROVE member understanding of how to control incontinence by educating them on treatment options such as medication, engagement in bladder training exercises, or surgery.
- IMPROVE member safety by reducing fall risk. Encourage members to remove throw rugs, clutter and tripping hazards. Advise on proactive solutions such as handrails on stairways, grab bars in bathrooms, non-slip shower mats and use of nightlights throughout the home.
- IMPROVE financial well-being. Alignment's ACCESS On-Demand Concierge team is available to provide members with their over-the-counter (OTC) allowance for help with obtaining personal care items, hearing aids or other health supplies.

3. CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY

The CAHPS survey is a member experience survey that asks members to rate their experiences with their health plan, drug plan, and providers using nine specific metrics: Care Coordination, Getting Needed Care, Rating of Care Quality, Self-Reported Flu Vaccine, Getting Appointments and Care Quickly, Rating of Health Plan, Customer Service, Rating of Drug Plan, and Getting Needed Prescription Drugs. Incorporating the following practices will improve the member's experience and promote high-quality patient care:

- ALWAYS reserve daily time blocks for walk-in and urgent same-day appointments, ensuring your members that you are ALWAYS there for them.
- ALWAYS provide the phone number for a 24/7 or after-hours urgent care facility on your answering service. The Alignment Health Plan Concierge team is also available 24/7 (see Exhibit 1.1: ACCESS On- Demand Concierge).
- ALWAYS set expectations for in-office wait time by providing members with estimated wait time and updates during check-in – this can improve perceived wait time.
- ALWAYS have the member leave the office with helpful materials in-hand such as an appointment reminder card or copy of a referral. These resources will help to decrease delays in care and improve perception of getting care as soon as needed.
- ALWAYS have the office staff assist in scheduling a specialty appointment or follow-up visit prior to the member leaving the office.
- ALWAYS review/update the member's medication list at every visit. Make sure the member understands the prescribed medications and encourage adherence.
- ALWAYS set expectations with members on receiving their test results. Set a practice goal to communicate test results to patients within 24 hours of receipt.
- ALWAYS ask the member if they have any questions and address any additional concerns before the end of the appointment.

Alignment conducts internal member surveys to improve Member satisfaction and experience, and for quality improvement purposes. Surveys may be conducted through mail, email, text, phone or a combination of modalities.

4. ADMINISTRATIVE MEASURES

CMS also measures Alignment on administrative measures related to process performance. These results include responsiveness to appeals, call center-monitoring audit scores, and member voluntary disenrollment numbers.

Health plans are also evaluated on prescription drug adherence for certain medications. Alignment ensures that members can easily access these drugs by placing them on the lowest formulary tier. IPAs/medical groups and/or providers are expected to direct members to the Alignment Health Plan Concierge team for assistance (e.g., disenrollment, benefits, marketing misrepresentation, claims processing, etc.) prior to outreaching to CMS (see **Exhibit 1.1: ACCESS On-Demand Concierge**).

For additional information, please review Alignment's Medicare Stars Program Best Practice Guide (see **Exhibit 1.1: General Resources**). This detailed guide is a valuable resource for learning about the Stars measures, data requirements and improvement processes.

To learn more about your Stars scorecard, best practices, improvement ideas and the Stars program, email the Stars team (see **Exhibit 1.1: Stars**).

SECTION 18 | RISK ADJUSTMENT AND CODING

OVERVIEW

Risk adjustment is a process that CMS uses to reimburse Medicare Advantage plans based on the health status of members. Risk adjustment ensures that CMS pays health plans appropriately for members' expected health costs based on their overall health status and demographic information. To ensure we accurately document our members' health status, Alignment will perform a Comprehensive Annual Health Assessment with members. This assessment is intended to identify chronic diseases, modifiable risk factors and urgent health needs. Additionally, we will delegate responsibility for this function to participating IPAs/medical groups or PCPs to complete as part of an Annual Wellness Visit (see **Section 13: Annual Wellness Visit**), compliant with CMS requirements.

P360 TOOL

Alignment's P360 is a clinical point-of-care tool designed to provide providers with current data regarding their members. This includes chronic year-over-year diagnoses, probable or suspected conditions, HEDIS® and other quality care gaps, hospitalizations, lab results, pharmaceutical history and recently reported diagnosis codes.

Alignment makes these forms available to the provider on **AVA®** (see **Exhibit 1.1: General Resources**). These forms are updated frequently.

2. MEDICAL RECORD DOCUMENTATION REQUIREMENTS

In accordance with CMS published official documentation guidelines, all medical record notes must be complete and legible. The medical record should include the following:

- Reason for the visit
- Relevant history
- Current medications, including dosage and any allergies to medications
- Physical exam
- Prior diagnostic test results
- Assessment, clinical impression, or diagnosis
- Plan of care (for each diagnosis listed in the assessment and/or being submitted)
- Date of encounter
- Clinician name and credentials
- Signature, credentials and date of signature
- If diagnostic tests or ancillary services are ordered, the diagnosis should be documented or the reason for ordering them should be easily inferred from the documentation
- Appropriate health risk factors should be identified
- Progress, response to, and/or changes in treatment, and any revision in the diagnosis should be documented

The diagnosis and treatment codes reported on the claim form should be supported by the documentation. Documentation should be completed and signed during the encounter, immediately following the encounter, or as soon as reasonably practicable after the encounter.

3. RISK ADJUSTMENT SUBMISSIONS

All data required for submission for CMS sweep periods must be submitted to Alignment within 20 working days prior to the sweeps deadline to allow processing and error corrections.

The table below references the CMS Sweep Data Collection period and the IPA/medical group submission timeline, as well as Alignment's timeline to submit to CMS. The initial cutoff date is approximately 20 working days from the CMS deadline. Alignment will accept data up to 10 business days prior to a sweep but cannot guarantee that the files will be processed if submitted after the initial cutoff date listed below. The provider is responsible for ensuring that all data submitted to Alignment is accurate, complete and documented in a compliant medical record from an acceptable provider type.

RISK SCORE RUN	DATES OF SERVICE	DEADLINE FOR SUBMISSION OF RISK ADJUSTMENT DATA	DEADLINE TO SUBMIT TO ALIGNMENT (4 WEEKS PRIOR)
PY2025 Initial	07/01/2023-06/30/2024	Friday, 09/06/2024	Friday, 08/09/2024
PY2024 Final Run	01/01/2023-12/31/2023	Friday, 01/31/2025	Friday, 01/03/2025
2025 Mid-Year	01/01/2024-12/31/2024	Friday, 03/07/2025	Friday, 02/07/2025
2025 Final Run	01/01/2024-12/31/2024	Monday, 02/02/2026	Monday, 01/05/2026

Dates subject to change dependent on updates of CMS calendar.

4. QUALITY AND COMPLIANCE

Providers are required to provide legible documentation for the encounter, as outlined under CMS **Medical Record Documentation Requirements**. If the medical record is handwritten, it must be legible. All codes submitted for reimbursement must be supported by the documentation. Documentation should be complete and written in a way that anyone can easily understand why the patient was seen and/or what the patient was treated for on that date. Providers should document to the highest specificity possible to ensure accurate code assignment. Medical records that are illegible will not support the encounter.

Late entries, addendums and corrections should be done only when necessary and not as a normal part of documentation.

- A late entry supplies additional information that was omitted in the original documentation. It is only used if the person documenting has total recall of the omitted information and is signed and dated by the person making the addition or correction to the medical record.
- An addendum is used to provide additional information that was not available during the original encounter. The entry must be signed, dated and include the reason for the addendum.

As suggested by CMS, addendums to medical record documentation may only be accepted within 45 calendar days from the original date of service of the visit.

A late entry or addendum is not used to provide information or report a condition that was not addressed on the original date of service.

- A correction to handwritten records must have a single line through the incorrect information. The correct information should be entered, and the entries must be initialed and dated. DO NOT use correction fluid or black out, and DO NOT erase, or otherwise, cover up the incorrect entry.
- A correction to an electronic record should track both the original and the corrected entry with the reason for change initialed and dated by the person making the correction.

Medical record documentation should be completed during the encounter, immediately following the encounter, or as soon as reasonably practicable after the encounter. Best practice is within 48 hours after the date the service is rendered. Documentation must be dated and include a legible signature along with credentials.

5. HISTORICAL DATA

Alignment utilizes both current and historical data to be proactive in the care of our members. Accurate and complete data supports Stars and Risk Adjustment outcomes and helps to improve the overall member experience.

Providers are encouraged to work with their Alignment Provider Relations Representative for current submission format requirements (**Exhibit 1.1: Network Management/Provider Relations**). The below table provides some examples of the types of data submissions.

LAYOUT NAME	DESCRIPTION
Member Eligibility Data	Data Attributes for Member
Provider Data	Data Attributes for Provider
Claims Encounter Data	Data Attributes for Claims
Rx Data	Data Attributes for Pharmacy
Lab Data	Data Attributes for Lab
HEDIS Result	Data Attributes for HEDIS Part C Measures
HEDIS Med Adherence	Data Attributes for HEDIS Part D Measures
Authorization	Data Attributes for Authorization
MOR	Standard CMS Template for Monthly Output Report
MMR	Standard CMS Template for Monthly Membership Report
RAPS Return	Standard CMS Template for RAPS Return
MAO-004	Standard CMS Template for EDS Return

6. RETROSPECTIVE CHART REVIEW

Alignment may conduct a retrospective chart retrieval and coding initiative on an annual basis.

For our non-delegated providers, Alignment will coordinate efforts to retrieve and code medical records. The cost for copying medical records is the responsibility of the provider. The provider is responsible for ensuring that all data submitted to Alignment is accurate, complete, and documented in a compliant medical record from an acceptable provider type.

Delegated providers are responsible for retrieving, accurately coding their medical records, submitting accurate and complete data in a timely manner to Alignment. Typically, Alignment does not pay record-copying fees when obtained for the purposes of a medical record review. The IPA/medical group is responsible for ensuring that all data submitted to the Health Plan is accurate and complete and is documented in a compliant medical record from an acceptable provider type (see Program Resources in this section for link).

7. CODING PRACTICES AND PROCEDURES

Providers are expected to comply with all CMS guidelines when evaluating and documenting diagnoses. A member's medical record must always support the associated diagnosis coding that is submitted to Alignment.

Should a CMS Risk Adjustment Data Validation audit find that medical-coding standards are not being met, the provider may be responsible for penalties imposed by CMS.

8. PROGRAM RESOURCES

- Medicare Advantage Encounter Data and RAPS Data (CMS Customer Service and Support Center): **Acceptable Physician Specialty Types by Payment Year**
- CMS: **Medicare Risk Adjustment Eligible CPT/HCPCS Codes**
- CMS: **Medicare Risk Adjustment Information**
- CMS Medicare Learning Network: **Evaluation and Management Services**
- CMS Medicare Learning Network Fact Sheet: **Complying With Medical Record Documentation Requirements**
- CMS Medicare Learning Network Fact Sheet: **Complying With Medicare Signature Requirements**

9. EDUCATION

For HCC educational materials, contact Alignment via Alignment Health Plan's **Provider Resources** page (login needed) or our HCC email address. (See **Exhibit 1.1: Risk Adjustment** and **Exhibit 1.1: General Resources**, respectively.)

SECTION 19 | FINANCIAL AND CONTRACTUAL

OVERVIEW

Alignment's Finance Department monitors its providers to ensure that they are financially solvent and have the ability to pay timely claims on behalf of members and in accordance with the law. This policy encompasses all providers to whom financial risk has been contractually delegated by Alignment.

1. FINANCIAL REQUIREMENTS

The participating provider is required to maintain financial reserves, working capital and contingency plans that are 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 statements and audited or unaudited quarterly statements. These shall include a balance sheet, statement of income, and a statement of cash flow prepared in accordance with generally accepted accounting principles (GAAP). All such financial statements shall be certified by the provider's Chief Financial Officer as accurately reflecting the financial condition of the provider. The provider shall provide to Alignment, no later than 45 calendar days following the end of each of the provider's fiscal quarters, quarterly financial statements for the immediately prior three-month period.

Annually, the provider shall provide Alignment with copies of the provider's audited annual financial statements for the most recent fiscal year-end, along with an opinion letter from the accounting firm that completed the audit. Said Financial Statements shall be provided to Alignment no later than 150 calendar days after the close of the provider's fiscal year. Alignment also agrees to maintain these statements in a confidential manner. The provider will provide the following:

- A statement as to whether 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. This report must describe in detail the reason for the deficiency, the action taken to correct the deficiency, and the results of that action. This document is the corrective action plan (CAP).
- A statement as to whether the provider 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 describing in detail the nature of the deficiency, the reason for the deficiency, action taken to correct the deficiency, and results of that action. The provider 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. Alternatively, it may have a TNE in an amount approved and met by the compliance guidelines established by law.
- Written verification attached to each report stating that the report is true and correct to the best knowledge of the Chief Financial Officer of the provider and is signed by the Chief Financial Officer.

Outcome and financial status of the provider will be discussed at Alignment's quarterly Delegation Oversight Committee meetings.

2. SHARED RISK FUND SETTLEMENTS

The shared-risk fund settlements reports are prepared by Alignment's Finance Department and forwarded to each provider electronically, based on the terms of the contract. The reports contain the shared-risk fund settlement summary, claims data, and Part B drugs data. The provider has a set period specified in the contract during which to respond with any inquiries or disagreements with the reports.

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