Alignment Healthcare

Florida

Provider Manual

Alignment Healthcare Florida Provider Manual

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Alignment Healthcare, a Transformative Approach
Our current healthcare system is not aligned with the needs of the population. The Alignment Healthcare (AHC) model is designed to lower cost and increase quality to create value for the patient. With an advanced clinical model, IT & Enablement systems, risk experience, and capital, AHC provides a framework for population health transformation. Through integrating with hospitals, physician groups, health plans and employers, AHC is a partner for building a smarter and better healthcare system for our communities.

For the first time, the interests of hospitals, physicians and payers can align to deliver truly excellent, patient-centric care. Our proprietary Alignment business and Advanced Clinical Model is a platform that enables health care systems and providers to become population health leaders. With Alignment, Doctors have more time to interact with patients, hospitals extend their reach deep into the communities they serve and payers are able to put resources where they will do the most good.

The end result is perfect alignment of all interests: happier, healthier patients and increased profitability for hospitals, doctors, and payers. We are currently establishing partnerships with leading healthcare providers nationwide. If your job is to deliver better patient care or better bottom line results, contact AHC to learn how we will help improve both.

AHC is an intermediary organization which contracts with professional, institutional and ancillary health care providers to make the health care services of such providers available to individuals enrolled as Members in certain Medicare Advantage plans offered by managed care organizations, including health maintenance organizations and other prepaid health plans which are contracted with AHC Contracted Managed Care Organizations (MCOs).

AHC MISSION AND VISION STATEMENTS

Our Mission
We relentlessly focus on improving healthcare value for patients and partners.

Our Vision
To lead a movement that transformationally improves healthcare.

Section 1: Departments Description

Alignment Healthcare Corporate Headquarters
1100 W. Town & Country Road
Suite 1600
Orange CA 92868
(844) 215-2442
www.alignmenthealthcare.com

DEPARTMENTS DESCRIPTION

Sales and Marketing Department
The health plan Marketing department promotes AHC within the service area communities through Community events, new member orientations, distribution of educational and marketing materials throughout the community, and participating in community activities geared toward marketing benefits and services. The sales staff schedules and conducts presentations in the community and private homes to ensure potential members understand the health plan's benefits and the enrollment process. The sales representatives interact with Primary Care Physicians (PCP) offices and their staff specifically related to enrollment and retention. Also, the Sales department coordinates all sales events and develops collaterals and other printed materials.

Network Operations Department
Provider Contracting Management: Negotiates and maintains all contracts for medical services provided to our members.

Provider Data Management: Inputs all provider data and practice information into the computer system such as demographic information from profile sheets, and signature pages.

Eligibility Department
The Eligibility department verifies member eligibility for services for the participating provider's offices, vendors, pharmacies and internal departments as needed (via phone, website or fax).

Finance Department
The Finance department processes Guaranteed Monthly Payments (GMP) for Participating Primary Care Physicians and payments for AHC's contracted providers and other medical services vendors as appropriate.

Stars Performance Improvement Department/Risk Adjustment Department
In order to provide the best care for health plan members, the Stars Process Improvement Program establishes guidelines in order to achieve the common goal of achieving a 5 Star status. Members with chronic diseases are monitored to assure best outcomes and best practices in treating their diseases. In order to serve the greatest good for health care and cost containment, the risk adjustment department assures that complete data is gathered through coding and other documentation of services provided to each member at every visit. The Centers for Medicare and Medicaid Services (CMS) has given ratings to the health plans based on how well a health plan is providing clinical quality, customer services and member satisfaction to its membership. The Stars Performance Improvement department monitors and assists the physicians and other medical services providers to help improve their individual Star ratings, which in turn, increases the overall Star rating for the health plan.

Member Services Department
The Member Services department answers all member calls regarding referrals, benefit inquiries, complaints, Part D coverage, grievances and appeals.

Claims Department
The Claims department processes claims for payment to providers, and assists providers with claims status inquiries. The Claims department maintains provider files and information to ensure proper reimbursement according to contracted rates, or to reimburse at Medicare rates for non-contracted providers who provide services to our Members.

Utilization Management (UM) Department
The Utilization Management department ensures all medical services are provided appropriately, are in the correct settings, and with participating providers (whenever possible). The UM department reviews medical records to determine approvals of medical care. Reviews may be required for the following medical care: medical services referrals, level of care determinations, length of stays, and approval decisions of non-delegated services based on medical necessity.

Quality Management (UM) (including Delegation Oversight and Credentialing)
Quality Management is responsible for all quality activities, including: conducting quality improvement projects in compliance with the Centers for Medicare and Medicaid guidelines and performing credentialing for all practitioners and/or health delivery organizations (SNF, HHA, Hospitals) that are contracted with AHC.

Section 2: Members Rights and Responsibilities

Member Rights:
Treated with fairness, respect, dignity, and consideration for privacy; including their personal health information:

- Privacy of their medical records and personal health information.
- Confidentiality of personal and health information regardless of the format of that information. (*i.e., spoken communications, written materials, electronic records, or facsimiles).* This includes the release of medical records.
- Access to personal medical records only in accordance with law.
- Free from discrimination based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or health status.
- Timely access to network providers and to be able to see specialists when care from a specialist is needed.
- Access to emergency health care services without prior authorization.
- Choose a network physician to provide primary care based upon the providers panel (open or closed panel).
- Participation of decisions about their personal healthcare and education of available treatment options (including the option of no treatment) or alternative courses of care in an understandable language.
- Utilize an advance directive (such as a living will or a power of attorney).
- Appoint a representative to make health care decisions including the decision to withhold resuscitative services, or withdraw life-sustaining treatment if requested by the member.
- File complaints, and obtain a prompt resolution of issues (including complaints, grievances or appeals) relating to the authorization, coverage, or payment of services.
- Obtain information regarding health care coverage and costs.
- Obtain information about, affiliated IPA/Medical Groups and any contracted providers.
- Obtain more information about their rights from the plan if requested.

Members Responsibilities:
A general understanding of their health care coverage, and the rules that must be followed to receive care, as a member:

- Members will provide their physicians and other health care provider information necessary to provide appropriate health care.
- Payment of any applicable co-payment, deductible, co-insurance or charge for non-covered services when requested by their AHC physician.
- Appropriate behavior in and around health care providers' place of business to promote a healthy environment to receive health care.
- Inform the health plan of any questions, concerns or suggestions.

Practitioner Advocacy on Behalf of Members:
Practitioners are not prohibited from advocating on behalf of the member, and are advised of the following:

- The expectation to educate members regarding health needs.
- To share findings of medical history and physical exams.
- To discuss potential treatment options (including those that may be self-administered) and the risks, benefits and consequences of treatment or non-treatment. Discuss the side effects and management of symptoms (without regard to plan coverage).
- Recognize that the member has the right to receive sufficient information, to be able to provide input into the proposed treatment plan and has the final decision in the course of action to take among clinically acceptable choices.

Section 3: Protected Health Information (PHI)

Protected Health Information (PHI)
AHC members' personal health information, whether it is written, oral or electronic, is protected at all times and in all settings. AHC, practitioners and providers can only release protected health information (PHI) without authorization for the following reasons:

- Needed for payment.
- Necessary for treatment or coordination of care.
- Necessary for health care operations (including but not limited to HEDIS® reporting, Appeals and Grievances, Utilization Management, Quality Improvement, and disease or care management programs).
- When permitted or required by law.

Any other disclosure of an AHC member's PHI must have a prior, written member authorization. AHC, practitioners and providers must ensure that only authorized people with a need-to-know have access to a member's PHI. Participating Providers must obtain HIPAA Business Associate Agreements from individuals or organizations with which the Participating Providers contract to provide clinical and administrative services to members. Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, AIDS or substance abuse. To release a member's PHI regarding sensitive conditions, AHC practitioners and providers must obtain prior, written authorization from the member (or authorized representative) that states information specific with regard to the sensitive condition may be disclosed.

Section 4: Member Eligibility and Disenrollment

Website Verification
Providers have access to obtain member eligibility status through the health plan's website or by calling the health plan's Provider Services department. To obtain eligibility providers must have the member ID# (example: 00012345601) and date of birth. You may only verify member's eligibility for date of service in the current calendar month (up to actual calendar date) or the previous calendar month. Members with future effective dates will only be able to be checked on or after their effective date. Please refer to list of contracted AHC health plans attached.

Provider Initiated Disenrollment
The PCP of record must send a certified letter to the Member Services Department at AHC stating the reasons for the request for member transfer. The Member Services Department must evaluate the request and determine the conditions that would warrant the request.

Member Identification Card
New members are mailed their member ID card by the health plan in their Welcome Packet upon enrollment. Providers should always verify eligibility prior to rendering services to any member.

AHC Contracted Health Plans – How to verify eligibility – Exhibit 4.1
Sample Member Identification Card - Exhibit 4.2

Exhibit 4.1
Alignment Healthcare Contracted Health Plans

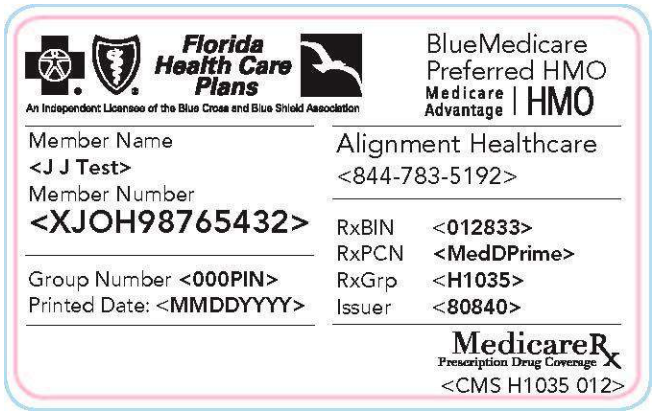
How to Verify Eligibility

Health Plan Name

Call Provider Services Department at: 1 (844) 783-5191

Or visit website: FLProviders@ahcusa.com

Exhibit 4.2
Sample Member Identification Card



Section 5: Oversight Compliance Standards/Encounter Data Submission/Claims Risk Adjustment Overview

AHC recognizes the vital role our Participating Providers play in delivering high quality health care to AHC members, and understands that compliance with regulatory requirements results in the delivery of high quality care. AHC is committed to ensure that the provider network delivers services which meet or exceed AHC accepted standards of medical practice.

The AHC's Provider Contracting department communicates the health plan's expectations to contracting providers and enforces the requirements of various regulatory bodies, including DMHC, CMS, NCQA and others. The department is composed of staff experienced in provider contracting, provider relations, auditing and reporting.

The following activities are conducted by the Delegation Oversight Committee:

- Monitor Participating Providers standards. Standards include, but are not limited to, access and availability, claims timeliness, encounters submissions and provider education
- Complies and monitors any corrective action plans
- Holds Oversight Committee monthly meeting chaired by the Administrator. The Committee is comprised of senior management
- Follows department policies approved by the Oversight Committee. The policies and procedures encompass claims timeliness, contracts, provider education, financial viability, access/availability and encounter data. The policies also detail what is expected of providers, how compliance will be measured and how corrective actions will be addressed
- Conducts a three-step Corrective Action Plan (CAP) process: notice of deficiency, warning and sanction. The process includes notifications to providers of the institution of corrective actions and a tracking system to follow providers through the various steps of the corrective action process and ensure that they have been designed and implemented

Regulatory Compliance Standards
Provider Education – AHC ensures that each Participating Provider has access to written processes for timely distribution, communication and implementation of AHC policies, procedures, manuals, bulletins, newsletters and reports. The health plan is required to publish provider network directories quarterly. Participating Providers must also achieve 85% or higher satisfaction from members on education and service matters. Provider services and member service education programs for Participating Providers also will be held at least annually.

Access Standards
AHC is responsible for monitoring data to ensure Participating PCPs adhere to the following access standard: 85% of participating PCPs are open to new AHC members.

Appeals and Denials
To ensure compliance with CMS regulatory standards, the auditor checks to ensure AHC generates a letter or notice to the provider and/or member as appropriate, specifying the specific service and reason for denial. The initial adverse determination notice that is clearly sent to a member must state the service and specific reason for the denial, inform the member of the right to appeal, give information on the availability of legal assistance, and provide reasonable opportunity to present evidence relating to the issue in dispute, in person as well as in writing.

Encounter Data Submission and Requirements
Encounter information must be submitted electronically to AHC's clearinghouse directly. At the discretion of AHC, hard copy encounters may be submitted to its clearinghouse as well as directly to AHC. Encounter data must be received by AHC ninety (90) days following the date of service. All encounters submitted must be in compliance with the HIPAA electronic transactions and code sets and protected health information (PHI) policies. Participating Providers are required to submit complete and accurate encounter data to AHC in a timely manner. The following shall constitute the minimum set of data elements to be submitted to AHC for the purpose of submission of encounter data:

- Provider National Provider Identification (NPI) Number
- Provider Tax ID (Site)
- Provider Service Address, City, State, Zip Code
- Rendering Provider Last and First Name
- Rendering Provider State License Number and NPI
- Patient Last Name
- Patient First Name
- Patient Birth date
- Patient Sex
- Enrollee ID Number (Subscriber No/Person No)
- Diagnosis Code(s)
- Service '"From" Date
- Service "Through" Date
- Place of Service
- CPT-4 Procedure Code(s)
- Units of Service

AHC will measure PCP's compliance with electronic encounter data submission. Encounter data will be reviewed quarterly to validate compliance. Error reports will be provided to Participating Provider to ensure the issues with any encounter submission are addressed timely and appropriately.

Claims Risk Adjustment Submission and Process Overview
Providing the best care for members with chronic diseases is crucial for members who meet the criteria. In order to serve the greatest good for health care and cost containment, complete data must be gathered through the documentation of services provided to each member at every visit. There are a number of reasons why capturing this information is important for example:

- System efficiencies across providers
  - Care coordination
  - Managing transitions across settings
  - Not solely internal provider efficiencies
- Share clinical information
  - Reduce duplicative tests and procedures
- Improve processes and outcomes
  - Increase guideline compliance
- Avoid unnecessary inpatient admissions and readmissions as well as emergency room visits
- Substitute outpatient services for inpatient services
  - Less invasive procedures for more invasive procedures
- Shorten length of stay

Provider Fraud, Waste and Abuse Training Requirements

AHC uses the Medicare General Compliance and Fraud, Waste and Abuse (FWA) Training presentation provided by CMS. Training is located on the CMS website at:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

Under "Downloads", please click on **"Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Part C and D General Compliance Training**" to review the training slides.

This training must be completed no later than 90 days from hiring or contracting date and annually thereafter.

***Please be aware that as of 1/1/16, CMS is requiring FDRs to complete the FWA training provided by CMS on the Medicare Learning Network.

Compliance Reporting Mechanisms

AHC would like to remind our providers that suspected or detected noncompliance, potential, or actual FWA must be reported. Providers may report a suspected violations by contacting the Compliance Hotline through any of the following methods:

- **Report Online:** www.reportlineweb.com/ahc (can report anonymously)
- **By Telephone:** (844) 215-2444. This line is available 24 hours 7 days a week.
- **By Email:** compliance@ahcusa.com

Providers may choose to report anonymously using the toll-free compliance hotline number or webline reporting mechanisms, 24 hours a day, 7 days a week to our third party hotline vendor. Providers may also report directly to the Compliance Department by sending us an email.

Section 6: Quality Management & Improvement Program (QI)

Quality Management Program Description
AHC has a Quality Management and Improvement (QI) Program that defines structures and processes, and assigns responsibility to appropriate individuals. Our mission is to improve the health outcomes and satisfaction of our members through collaborative efforts with contracting providers, education of members and ongoing process improvement for overall operational effectiveness. AHC's vision is to partner with our contracting providers to become a leader in the managed care industry through the obtainment of quality medical care. The QI Program supports our vision by promoting strategies that result in the achievement of meeting required standards as well as facilitating compliance with State, Federal and regulatory/accrediting agencies. The focus of the Program is to demonstrate a consistent attempt to deliver timely, safe, effective, patient care and services in an environment of minimal risk, and includes activities that have both a direct and an indirect influence on this care and service delivered to AHC members.

Board of Directors and Medical Services Committee
The AHC Quality Management & Improvement Program includes a written program description and an annually revised QI Work Plan which defines the activities and planned improvements for the year. The Work Plan will be developed following an evaluation of the previous year's activities and accomplishments. Following approval by the Medical Services Committee (MSC), the Board of Directors (BOD) will approve the annual program and work plan. Quality Management is not a delegated function. Participating Providers are required to comply with all AHC standards and requirements described in this Provider Manual and other relevant operational notices.

The AHC BOD has granted the MSC the authority to:
Develop and monitor the QI Program; implement the quality improvement initiatives; and communicate with participating physicians, as necessary.

The MSC reports to the BOD and on a quarterly basis presents a report of all activities for approval. The Medical Director serves as the chairperson of the MSC and presides over the meetings. In order to conduct a meeting, there must be at least three (3) physicians present in addition to the Medical Director. Minutes are maintained for the meeting and all discussions are considered confidential.
Goals and objectives include, but are not limited to:

- Improve the quality of care, safety, and service through quality improvement processes while maintaining member privacy and confidentiality
- Measure, monitor, and improve performance in key aspects of quality and safety of clinical care, including behavioral health, quality of service and satisfaction for members, customers, and contracting practitioners/providers
- Develop a systematic approach for identification and prioritization of opportunities to improve care and service to members
- Ensure compliance with and responsiveness to applicable requirements of Federal, State, and appropriate accrediting entities
- Facilitate communication and integration among key functional areas relative to implementing an effective quality management program
- Maintain appropriate governance and Committee structure for program implementation and monitoring progress
- Establish and promote guidelines for the provision of care and services in conjunction with practitioners

- Promote sound medical decision making processes at all levels
- Ensure continuity of care and service through the provision of appropriate practitioner availability and access
- Maintain appropriate oversight of provider groups for all delegated activities if any
- Initiate necessary corrective actions on identified issues to prevent problematic issues
- Utilize accepted Quality Management tools when making improvements, including the interface with the IT department/information analyst to create reports that identify opportunities for improvement
- Evaluate resource needs (both staffing and financial) to meet the needs of proposed activities for our membership
- Meet all planned activities specified in the annual Quality Management Work Plan

The MSC is composed of:

Physician members, who serve a two-year term on the committee and are either primary or specialty care physicians. There is also a panel of advisors, consisting of board certified physicians in many specialty areas (i.e., behavioral health) that are available to the Medical Director for consultation, if needed.

Non-physician members, from Health Care Services, and administration.
This committee meets on a regularly scheduled basis, no less than quarterly to:

- Improve and assure the provision of quality patient care and services
- Develop and maintain the QI Program description, policies and procedures, work plan and evaluation
- Develop and approve practice guidelines that are based on scientific evidence with quality indicators to monitor provider performance
- Analyze data to detect trends, patterns of performance or potential problems, and implement corrective action plans
- Review and resolve grievances related to quality of care and/or service
- Prioritize activities to ensure the greatest potential impact on care and services
- Recommend to the BOD any actions for follow-up on identified opportunities to improve
- Report findings of quality improvement activities for inclusion in practitioner/provider profiles
- Oversee and conduct Risk Management functions
- Oversee UM, Credentialing, and Delegation Oversight functions of Medical Groups (MG)/Independent Physician Associations (IPAs); if any, and
- Review the scope, objectives, organization and effectiveness of the QI Program at least annually and revise as necessary

The Health Care Services Department develops the work plan and the MSC approves the work plan for the year, which outlines the program activities, responsible person(s), and corresponding timeframes for progress and completion dates. This annual work plan, along with quarterly reports which focus on measuring progress toward the goals, is presented, along with the QI Program, to the BOD for review and approval.

On an annual basis, the MSC performs a retrospective evaluation of its activities to measure the performance achievements and activities for the year. If goals and objectives are not met, changes are recommended to the subsequent QI Program/Work Plan. This annual evaluation is also presented to the BOD for review and approval.

Roles and Responsibilities

Medical Director
The Medical Director is the designated, licensed physician who has a leadership role in the development and maintenance of the QI Program. He/she has the primary responsibility to provide medical leadership, support to the Quality Management Program, and serves as chairman for the Medical Services Committee. The Medical Director provides input on medical decision-making grievance resolutions, medical quality of care or medical coverage issues. In addition, the Medical Director is involved in strategic planning, policy development and coordination of activities at the executive level. The Medical Director also serves as a resource to the Health Care Services Department.

Director, Health Care Services (HCS)
The Director of HCS collaborates with the Medical Director, as necessary, and is accountable for implementation, facilitation and coordination of all QI activities throughout the organization. The Director duties, include, but are not limited to coordinating the oversight process of contracted providers, managing the clinical side of the appeals/grievance process, clinical review of quality issues, developing interventions, and policy revision according to legislative updates. Additionally, the HCS Director is responsible for the oversight of the UM, Credentialing and Delegation Oversight activities within the organization. The HCS Director along with designated staff will work with other departments to prepare and maintain minutes for the MSC.

Quality Improvement Process

Methods AHC uses the continuous quality improvement (CQI) techniques and tools to improve the quality of care and services. All departments in the organization are expected to adhere to this process improvement methodology and demonstrate continuous improvement.

Key Performance Indicators Quality of clinical care and quality of service are established and monitored on a regular basis in order to assess Participating Providers performance in the management of clinical care and service. Indicators are designed to reflect the demographic make-up of membership, prevalence of disease and/or utilization of services. Through continual surveillance, AHC can identify problematic areas and initiate timely interventions and follow up measures as needed. In this manner AHC will address all problems that come to its attention through internal surveillance, complaints, or other mechanisms.

Performance Improvement Projects and Measurement

AHC will conduct performance improvement projects to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical care areas that can be expected to have a favorable effect on health outcomes and member satisfaction.

AHC will measure performance, using standard measures required by CMS. Clinical areas may include effectiveness of care, member perception of care, and use of services. Non-clinical areas include access to and availability of services, and appeals and grievances. AHC measures quality of care and service provided to members in a number of ways, including the Healthcare Effectiveness Data Information Set (HEDIS®), Member Satisfaction Surveys like Consumer Assessment of Health Plan Surveys (CAHPS®) and Health Outcomes Surveys (HOS®). AHC also gathers information from practitioners through satisfaction surveys that focus on specific topics, including utilization management and continuity and coordination of care. Information gathered from these sources will enable AHC to address opportunities for improvement. Additionally, in accordance with the CMS Medicare Advantage program, AHC must report HEDIS® measures per NCQA guidelines. AHC staff will be the collectors of such data from Participating Providers. It will be expected that the requested data from Participating Providers will be available in a timely basis to the collector and/or copy service employed.

Program Scope
The scope is broad and includes monitoring efforts to improve the quality and safety of clinical care including behavioral health care as well as service quality improvement. The Program provides a framework of prospective, concurrent, and retrospective activities for monitoring, assessment, analysis, and improvement of clinical, behavioral health care and service quality activities. Topic selection and study design are prioritized based on an ongoing evaluation of the enrolled population in terms of age/gender, disease incidence and prevalence, risk status, and results of audits.
The activities monitored and reviewed by the Quality Management Program include but are not limited to the following:

Patient Safety
AHC takes patient safety seriously and strives to provide an environment conducive to improving the safety of members and to support providers in their efforts to promote safety. AHC will implement efforts to assist direct care providers with improving patient safety. Ongoing activities may include but are not limited to the following:

Pharmacy programs - which alert pharmacists of potential drug-to disease and drug-to-drug interactions, distributing information to members to improve their knowledge about clinical safety, distributing information to members that facilitates informed decisions based on safety.

- Monitor member complaints regarding safety issues
- Monitor medication errors
- Monitor pharmacy dispensing errors
- Focusing quality improvement activities on patient safety

Behavioral Health Care
The AHC QI Program scope incorporates both medical and behavioral health care services. AHC includes a designated behavioral health practitioner in the Committee structure as needed to encourage appropriate input on behavioral health issues. AHC will contract with behavioral health vendors and/or provider groups to provide behavioral health services. Coordination of care between general medical care and behavioral health care is important to the well-being of members. Processes are designed to facilitate the exchange of information in an effective, timely and confidential manner. AHC collaborates with its Participating Providers to assist them and the member to access all care required.

Credentialing
The credentialing of providers is either performed directly by the Plan or AHC whose review systems comply with CMS, NCQA and Plan requirements. The credentialing/re-credentialing process is designed to evaluate the qualifications of practitioners who contract with AHC and its contracted/delegated entities. Credentialing is conducted prior to participation and is performed again on a periodic three (3) year basis. Practitioners that are credentialed include MDs, DOs, DPMs, chiropractors, behavioral health professionals, and other licensed, contracted independent practitioners. Clinicians and all other Participating Providers, (e.g., acute care facilities, radiology, free standing dialysis units, skilled nursing facilities, home health agencies, laboratories, surgical centers, etc.), are all credentialed prior to acceptance into the network. Re-credentialing is performed every three years.

Member Satisfaction
The monitoring, evaluation, and improvement of member satisfaction are a key component of the AHC's Quality Management program. This is accomplished through the review of a number of surveys as well as through the aggregation, analysis, and trending of member complaints and PCP transfer data. On an annual basis, AHC monitors Member satisfaction with access to Member services. AHC will participate in the HEDIS/CAHPS survey that includes questions about access to care and service. Aggregated data will be reviewed and analyzed on an annual basis. This annual analysis will be

presented at the Medical Services Committee (MSC) and included in the QI Program Annual Evaluation.

Culture and Linguistics
Quality Management will include a focus on racial and ethnic minorities, whenever possible. The primary goal is to make all efforts to cultural considerations of the enrolled members to ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

Appeals and Grievances – Process Resolution
AHC provides a mechanism for members to express and resolve grievances and appeals concerning services, claims, benefits, contracting practitioners, and administrative policies. The process facilitates a thorough evaluation of all member issues, analysis, and their timely resolution.

Medical Management Programs (MM)
Medical Management ("MM") Program are those standards, protocols, policies and procedures adopted by AHC regarding the management, review and approval of the provision of Covered Services to Members.

The goal of these programs is to provide a systematic, information-based process of continuously analyzing, evaluating and improving the value of healthcare delivery across the continuum of care and across all care setting from the perspective of the member, practitioner, and AHC. AHC identifies chronic conditions relevant to the population that its disease management programs address. The conditions are chosen based on prevalence within the AHC population and the likelihood that there will be a positive change in the health of the member as well as the satisfaction with his/her quality of life. Members must meet certain inclusion criteria (which is disease-specific) to be chosen for the Medical Management Program (MM). Participation will mean that they are taking an active role in changing their lifestyle(s) in order to positively impact their overall health. The member may be involved in one of several different levels of participation which may include periodic "contact" communications by a coordinator to screen for issues on a monthly, quarterly, or yearly basis all the way up to intensive and complete case management by a licensed nurse on more frequent basis dependent upon member's needs. Member's progress toward outcomes will be monitored as well as their satisfaction with the MM itself. There may be members in case management that do not concurrently participate in the MM but are being case managed for other reasons (i.e., non-compliance with medication, frequent ER visits or hospitalizations, home health involved in the case, etc.). These members will be case managed, but will not be a part of the official MM unless they meet inclusion criteria and opt to participate.

Case Management Process
Members who are case managed, either through the MM or through the conventional case management process, will be screened for needs when the case is initially opened. Once opened and screened, the case will be assigned to the appropriate level of case management based on need. Periodic contacts with the member will be initiated, again, depending upon the member/family needs. Communication will occur with the Primary Care Physician as needed, as well as with any Specialty Care Providers that may be involved in the member's care. The member and family, as appropriate, will be actively involved in the treatment plan which will be documented and referred to on a periodic basis. Both short and long term goals will be formulated, and the member's progress toward those goals will be documented. Outcomes are documented when the case is closed, and member satisfaction with the case management process will be assessed periodically. All pertinent information is relayed in a timely manner to the Participating Provider as necessary, throughout the case management process. Referrals may be made in to the AHC case management program by calling one of the Nurse Case Managers at (919) 803-4820 or faxing the request to (919) 803-4821.

Clinical Practice Guidelines
AHC adopts guidelines with consideration of the needs of the enrolled population. The Clinical Practice Guidelines development is based on review of the latest scientific data and medical evidence, national or regional consensus of health care professionals in the particular field. Guidelines are developed in consultation with the involvement of contracted practitioners. These guidelines are continually reviewed, improved, updated, and redistributed at least every two (2) years or sooner, if indicated.
These guidelines identify best practices for preventing or treating acute, chronic, and behavioral health conditions. The guidelines are intended to:

- Improve the effectiveness, efficiency, and consistency of patient care
- Provide decision support tools to contracting providers
- Promote the standardization of processes, which support clinical care.

The guidelines are presented and approved at the MCS, communicated to providers and as appropriate to members.

Preventive Health Guidelines
AHC has adopted age specific preventive health guidelines for the prevention and early detection of illness and disease. The guidelines are based on CMS, CDC, and other relevant entity recommendations and are developed in cooperation with practitioners who have appropriate knowledge specific to those guidelines and recommendations of nationally recognized organizations. These guidelines are reviewed and revised at least, on an annual basis and are presented and approved at the MSC. Preventive health guidelines are distributed to members and practitioners annually. AHC encourages members to use health promotion, health education, and preventive health services offered by the Participating Providers. Performance against the adopted guidelines is monitored on an annual basis as part of the HEDIS® audit.

Member Health Education
In our continued commitment to provide educational information regarding health for AHC members, we currently have member health education available on our website. Health education bulletins are linked to a different health focus for each month, with various topics such as; Breast Cancer Screening, Medication Safety for seniors and information on Heart Diseases. Visit the provider webpage at www.alignmenthealthcare.com for more information.
Participating Providers are also responsible for meeting the health education needs of their members. Appropriate brochures and class offerings are available for the providers to distribute to their members.

Member Rights
AHC's Members' Rights and Responsibility policy supports the AHC's commitment to treating members with dignity and honor their rights and responsibilities. The statement is published annually in the member newsletter.

Clinical Studies
AHC identifies clinical issues that are relevant to the membership and reflect the health needs of significant group within the population. These address acute or chronic conditions. Clinical studies may be based on non preventive HEDIS® results. Clinical quality improvement is accomplished through a systematic process, using sound methodology, validity, reliability, and consistency of assessment measure as well as data collection to draw meaningful conclusions. Data is analyzed to assess performance and identify any barriers to improvement. Opportunities for improvement are identified, interventions are developed and implemented, and the effectiveness of those interventions is measured.

Delegation
Delegation is defined as the formal process by which the plan gives a contractor the authority to perform certain functions on its behalf. Quality Management/Improvement functions are not delegated. Prior to delegation if any, a pre-delegation audit will be performed and results must meet AHC's delegation thresholds. Additionally, each delegated Participating Provider shall undergo an annual Credentialing and UM audit to ensure that the delegated tasks are being performed per the established guidelines. Additionally other methods to monitor a Participating Provider's compliance include the following:

- Performance of Delegation Audits (credentialing and/or utilization management) and follow up on identified deficiencies.
- Submission of all required documents (Annual QI/UM Plan, Work Plan, Quarter Reports).
- Submission of UM Denial Information (Monitored by UM Department).

Provider Participation in Quality Management Activities
Participating Providers are required to participate in the AHC's QIP. Accordingly, AHC has established processes in place to include Participating Providers in participation with the AHC's QIP activities and related policies and procedures. Participating Provider input shall be sought in making improvements in the quality of health care and services provided.
As such, QI activities may include the following:

- Participating Provider participation in AHC committees
- Participating in Disease Management Programs
- Adhering to adopted clinical and preventive health guidelines
- Appropriately responding to Member appeals and grievances
- Meeting Member access requirements
- Participating in clinical reviews
- Maintaining medical record standards
- Maintenance of the confidentiality of Member information and records

All Participating Providers shall receive communication and feedback on the QIC and related processes. QIP standards and guidelines addressing the provision of services, access to health care, referrals, appeals and grievances, and reporting requirements appear within this Provider Manual. Additionally, Participating Providers receive education and information on health care and service-related issues through newsletters, memoranda, and specific Clinical Forums. All requirements for corrective actions are communicated to the appropriate provider so that improvements can be made.

Facility Review
AHC requires that all Participating Providers follow AHC's policies when performing initial and re-credentialing functions. In addition site visits may be conducted for routine or causal investigation of quality and acceptability of facilities and services or for educational purposes by either AHC or the plan, as appropriate. The purpose of such reviews is to validate the acceptability of the physical environment, verify compliance with pertinent licensing and regulatory requirements, including procedures for sterilization of equipment, storage of drugs, use of radiation, and to evaluate the accessibility of services.

During on-site reviews at Participating Provider offices by AHC, accessibility of care is verified through observation of office set-up and administration. Appointment books are reviewed to assess the length of time allocated for various types of visits and the ability to schedule new Members and recalls is tested. Waiting times for scheduled appointments are also examined through the review of "sign-in logs" and observation of the waiting areas. The AHC QI Department notifies the Participating Provider of facility review results. Some items may be addressed over time, while others require immediate evidence of correction. If the Participating Provider's site does not meet the performance threshold, a

summary of deficiencies and a corrective action plan ("CAP") is required within a specified time frame for implementation of corrections; a follow-up audit(s) may occur.

Focused Quality Improvement Reviews
The demographic and epidemiological characteristics of the Plan membership are used to identify and select, by their relevance to and potential impact on the Member population, important aspects of care for routine monitoring, evaluation and special study. The Medical Services Committee reviews, provides feedback on the appropriateness of the Focused QI Review, and approves the organization's quality improvement projects for the year.

Access Measurement
AHC monitors for the annual completion of an access audit at each Participating Provider's site.

Member Complaints
Problem solving for individual member complaints is performed by AHC's Member Services (non-clinical issues) or Quality Management (clinical issues) departments. All member complaints are tracked and trended. Member complaints with potential quality of care issues are handled by the Quality Management department. AHC conducts an investigation of each issue, tracks and trends quality of care issues by provider, and type of issue. This information is reported to the Medical Services Committee quarterly and taken into consideration during the re-credentialing process. During the investigation of potential quality of care issues, AHC may request information, or medical records, interface with the AHC Medical Director and the implementation of provider-specific corrective action plans may result. Provider-specific cases are prepared and presented to the Medical Services Committee for review and action. Participating Providers are required to refer complaints to the health plan immediately, as none of the Participating Providers are delegated for this function.

Health Risk Assessment (HRA)
All new members enrolled in AHC will receive a Health Risk Assessment form mailed to them in their welcome packet. It is mailed back to AHC and forwarded to the Health Care Services Department for further evaluation to identify members who may have risk factors indicating they may be at high risk for Emergency Room utilization or hospitalization in the near future. Once the assessment is completed by AHC, the HRA form will be mailed to the members' assigned PCP. All members identified as High Risk, should be contacted by their PCP to ensure they are seen for an initial visit within fourteen (14) calendar days.

Health Information System
AHC has a customized health information system that collects, integrates, analyzes and reports data necessary to maintain its QI Program. Integrated data is used to develop a comprehensive overview of member needs and utilization, including changes in patterns over time. The system pools data on member demographics, provider demographics and utilization, and services provided to members. With this system, AHC is able to generate treatment profiles by diagnosis by member, PCP referral profiles, disease prevalence, and prescribing patterns. As a Participating Provider, you will be required to submit data so that QI projects can be adequately conducted by AHC. AHC will review reported data for accuracy, completeness, and consistency. Identified deficiencies in reported data will be addressed through provider education and other corrective action methods.

Preventative Health Services Chart – Exhibit 6.1
COMPLEX Case Management Program – Exhibit 6.2

Exhibit 6.1
Preventative Health Services Chart

Screen	Test/Service	How Often	Age Range
Physical Exam	Preventive physical exam	Annually	All Medicare members
Cardiovascular screen	Cholesterol, Lipid, Triglyceride Levels	Every 5 years	All Medicare members
Breast Cancer Screen	Mammogram	Once every 12 months	All women with Medicare age 40 and above (One baseline exam between 35 and 39)
Cervical / Vaginal Cancer Screen	Pap Smear (including screening pelvic exam and clinical breast exam)	Once every 12 months (high risk) and every 24 months (low risk)	All women with Medicare
Colorectal Cancer Screen	Fecal Occult Blood Test	Once every 12 months	All people with Medicare age 50 and older.
	Flexible Sigmoidoscopy	Once every 48 months (every 120 months when used instead of colonoscopy for those not at high risk)	All people with Medicare age 50 and older.
	Colonoscopy	Once every 24 months (if high risk) or once every 10 years, (if not high risk)	All people with Medicare age 50 and older. However no minimum age for screening colonoscopy
	Barium Enema	Every 24 months if high risk for colorectal cancer & every 48 months if not high risk, when used instead of sigmoidoscoy or colonoscopy	All people with Medicare age 50 and older.
Prostate Cancer Screen	Digital Rectal Examination	Once every 12 months	All men with Medicare age 50 and older
	Prostate Specific Antigen (PSA)	Once every 12 months	All men with Medicare age 50 and older
Immunizations	Flu	Once a year in the fall or winter	All people with Medicare
	Pneumococcal	Once in a lifetime Repeat if < 65 when vaccine given and at least five years have elapsed	All people with Medicare
	Zostavax	One time dose	All people with Medicare age 50 and older
	Tetanus (Td)	Booster every ten years	All people with Medicare one time Tdap for those under 65 as one time booster in place of Td
	Hepatitis B	Three shots for complete protection	Medicare members at medium or high risk
Bone Mass Measurements	Bone Density Measurement	Once every 24 months, more often if medically necessary	All people with Medicare at risk for osteoporosis
Diabetes Screening	Glucose	Twice per year for those designated as pre-diabetic; once for others	All people with Medicare
Diabetes Self-Management Training	Diabetes Self-Management Training	Once every twelve months	Medicare members who are at risk for complications from diabetes. Requested by Physician
Hearing & Balance Screening	Hearing and Balance Exam	Once every 12 months	All Medicare members
Glaucoma Screening	Glaucoma Screening	Once every 12 months	All Medicare members at high risk for glaucoma
Abdominal Aneurysm Screening	Abdominal Ultrasound	Once in a lifetime	Male Medicare members 65 and older who have smoked more than 100 cigarettes in a lifetime, have cardiovascular disease and have a family history
Smoking and tobacco-cessation services	Counseling	Two cessation counseling attempts every twelve months	All people with conditions affected by tobacco use.

References: CMS Quick Reference Information Medicare Preventive Services - January 2009

Exhibit 6.2
COMPLEX Case Management Program

Any member identified with a listed diagnosis below should be referred to AHC Complex Care Management for review and consideration to be included in either the Case Management Program managed by AHC Chronic Care Improvement Program (CCIP) or followed by Complex Care Management.

Members may be followed by AHC directly or in coordination with the Participating Providers for such diagnoses as:

- All Organ Transplants
- Bone Marrow Transplants
- Traumatic Brain Injury including CVA
- Spinal Cord Injury
- Serious Trauma
- Multiple Chronic Illnesses
- Heart Failure – CHF
- Heart Attack or Myocardial Infarction (MI)
- Cancer Diagnoses
- Chest Pain – Angina
- Heart Valve Disorders
- Cardiac Arrhythmias
- Heart Block
- Coronary Atherosclerosis
- Osteomyelitis in Diabetes
- Coma, Ketoacidosis
- Hyperglycemia or Hypoglycemia Shock
- Diabetes
- Gangrene, Skin Ulcer, Non-Healing Diabetic Wound
- Amputation
- Cellulitis
- Frequent ER Visits
- Frequent Inpatient Admissions

Section 7: Utilization Management/Authorization Program (UM)

Overview
The Utilization Management (UM) Program's aim is to ensure consistent delivery of quality health care and optimum member outcomes, as well as provide and manage coordinated, comprehensive, quality health care within the service area, without discrimination toward any individual and in a culturally competent manner.

The purpose of this program is to provide a process in which review of inpatient and outpatient services are performed in accordance with health plan and regulatory/accreditation [i.e., CMS, DMHC, the Department of Health Services (DHS) and/or National Committee for Quality Assurance (AHCQA)] agencies.

AHC's Board of Directors and Medical Services Committee
The focus of the program is to ensure efficiency and continuity of this process by identifying, evaluating, monitoring and correcting elements which may impact the overall effectiveness of the UM Process. The program's activities are developed and approved through the Medical Services Committee (MSC) and by the AHC Board of Directors (BOD). The program is reviewed on an annual basis and revised, when appropriate. All revisions are approved by the MSC and the BOD.

Goals and objectives include, but are not limited to:

- Ensure appropriate levels of care in a timely, effective and efficient manner
- Monitor, evaluate and optimize health care utilization resources, on a continuous basis, by applying UM policies and procedures to review medical care and services
- Monitor, document and submit for review any potential quality of care concerns, for both inpatient and outpatient care
- Monitor utilization practice patterns of contracted providers and/or their practitioners to identify variations
- Conduct medical review of all potential denials of service for medical necessity
- Identify high risk members and ensure appropriate care is delivered by accessing the most efficient resources
- Update and revise utilization criteria, on a continuous basis, based on outcome data and review of the medical literature

The AHC BOD has granted the MSC the authority to:

- Develop and monitor the UM Program
- Oversee the activities to develop clinical criteria
- Serve as an expedited and standard appeals panel, if necessary
- Communicate with participating physicians, as necessary

The MSC submits a quarterly report of all activities to the BOD for review and approval. The Medical Director serves as the chairperson of the MSC and presides over the meetings. In order to conduct a meeting, there must be a quorum of at least three (3) physicians present. Minutes are maintained for the meeting and all discussions are considered confidential.
The MSC Committee is composed of:

1) Physician members, who serve a two-year term on the committee and are either primary or specialty care physicians.
    a. There is also a panel of advisors, consisting of board certified physicians in many specialty areas (i.e., behavioral health) that are available to the Medical Director for consultation, if needed.
2) Non-physician members from Health Care Services, and
3) Administration.

This committee meets on a regularly scheduled basis, no less than quarterly to:

- Develop, evaluate and implement the UM Program
- Assist in the development, implementation and monitoring of clinical guidelines relating to quality of care
- Investigate, resolve and monitor daily operations relating to UM activities
- Monitor appropriate levels of healthcare and timeliness of the delivery of healthcare services
- Review proposed UM policies and procedures for utilization by the clinical and non-clinical staff
- Review clinical appeals
- Monitor inpatient services
- Evaluate new and existing technology
- Coordinate quality issues with the QM Department
- Monitor effectiveness of the UM process through member and practitioner satisfaction survey results
- Provide information for inclusion in the annual QM work plan
- Review the annual evaluation of the QM Program for accuracy concerning UM Committee functions
- Monitor practice patterns of Participating Providers
- Assist Participating Providers in providing continuing education programs for their practitioners
- Assess pharmacy utilization

The Health Care Services Department develops and the MSC approves a work plan for the year, which outlines the program activities and corresponding timeframes for progress and completion dates. This work plan, along with quarterly/semi-annual reports which focus on measuring progress toward the goals, are then presented, along with the UM Program, to the MSC and the BOD for review and approval.

On an annual basis, the MSC performs a retrospective evaluation of its activities to measure the performance achievements and activities for the year. If goals and objectives are not met, changes are recommended to the subsequent UM program/work plan. This annual evaluation is also presented to the MSC and the BOD for review and approval.

Separation of Medical Decisions and Financial Concerns
Under existing law (Health and Safety Code Section 1367(g), medical decisions regarding the nature and level of care to be provided to an enrollee, including the decision of who will render the service (primary care physician, specialist, in-network provider, out of network provider, etc.), must be made by qualified medical providers, without regard for fiscal or administrative concerns. Utilization management decisions must be made by medical staff and based solely on medical necessity and medical appropriateness in coordination with the provider contract language and CMS.

AHC's Utilization Management Program includes provisions to ensure that financial and administrative concerns do not impact utilization management decisions. AHC monitors compliance with this requirement.

Utilization Management Goal
The goal of the AHC Utilization Management Program is to provide members access to the health services delivery system in order to receive, timely, appropriate, and quality medical care in the most appropriate setting. The UM system is also intended to analyze and measure effectiveness while striving for continuous improvement of services. On an ongoing basis, AHC collects encounter data from Participating Providers and data from the AHC electronic claims processing system(s) to monitor Participating Providers' over- and under-utilization. The following types of data are collected/monitored on an ongoing basis:

- Member services complaints
- Member satisfaction surveys
- PCP transfer rates
- Encounter data
- System reports including monthly census and authorization detail reports
- Other utilization statistics
- Utilization management denial and appeal logs
- Utilization Management Objectives

The objectives of the AHC Utilization Management Program include, but are not limited to, the following areas:

- Monitoring the health services delivery system for appropriateness, effectiveness, timeliness and outcome of care provided by Participating Providers
- Arranging for the provision of medical care to members at the appropriate level, and focusing on utilization of medical services which may be unnecessary, including monitoring and evaluating member health status and medical care outcomes for patterns of under and over-utilization
- Analyzing and measuring effectiveness of outcomes achieved from utilization/care management
- Identifying and conveying relevant information to quality improvement for tracking and trending
- Providing continuing member and provider education to ensure easy access to and appropriate use of the health care delivery system
- Analyzing patterns of health care utilization to identify opportunities to improve effectiveness and efficiency
- Reviewing and revising the utilization management plan on an annual basis in response to changes in the health care environment

Timeliness Requirements for Utilization Review Decisions
The authorization request determinations made by the licensed professional in the Utilization Management staff and the Medical Services Committee are based only on the appropriateness of care and service. AHC does not compensate physician or nurse reviewers who conduct utilization review determinations for any denials of coverage or service. There is no financial incentive that is provided to encourage inappropriate denials of service.

All medically necessary decision determinations are based on sound clinical evidence and are criteria based. The criteria are updated, adopted, reviewed and revised, when appropriate, and approved on an annual basis by the Utilization Management Committee. The Senior Medical Officer has substantial involvement in the implementation of the Utilization Management Program, will oversee the criteria selection, development, and adoption and application process. Participating practitioners, in appropriate specialty areas, are available to assist in the review, revision and acceptance of criteria when appropriate. The criteria are available to the practitioners, members and public upon request. Supporting policies and procedures are in place to provide:

- A mechanism for checking the accuracy and consistency of application of the criteria by the physician reviewers and non-physician reviewers annually by the inter-rater reliability testing.

- The application of the criteria that justifies the appropriateness of services is clearly documented and considers individual patients and the characteristics of the local health care delivery system.
- The process for practitioners, members public to follow when requesting copies of criteria is in place.

Emergency services, necessary to screen and stabilize members, will be authorized, without prior notification or prior authorization, in the event where prudent layperson acting reasonably would have believed that an emergency medical condition existed.

Efforts are made to obtain all necessary information, including pertinent clinical information, and documented phone conversations with the treating physicians, as appropriate, for the purpose of reviewing all authorization requests.

Referral/authorization process and associated timeframes for decisions, notification and confirmation are implemented and monitored to comply with the governmental regulatory and NCQA standards.

Preauthorization, concurrent review and complex case management decisions and processes are supervised by qualified licensed medical professionals. Physician consultants are utilized to review cases as appropriate from specialty areas of medicine, surgery, and behavioral health.

Only the Senior Medical Officer, Clinical Medical Director or his/her physician designee can make the decision to deny service after conducting a review for medical appropriateness and benefit coverage. Reasons for denial, including criteria used, are clearly documented and available to the member and requesting physician. Notification to the member and requesting physician on a denial of service includes information and instructions regarding the process for expedited and non-expedited appeal. Notification to the requesting physician includes information of the Senior Medical Officer's availability to discuss the case. These processes are detailed in the supporting policies and procedures.

Utilization management determinations and decision notifications are made in a timely manner consistent with regulatory requirements. The urgency of the situation is always considered to ensure that the request and notification are processed appropriately and according to established timeframe in compliance with regulatory, health plan and ICE standards. The turnaround time for authorization request is monitored on a regular basis and corrective actions are implemented when appropriate.

The health plan measures member satisfaction and practitioner satisfaction annually, either internally or through outside vendors, with a focus on the ease of getting requested services approved and obtaining authorizations. Any areas of dissatisfaction are subject to corrective action and re-measurement for achieving and demonstrating performance improvement.

Utilization data is tracked and trended on a regular basis. The data reports are submitted to the Medical Services Committee, Board of Directors and health plans on a quarterly or semi-annual basis as required. The analysis of the data focuses on outcomes related to over/under utilization and acceptable rates established for the population being served. The Medical Services Committee will review and make recommendations for improvement when necessary. A re-measurement process will determine improvements or whether further analysis and actions are required.

Quality of care and quality of service issues are referred to the Quality Management Department and to the Medical Services Committee for investigation and determination. The Medical Services Committee and the Quality Management Department, UM Department and QM Department work collaboratively to resolve any cross related issues or problems.

The Utilization Management Program will include the effective processing of prospective, concurrent and retrospective review determinations by qualified personnel. The areas of review includes, but not limited to:

- Emergency department services

- Inpatient hospitalizations (acute, rehabilitation and skilled nursing)
- Outpatient surgeries (all procedures done outside of the practitioner's office)
- Selected outpatient services
- Selected ancillary services
- Home Health services
- Selected physician office services
- Out-of-network services
- Specialist to specialist referrals
- Specialist self-referrals

Utilization Management staff are accessible by calling (844) 215-2442.

Provider and member appeals will be processed according to the health plan appeals policy and procedure by the Quality Management Department, in accordance with regulatory requirements and Center for Medicare and Medicaid Services.

The Complex Case Management Program will identify, coordinate, and evaluate services delivered to those members who require intensive management of complex medical care and services. The large case management nurse works closely and in conjunction with the case management programs as well as the disease management programs of the health plan.

The Utilization Management Program and the supporting policies and procedures will be reviewed, revised as necessary and approved annually, or as needed, by the Utilization Management Committee and the Board of Directors.

Encounter data report will be reported to the health plans on a timely basis as required by contract.

Urgent Care: Pre-certification of urgent care requests must be determined within 72 hours of obtaining all the information necessary to make a decision. The requesting provider must be informed of these decisions via phone or fax within that same 72 hour timeframe.

Concurrent review: Decisions for urgent care requests must be made within one business day of obtaining all the information necessary to make a decision.

Utilization Management
Providers are required to submit requests for services containing the following information to AHC for authorization utilizing the AHC's approved form:

- Patient name
- Patient Identification Number
- Requesting Provider Name
- Requested Facility or Provider Name (as appropriate)
- Admit Date (if scheduled) or service start date (if applicable)
- Diagnosis (description and ICD-9 code)
- Procedure (description and CPT code)
- Clinical rationale for service
- Description of treatment related to diagnosis and requested service and services to date (to include but not limited to: diagnostics (labs, scans, etc.), consults, treatment to date (such as Physical Therapy, procedures) and recommendations. Elective referrals, inpatient services, and outpatient procedures requested by physicians must be authorized by AHC prior to the services being rendered. The request should be forwarded to AHC. The Health Care Services (HCS) staff will review the request and the authorization will be either approved or denied. Only a

licensed physician can deny services. This will be communicated in writing to the requesting physician and the member.

The Participating Provider should submit the following information to AHC:

- Written referral for prior authorization which includes the services requested, number of visits, clinical information justifying the request and clinical information containing all pertinent details so the clinical staff has enough information to determine the medical necessity of the request.
- Prospective hospitalization review information documented by the Participating Provider and submitted to AHC should include the necessity of the admission, preadmission work-up results and prior authorization for the initial number of medically necessary days.

Retrospective Review
Retrospective review includes two components: retro-authorization request review and retrospective utilization review.

- Retro-authorization request review is performed when medical services were provided without obtaining prior authorization. Retro-authorization requests will be considered for authorization only under certain circumstances as described in a separate policy.
- Retrospective utilization review includes the review of individual provider's referral patterns, appropriateness of referrals and procedures. The information is collected and analyzed on regular basis, at least annually. After conducting the retrospective utilization review, the individual provider maybe placed on focus review on a prospective basis to determine the future appropriateness and medical necessity of requested services.

Concurrent Review
AHC Utilization Management staff will perform concurrent review when inpatient utilization management functions are not delegated. The objective of concurrent review is to review clinical information during a member's hospitalization, perform discharge planning, and assist in determining medical necessity at an appropriate level of care along with quality improvement screening. The hospital is required to notify AHC Utilization Management staff within 24 hours of admission whenever a member is admitted. Concurrent review occurs within 24 hours of admission and is generally performed telephonically. Providers may call (844) 783-5191

A completed FACE cover sheet should be faxed by 10:00 am in the morning following admission to: (844) 237-1915.

Based on the initial review, the level of care is determined and discharge planning is initiated. The HCS staff (physician and non-physician reviewers) use standardized review criteria to ensure consistency of decision making. Concurrent review is required on an ongoing basis. Once an acute level of care is determined to no longer be medically necessary, the AHC Utilization Management staff will review the clinical information with the Medical Director. The hospital UM staff will also be notified that the continued stay is questionable. The Medical Director will call the attending physician to discuss alternatives. If he/she agrees with the determination, the member will be discharged home or transferred to a lower level of care setting. AHC staff will coordinate the transfer and make arrangements for discharge services. If the Medical Director and attending physician disagree, AHC will send a denial letter to the hospital and copy the attending physician and member. The denial letter contains the basis for the denial along with the grievance and appeals process.

Concurrent Retrospective Review
Elective services with the exception of emergency services require prior approval. AHC does require notification of an urgent or emergency admission within 24 hours. Retrospective review of admission and length of stay (LOS) will be conducted upon notification of hospitalization.

Hospital Admission Notification
AHC requires notification of all elective, urgent and emergency member admissions, regardless of whether the services are in or out of the service area. Hospitals are directed to call AHC at (844) 783-5191 or fax to (844) 237-1915. Participating hospitals are notified of this requirement with contract implementation. The process also will be available on the back of the Member ID card.

Emergent Admissions
Hospital admissions due to an emergent condition do not require authorization prior to the service(s) being rendered. Emergency services refer to covered inpatient and outpatient services that are furnished by a facility qualified to provide emergency services, and are needed to evaluate or stabilize an emergent medical condition.

An emergent medical condition is considered to be a condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. AHC should be notified of emergent admissions within 24 hours of the admission.

Continuity of Care
AHC expects all contracted specialists, primary care physicians and practitioners to cooperate with the continuity of care efforts that promote high quality effective medical care. Behavioral health specialists, with written consent from the member, will collaborate with primary care physicians in order to provide safe, appropriate and coordinated health care.

AHC will coordinate with the health plans in order to provide continuing health care to members with specific conditions, who have been receiving care from a terminated provider, for a period of time or until a safe transfer to new providers can be arranged.

Out of Area Services
AHC will provide prior authorization, concurrent, and retrospective review to members who receive care outside the service area. Members are encouraged to contact their physician to determine the optimal plan for obtaining medical care and follow-up.

Referrals for Specialty Care
The PCP is responsible for management and coordination of a member's complete medical care, including initial and primary care, maintaining continuity of care and initiating specialist referral. The PCP refers for specialty care when additional knowledge or skills are required.
When referring the member for specialty care, the PCP must follow the guidelines outlined below:

- The PCP selects a specialist who participates in AHC
- The PCP must follow AHC's referral guidelines
- The initial referral should be completed within 14 days (non-urgent) or 72 hours (urgent) from the time of the authorization to the date of the appointment to receive the services. When scheduling the appointment, the wait time for specialty care must not exceed the above and needs to be coordinated with the PCP based on the severity of the member's condition
- The specialist treats the member as indicated on the referral and notifies the PCP of the findings
- The contracted specialist may order diagnostic tests, x-ray and laboratory services, and request DME. The specialist must follow AHC's referral guidelines and use the provider panel network when referring for lab, X-ray, DME and other ancillary services
- If the member requires treatment beyond the services requested by the PCP, the specialist must contact the PCP for an additional referral, as required by AHC's guidelines.

Referrals are only valid between contracting providers. Any referrals to non-contracting providers require prior authorization from AHC. Contracted providers are required to monitor referrals that have been authorized for medically appropriate care to ensure members' access and follow up with the PCP.

In turn, the PCP is responsible for maintaining continuity of care for AHC members during the referral process. This may entail monitoring the referrals made for their AHC members to ensure that appropriate services are accessed and pertinent specialty service reports are received for inclusion in the primary care medical record.

Authorization for Admission to the Hospital or Skilled Nursing Facility (SNF)
AHC will make hospital arrangements when a participating physician determines that inpatient or outpatient hospitalization is necessary for a member. The arrangements are made following established procedures for review and approval. Participating Providers must report SNF-confined members to AHC. Participating Providers may fax the information to Utilization Management at (844) 237-1915. When notifying AHC of the admission, the following information will need to be given:

- Member name and member identification number
- Skilled nursing facility name and telephone number
- Admission date
- AHC authorization number, if appropriate
- Admitting diagnosis
- Admitting and/or attending physician

Transplants
The PCP or referred specialist is responsible for the initial diagnostic work-up prior to a referral to a contracted transplant center. During the initial diagnostic work-up, all prior authorizations for needed procedures or referrals to specialists, second opinions, or hospital admissions follow prior authorization referral procedures. Participating Providers must receive prior authorization from AHC Medical Management for all transplant services. Scheduled admission or referral to Tertiary or general acute hospitals must be jointly authorized by AHC and the health plan. AHC referrals for patient transfers require prior authorization and are reviewed by the medical director prior to transfer to a Tertiary and Non-Primary hospital. If a patient needs an organ transplant, AHC will arrange to have the case reviewed by one of the transplant centers that is approved by Medicare.

UTILIZATION MANAGEMENT POLICIES AND PROCEDURES

Components of the Utilization Management Program are supported by individual policy and procedure which outlines the process in details.

Authorization of Ancillary Services
Home Health Authorization Same as other inpatient and outpatient processes for authorizations
Hospice Authorization The patient needs to sign the AHC designated authorization form indicating that he/she has elected hospice and the physician must sign a certification of terminal illness and medical prognosis
Mental Health/Substance Abuse Same as other inpatient and outpatient processes for authorizations

24-Hour Answering Service
In compliance with the law, Participating Providers will have medical services available and accessible 24 hours a day, seven days a week. An answering service will be used to provide members access to necessary services. The answering service will be monitored to ensure that the correct emergency and other procedures are followed.

Confidentiality
All members of the Medical Services Committee are required to sign a confidentiality statement at least annually. The confidentiality statement will be kept on file. All Medical Services Committee records and proceedings are confidential and protected as provided by Section 1157 of the California Evidence Code, whether or not marked: “Confidential and protected as defined by Section 1157 of the California Evidence Code”. Signed minutes are maintained in a locked file and available only to authorized persons.

Medical Services Committee minutes and documents may be reviewed by authorized health plan representatives. However, no copies will be provided and confidentiality of the information will be preserved.

Financial Incentive
During the course of Medical Services Committee activities, there may involve incidents where a utilization management decision is made resulting in denial or recommendation of denial of services. The Medical Services Committee members are not incentivized or reimbursed for adverse decisions relating to utilization management decisions. The utilization management decision is independent and impartial and is solely based on appropriateness of care and service and existence of coverage.

Utilization Management Timeliness Standards – Exhibit 7.1

Exhibit 7.1
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed.	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	▪ Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. ***Extension Notice:*** ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite Determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.

Exhibit 7.1
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination - If No Extension Requested or Needed (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ **Approvals** – Oral or written notice must be given to member and provider within 72 hours or receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be received by member and provider within 72 hours or receipt of request. ▪ **Denials** – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. If only written notice is given, it must be received by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

Exhibit 7.1
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination **-** If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	▪ Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. ***Extension Notice:*** ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ **Approvals** Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider no later than upon expiration of the extension. ▪ **Denials** When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. Document date and time of oral notice. If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

Exhibit 7.1
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)

Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained.
	
	Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM):
	1) within 2 calendar days of admission to a hospital inpatient setting.
	2) not more than 2 calendar days prior to discharge from a hospital inpatient setting.
	
	Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).
		Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time.
		
		Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital.
		
		▪ NOTE: Follow up copy of IM is not required:
		  ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge.
		  ▪ When member is being transferred from inpatient to inpatient hospital setting.
		  ▪ For exhaustion of Part A days, when applicable.
		
		If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.
			Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO.
			
			The DND must include:
			▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered.
			▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization.
			▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based.
			▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.
			▪ Any other information required by CMS.

Exhibit 7.1
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)** ▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** **Note**: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** A determination that such services are no longer medically necessary.	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative ▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. **Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

Section 8: Grievances and Appeals, Initial Determinations, Notice of Denial of Medicare Coverage

Overview
Reconsideration and Redetermination procedures apply when a member disagrees with a decision about payment for, or provision of, services (either pre-authorization denial claim denial, or prescription drugs, in whole or in part). Federal regulations require special appeals process procedures for Medicare enrollees who are members of a Medicare program offered through an HMO.

Initial Determination
An initial determination is made when either AHC or the Participating Provider may deny payment on a service rendered, or have failed to authorize or provide a service requested. AHC must make an initial decision on a request for a service as quickly as the member's health permits, but not later than 14 days from the date of receipt of the request (or 72 hours from the date and time of receipt of the request). An extension of up to 14 days may be permitted in certain circumstances as long as the extension is in the member's best interest. For example, if the member requests the extension or AHC justifies a need for additional information. An extension cannot be taken if the health plan is attempting to obtain existing information from a contracted Participating Provider. The written decision must include the specific reason for the denial and must inform the member of the right to use the reconsideration and appeals process. Failure to make an initial determination within the proper time frame is deemed an adverse determination and automatically entitles the member a right to the reconsideration and appeals process. AHC or the Participating Provider may be required to pay the claim or provide the service.

Such requests for reconsideration of an initial determination must be submitted by the member in writing to the health plan.

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

If AHC denies a request for service and the member appeals the decision, AHC must reconsider its decision as quickly as the member's health permits but no longer than 30 days (standard request), or 72 hours (expedited request) after receipt of the member's written appeal.

AHC is required to take the following actions:

- Review the initial determination
- Assures that the reconsideration/redetermination decision is not made by the same person or persons who were involved in making the initial determination
- AHC sends written notification of the appeal decision. For reconsiderations (medical services or claim payment appeals), if the decision has been made to uphold the initial determination, the interested party will be informed that the case has been forwarded to an Independent Review Entity (IRE) MAXIMUS Federal Services, for third party review. Standard and expedited appeals received by AHC 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 the health plan overturns the original decision to deny a service, AHC will authorize or provide the service in question as quickly as the member's health requires, but no later than 30 calendar days from the date reverses its determination.

MAXIMUS Federal Services
If the original determination is upheld in whole or partially, the health plan is required to send a new notification to the member stating this information. At this point, the case file is forwarded to the CMS contractor, MAXIMUS Federal Services for processing. The health plan will prepare the files for MAXIMUS by identifying each one with the member's name and Health Insurance Number. The health plan will communicate to the member that the final determination will be made by CMS. If the decision is overturned by MAXIMUS, AHC must authorize or provide the service in question as quickly as the member's health requires but no later than 30 days from the date of the MAXIMUS letter informing the health plan and AHC of the decision. AHC does not have the right to appeal the MAXIMUS decision, and the determination is binding.

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

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

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

Either AHC or the member may request judicial review of the ALJ decision in Federal District Court if the amount in controversy is an amount pre-determined by CMS. Any decision may be reopened, by any entity that rendered a decision, within 12 months of the notice of initial or reconsidered determination, after such 12-month period, but within 4 years for "just cause", or at any time for a clerical correction, suspected fraud, or to consider new evidence that was not available earlier.

Member Appeals and Grievances
Contracted MCO shall be responsible for resolving Member claims for benefits under the MA Plan and all other claims against Contracted MCO. Participating Provider will immediately refer Members to contact Contracted MCO or deliver any written complaint, grievance or appeal to Contracted MCO for handling pursuant to Contracted MCO's Member Appeals and Grievance Procedures. Participating Provider shall comply with all final determinations made by the Contracted MCO through the Member Appeals and Grievance Procedures.

Expedited Appeals Overview
CMS routinely publishes regulations for the expedited determination of preauthorization and appeals. These regulations apply to Medicare contracted Participating Providers.

Expedited Appeal Process
A member, or physician on behalf of the member, can appeal if they do not agree with the health care decisions made by the AHC or the health plan. A member has the right to appeal if the health plan or AHC will not approve or provide the member with care that the member believes is a covered service or if the health plan is terminating coverage or care that the member still believes is needed.

Expedited Appeal Process (72-Hour)
Health plans routinely have 30 days to process a standard appeal (seven calendar days for an appeal regarding medication). However, in certain cases, the member has a right to an expedited, 72-hour appeal (72 hours for an appeal regarding medication). The member can receive a faster expedited appeal if the member's health or ability to regain maximum function could seriously be harmed by waiting for a standard service appeal, which might take up to 30 days. If an expedited appeal is requested by the member, AHC will evaluate the request and determine if it qualifies for an expedited appeal. If it does not meet the requirements, the 30 day processing time will be invoked. The member may file an oral or written request for a 72-hour appeal if the member has missed the deadline for requesting a Quality Improvement Organization (HSAG) review of a termination of services from a SNF, Home Health or Comprehensive Outpatient Rehabilitation Facility services. The member must specifically state that an expedited appeal is being requested and that the member believes that his/her health could be harmed by waiting the standard appeal time period. If any doctor asks AHC, on behalf of the member to conduct an expedited appeal or supports the member's request for a quicker appeal, AHC must expedite the appeal.

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

Oral Requests for Expedited Appeals
Oral requests for expedited appeals should be directed to the Health Plan Member Services Department. The Health Plan will document the oral request in writing. The Centers for Medicare and Medicaid Services (CMS) requires that Medicare Advantage (MA) and delegated contracting Participating Providers have a process in place to record and respond to all verbal requests for an appeal. Requests for appeals may be received in writing by the Medicare Advantage Plan, delegated contracting Participating Provider, 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 Plan or delegated contracting Participating Provider must:

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

Fax Request for Standard or Expedited Appeals
Written requests transmitted via fax machine should be directed to the Health Plan Member Services Department. If a member is in a hospital or skilled nursing facility, he/she can request assistance in having a written appeal transmitted to the health plan by use of a fax machine. It is important to note that the time limit for the review of the appeal will not begin until the request for the appeal has been received. Participating Provider should direct members to call the Health Plan Member Services Department for all expedited determination requests which include initial determinations, review or appeals.

Grievance Overview
Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare Advantage (MA) plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member may make a complaint or dispute either orally or in writing, to the Health Plan Member Services Department. A grievance may also include a complaint that AHC (or its delegated entity) refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frames. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet acceptable standards for delivery of health care (quality of care complaint).

How to File a Grievance
A member who is dissatisfied, or one who has a grievance that falls into the above mentioned categories, may call the Health Plan Member Services department.

Members may also write to AHC at the following address:

Alignment Healthcare
Attention: Appeals and Grievances
1100 W. Town and Country Road, Suite 1600
Orange CA. 92868

The member must include all pertinent information from the AHC ID card and the details of his/her concern. AHC will acknowledge receipt of the request within 7 business days and will review the grievance and respond to the member in writing with 30 days (plus 14 days if an extension is taken). The written response will state whether additional time is necessary to complete the review or provide a determination regarding the case. A written notice will be sent once the determination has been made.

Health Plan Grievances and Appeals Telephone Numbers – Exhibit 8.1

Exhibit 8.1
Alignment Healthcare
Health Plan Grievances and Appeals Telephone Numbers

BlueMedicare Preferred HMO

Call: 1 (844) 783-5192 / Hours are 8:00 a.m. – 8:00 p.m. ET, seven days a week.

Fax: 1 (323) 201-5690 for expedited appeals only

Write: Appeals & Grievances Dept.
BlueMedicare Preferred HMO
P.O. Box 14010
Orange, CA 92863-9936

Online Complaints to Medicare go to: www.medicare.gov/MedicareComplaintForm/home/aspx

Section 9: Claims Submission Instructions and Timely Filing Guidelines

Claims Submission Instructions
AHC will adjudicate complete claims, which is a claim or portion of a claim that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. AHC may require additional information from a provider where AHC has reasonable grounds for suspecting fraud, misrepresentations or unfair billing practices.

Claims will be submitted to AHC, with the appropriate documentation. The requirements for documentation are designed to streamline the claims payment process. Submission of complete, timely claims allows the payer to process the claims with a minimum of manual handling.

The following information must be included on every claim:

- Provider name and address
- Member Name, Date of Birth, and Health Plan Member ID Number
- Date(s) of Service
- Place of Service
- ICD-10 Diagnosis Code(s)
- Revenue, DRG, CPT, or HCPCS code for service item provided
- Billed charges for services provided and place of service or UB04 bill type code
- Submitting Provider Tax Identification
- Name and State License Number of attending provider
- National Provider Identification (NPI) number

Documents that do not meet the criteria described above will be returned to the provider indicating necessary information missing. In addition, claims must be submitted on the proper claims form, i.e., a UB04, CMS 1500, or Universal Drug Claim Form. The forms are readily available from office supply stores and medical forms vendors. AHC will only process legible claims received on the proper form that contains the essential data requirements.

Claims Timely Filing Guidelines for Medicare Claims
Contracted providers, please refer to the provisions of your contract governing claims submission timeframes.

AHC will not reimburse claims that are submitted past the timely filing limit. Claims submitted by mail are considered filed on the date postmarked within the United States. Claims submitted outside of these time frames will be denied as untimely. Patients may not be charged more than the 20% coinsurance and deductible (if applicable) on claims that have been submitted untimely. These established limits for filing can be waived if it can be documented that the claimant failed to file within the time limitation because of an administrative error or delay on the part of the Social Security Administration (SSA) or AHC. Exceptions to the 1 calendar year time limit for filing Medicare claims are as follows: (1) error or misrepresentation by an AHC employee.

Complete Claims
AHC will adjudicate complete claims, which is a claim or portion of a claim that provides reasonably relevant information or information necessary to determine payer liability, and that may vary with the type of service or provider. In select circumstances, AHC may require additional information from a provider for errors such as where the plan has reasonable grounds for suspecting possible fraud, misrepresentations or unfair billing practices. AHC will deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction.

Clean Claims
A "clean" claim is one that does not require AHC to investigate or develop external to Medicare Advantage operation. Clean claims should have all basic information necessary for claim adjudication, including required supporting documentation. See claims submission instruction section for "clean claim" data element requirements. Medicare requires that contracted claims are paid within the time frame set forth in the Provider's AHC contract terms.

Unclean Claims
An unclean claim is defined as an incomplete claim, a claim that is missing the required data elements mentioned above, or that has been suspended for additional information. AHC may reject the claim as incomplete, delay processing or make a payment determination (e.g., denial, reduced payment) that may be adjusted later when complete information is obtained.

Denied Claims
A claim where (a) one or more services will not be paid to a Provider and (b) payment is the responsibility of the Enrollee. Examples of some types of claims that are not denials and should not be reported, submitted or presented to AHC as "denied" claims include:

- Patients who remain enrolled with AHC but have transferred to another provider and the provider is forwarding the claim
- Payment responsibility belongs to another contracting entity (AHC or Hospital) and the provider is forwarding the claim duplicates
- Encounter only/capitated claims and no patient liability is involved, and
- Reduced payment amounts due to contract terms or allowed Medicare fee schedules

AHC will ensure that all denials be adjudicated and mailed within a 60 calendar days turnaround time.

Claims Appeals
Providers must submit Appeal request for reconsideration within 90-calendar days of receipt of the applicable claims determination. Once the appeal is reviewed, more information may be requested from the provider to perform a prospective, concurrent or retrospective review. All appeals must be submitted in written form for consideration. AHC will review all Provider Appeals/Disputes and make a payment resolution determination on an Explanation of Benefits (EOB) summary form.

Electronic Claims Submissions. Use of EDI transactions allows a provider to submit transactions faster and be paid for claims faster, and to accomplish this at a lower cost than it is generally the case for paper or manual transactions. Submitting claims electronically in compliance with Health Insurance Portability and Accountability Act – Administrative Simplification (HIPAA-AS) regulations is easy. AHC accepts all commercial electronic institutional and professional claims through clearinghouses identified by simply using our Payer ID.

When submitting claims through clearinghouses, providers must supply the following payer ID for Alignment Healthcare:

Electronic Claims Payer ID: CCHPC

Additional Clearinghouse Information. 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: (360) 975-7000 Option 1 or info@officeally.com
Business Hours: Monday thru Friday 6:00 AM PT to 5:00 PM PT
After Hours Support is also available 24/7.

Helpful Hints for Electronic Submissions.

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

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

Alignment Healthcare EDI Contact Information
E-Mail Contact: AHCEDI@AHCusa.com
Support Contact: Toll Free (844) 460-2556 or (657) 218-7690

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 e-mail or voicemail correspondence.

AHC Claims Submission/Appeals/Denials Address:
P.O. Box 14010
Orange, CA. 92863

AHC Claims Recovery Correspondence Address:
P.O. Box 14010
Orange, CA. 92863
For inquires on claims status:
Phone: (844) 215-2442
Fax: (562) 207-4619

CMS 1500 Form - Exhibit 9.1
UB-04 Form - Exhibit 9.2

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Exhibit 9.1
HCFA 1500 Form

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ___ 3. ___ 2. ___ 4. ___		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Exhibit 9.1
HCFA 1500 Form

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Exhibit 9.2
UB-04 Form

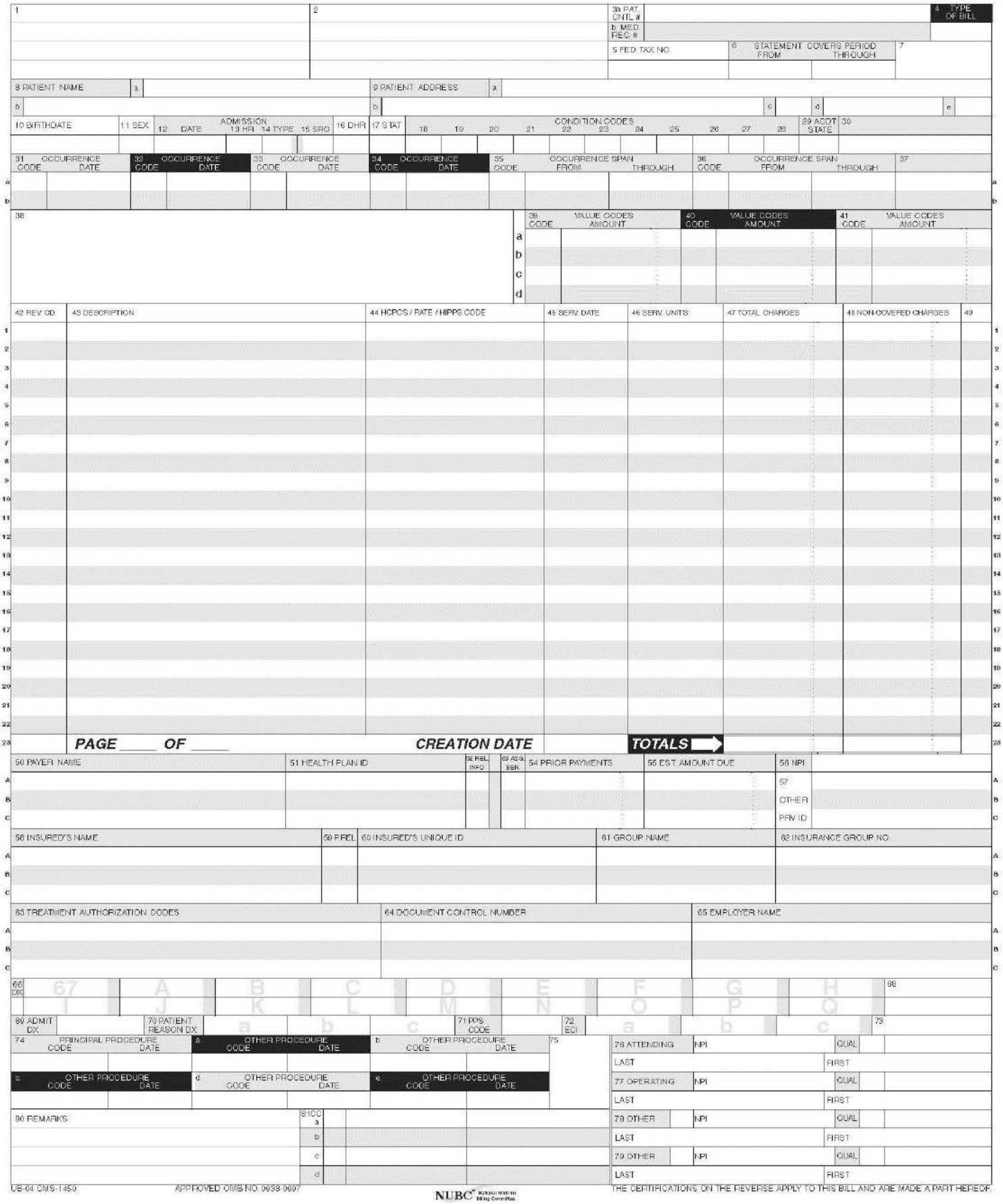


Exhibit 9.2
UB-04 Form

UB-04 NOTICE: **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Section 10: STARS Rating/HCC Coding/ Risk Adjustment Submission Process Overview

STARS Rating Overview

Shooting Stars Program-CMS Star Rating Program
AHC's "Shooting Stars" Program was established as a way to work with our providers toward a common goal of achieving a 5-Star rating status. CMS uses information from health plan's encounter data, member satisfaction surveys, plans and health care providers to give overall performance star ratings to health plans.

Overview of HCC Coding
The Centers for Medicare & Medicaid Services (CMS) adjusts the capitation received by health plans based on the accurate coding and documentation of various medical conditions experienced by Medicare members. Every year CMS assigns a Risk Adjustment Factor (RAF) score to each Medicare member after carefully evaluating the HCC ICD 9 Risk Adjusting codes related to the member. *This score is based on the validated codes supported by the documentation you submit.*
Because a valid, supported code is required, inappropriate coding, which does not reflect the severity of illness and quality of care, results in reduced capitation to the group. CMS requires that each chronic condition and co-morbidities be documented at least once every year.
In order to improve the accuracy of our HCC coding and documentation, as well as assist you in receiving the highest compensation for your HCC efforts, AHC provides you with the following:

1. A current list of your Medicare Advantage HMO members
2. Annual Health Assessment (AHA) Form
3. The member's profile from Ascender, which shows the member's HCC history and potential suspects, medication list and history, and any CMS Stars measures the member, may be due for
4. The guidelines for acceptable coding documentation

Documentation Requirements
The three key elements of proper documentations, each of which must be included in the documentation and without which you will not receive credit for your work are:

1. A diagnosis
2. The current status of the member's conditions, reported as stable, improved or worsening
3. A management plan for each condition

Each AHA form that you complete must be signed. A simple signature is not sufficient. Instead, your signature **must** include your credentials (i.e., John Smith, MD/DO/PAC/NP etc.). Furthermore, the assessment form **must** be dated, and **must** include the member's identifying information, including at least the member's name and date birth.

Risk Adjustment Submission Process Overview

Encounter Data Submission and Requirements

Encounter information must be submitted electronically to AHC's clearinghouse directly. At the discretion of AHC, hard copy encounters may be submitted to its clearinghouse as well as directly to AHC. Encounter data must be received by AHC ninety (90) days following the date of service. All encounters submitted must be in compliance with the HIPAA electronic transactions and code sets and protected health information (PHI) policies. The following shall constitute the minimum set of data elements to be submitted to AHC for the purpose of submission of encounter data:

- Provider National Provider Identification (NPI) Number
- Provider Tax ID (Site)
- Provider Service Address, City, State, Zip Code
- Rendering Provider Last and First Name
- Rendering Provider State License Number and NPI '
- Patient Last Name
- Patient First Name
- Patient Birth date
- Patient Sex
- Enrollee ID Number (Subscriber No/Person No)
- Diagnosis Code(s)
- Service "From" Date
- Service "Through" Date
- Place of Service
- Procedure Code(s)
- Units of Service

AHC will measure PCP's compliance with electronic encounter data submission based upon the submission of 8 encounters per enrollee per year. Encounter data will be reviewed quarterly to validate compliance. Error reports will be provided to Participating Provider to ensure the issues with any encounter submission are addressed timely and appropriately.

Claims Risk Adjustment Submission

Providing the best care for Medicare members with chronic diseases is crucial for members who meet the criteria. In order to serve the greatest good for health care and cost containment, complete data must be gathered though the documentation of services provided to each member at every visit. There are a number of reasons why capturing this information is important for example:

- System efficiencies across providers
  - – Care coordination
  - – Managing transitions across settings
  - – Not solely internal provider efficiencies
- Share clinical information
  - – Reduce duplicative tests and procedures
- Improve processes and outcomes
  - – Increase guideline compliance
- Avoid unnecessary inpatient admissions and readmissions as well as emergency room visits
- Substitute outpatient services for inpatient services
  - – Less invasive procedures for more invasive procedures
- Shorten length of stay

Section 11: Medical Records Standards

Medical Records Standards
AHC expects Participating Providers' medical records to be maintained in a manner that is current, detailed, and organized. Medical records should reflect all aspects of patient care, be readily available to health care practitioners, and provide data for statistical and quality-of-care analysis. Standards for the administration of medical records by Participating Providers were established by the AHC Medical Services Committee (MSC). The standards form the basis for evaluation of medical records by the Alignment Healthcare medical staff during the process of a peer review.

Written Protocols
Participating Providers are required to develop and maintain written protocols and/or a policy describing their internal medical record system as it pertains to the following areas:

- Confidentiality of patient information
- Release of information contained in the medical record
- Follow-up of broken appointments
- Physician acknowledgement of clinical reports
- Formal system for retrieval of medical records
- Guidelines for maintaining medical records and a system for archiving purged data
- Documentation requirements for a discussion of advance directives

Medical Records Documentation Standards
Although the responsibility for medical record reviews is not delegated, the Participating Providers are responsible for complying with the medical documentation standards. Medical records must be maintained in a manner that is current, detailed, complete, and organized, and permits effective and confidential member care and quality review. Additionally, medical records must reflect all aspects of patient care, be readily available to health care practitioners, and provide data for statistical and quality-of-care analysis.

DETAIL REGARDING MEETING THE MANDATORY STANDARDS IS AS FOLLOWS:

Confidential Patient Information- Participating Providers must have a written policy in place that provides for the protection of confidential patient health information in accordance with the Health Portability and Accountability Act (HIPAA). The policy must include a functioning mechanism for safeguarding records and information that is kept in hard copy or electronic format, against loss, destruction, tampering and unauthorized access or use.

Medical Record Documentation- Specific documentation standards must be followed when documenting in an individual member's medical record. Each page of the medical record must contain two identifiers - the patient's name and date of birth or identification number.

Personal biographical data- must be included in the record; Address, Employer (if applicable), Home Phone, Work Phone (if applicable), and Marital Status.

All entries must contain the author's identification- forms include handwritten signature, unique electronic identifier, or initials and must be dated.
The record must be legible- to someone other than the author.

The problem list must include- significant illnesses and medical conditions.

Medication allergies and adverse reactions- must be prominently noted in the record. If the patient has no known allergies or history of adverse reactions, must also be noted.

Past medical history must be easily identified- in the record and include serious accidents, operations and illnesses.

The H & P examination identifies- appropriate subjective and objective information pertinent to the patient's presenting complaints.

Laboratory and other studies- are ordered, as appropriate.

Working diagnoses- are consistent with findings.

Treatment plans- must be consistent with diagnoses.

Encounter forms or notes - have a notation regarding follow-up care, calls or visits when indicated. The specific time of return is also noted.

Unresolved problems- from previous office visits are addressed in subsequent visits.

There is review for **under- and/or over-utilization** of consultants.

If a consultation has been requested, there is **a note from the consultant in the record. Consultation, laboratory and imaging reports filed in the chart** are initialed by the practitioner who ordered them to indicate review of the findings. If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner. Consultation and **abnormal laboratory and imaging study results have an explicit notation in the record** of follow-up plans.

There is evidence that **the patient is placed at inappropriate risk** by a diagnostic or therapeutic procedure.

There is evidence that **preventive screening and services are offered** in accordance with practice guidelines.

Current medication is documented including complete dosage information, dates and refill information.

Presence of **an advance directive or evidence of education** about advance directives.

Medical Record Organization and Availability of Medical Records: Participating Providers must comply with the following documentation standards regarding organization and availability of medical records:

The **transmission of data to the medical record** is timely and accurate
The **medical record has a standard logical format** with all pages securely affixed

Results of **consultation reports and all diagnostic/therapeutic service reports** are available to the practitioner in a timely manner

The **records are accessible** during practice hours

The **medical record indicates when a portion of the record has been filed** elsewhere to alert authorized personnel of that portion's existence

The area housing the **medical records has adequate lighting and space**

Medical record **locations must be secured** and care must be exercised that **only approved personnel have access** to these areas

The **filing system must be alphabetical or numeric**

The **retention time of medical records is determined by state law and regulation** and by its use for patient care, legal and research purposes

Guidelines and procedures describe when a medical record becomes "inactive" and is to be retired offsite, microfilmed or destroyed

Advance Directive Requirements

The Federal Patient Self Determination Act requires that all individuals over age 18 receiving medical care must be given information about their rights under state law to make decisions about medical care, including the right to accept or refuse surgery or other medical treatment. In addition, health care providers are responsible for documenting in the patient's medical record whether the patient has been given information about or has executed an advance directive. An advance directive may include a Durable Power of Attorney for Health Care (DPAHC), or any other recognized advance directive. Practitioners must become well informed about advance directives and take an active role in helping members understand the benefits of these documents. Members must also be given information about their right to create advance directives. Although the Act does not require facilities to provide patients with actual forms, physicians may wish to offer them. These forms may be obtained through the Florida Medical Association (FMA), Alignment Healthcare or other medical societies.

Medical Record Audit Form - Exhibit 11.1

Exhibit 11.1
Medical Record Audit

DATE:	ID#			ID#			ID#			ID#			ID#			
PROVIDER:	DOB:			DOB:			DOB:			DOB:			DOB:			
AUDITOR:	SEX:	M	F	SEX:	M	F	SEX:	M	F	SEX:	M	F	SEX:	M	F	
	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	*SCORE*
1. All pages contain patient name or ID number																
2. Biographical/personal data																
3. Provider/practitioner identified on each entry																
4. All entries dated																
5. Record is legible																
6. *Significant illness/med conditions on problem list																
7. *Allergies/adverse reactions on NKDA noted																
8. *PMH (>3 visits) identified and documented																
9. Medication list (name of drug, complete dosage info., dates and refill information).																
10. Vital signs taken during each office visit																
11. Age appropriate immunization record/hx present (>3 visits)																
12. Age/gender specific preventative services documented																
13. Documentation of health educations (>3 visits)																
14. Documentation of drug, alcohol, depression, violence, nicotine/cigarettes																
15. Pertinent referral to behavioral health services																
16. There is documentation of patient approved exchanged of information between PCP and behavioral health practitioners																
17. Pertinent H&P																
18. Lab and studies ordered as appropriate																
19. Consultation, labs, reports and test results initialed by practitioner who ordered them to reflect review																
20. *Working diagnoses consistent with findings																
21. Follow-up plan noted of reach visit																
23. Unresolved problems from previous visits addressed																
24. Appropriate utilization of consultants																
25. Dictated consult letter/tx plan forwarded to PCP																
26. Presence of Advanced Directive or evidence of education available to members 18 years and older																
27. There is no evidence that the patient is placed at an inappropriate risk be a diagnostic or therapeutic procedure																
28. Cesarean section, cervical/breast cancer screening																
29. Diabetic retinal exam, Hemoglobin A1C																
TOTAL AVERAGE SCORE:																
COMMENTS:																

Section 12: Credentialing of Practitioners

Overview
The AHC Credentialing Program evaluates practitioners' professional credentials in accordance with federal, state and AHCQA requirements to ensure that they are adequately qualified to provide service to AHC members. AHC will not discriminate in terms of participation, reimbursement, or indemnification, against any healthcare professional who is acting within the scope of his or her license or certification under state law. Only licensed and qualified applicants who meet AHC's standards and participation requirements are accepted or retained in AHC's network. The credentialing process is administered by AHC or by entities delegated by AHC that agree to credential practitioners in accordance with AHC criteria.

Credentialing Process
AHC, or its delegated designees, must credential all physicians (MDs, DOs), dentists, (DDSs, DMDs), podiatrists (DPMs), chiropractors (DCs), clinical psychologists (PhD, PSY.D.), other licensed behavioral health practitioners (LCSWs, MFCCs, MFTs, MHCs, Psych. RNs), allied and ancillary health practitioners (PAs, NPs, CNMs, NMWs, CRNAs, acupuncturists, PTs, AUs, SPs, OPTs, OTs) and such other practitioners who are authorized by law to deliver health care services to AHC members. Healthcare Delivery Organizations (HDOs), which include hospitals, skilled nursing facilities (SNFs), home health agencies, dialysis centers, laboratories and ambulatory surgical centers, must be credentialed by AHC or its delegated designees prior to rendering care to AHC members. AHC is responsible for credentialing all practitioners (excluding certain hospital-based practitioners) and HDOs with whom it contracts directly. AHC is also responsible for oversight of any delegated credentialing activity of subcontracted IPA/MG or HDO.

Non-Discrimination Policy – Credentialing and Re-Credentialing
AHC will not consider age, sex, religion, race, creed, color, national origin or sexual orientation when determining a practitioner's qualification to provide health care services to members. Additionally, selection and retention criteria will not discriminate against health care professionals who service high-risk populations or those who specialize in treating costly conditions.

The Health Care Services Department reviews each credentialing application to ensure that all the required information is attached
This information consists of the following:

- Work history (continuous of at least five years) without gaps
- Application questionnaire including questions regarding:
- Physical and mental health status
- Lack of impairment due to chemical dependency or substance abuse
- History of loss of license or felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Name of primary admitting facility, if applicable. If no hospital staff privileges, evidence of ability to have a patient admitted by an AHC practitioner

Signed attestation by the applicant to the correctness and completeness of the application which includes:

- Release of information (signed and dated)
- Copy of current malpractice insurance face sheet including minimum coverage as required in your contract or as required by law
- Current medical license or certification number
- ECFMG certificate, as applicable
- Copy of current DEA License and current State License
- Copy of CV
- Practitioner's Rights

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 certifying expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners 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 practitioner believes that erroneous information has been supplied to AHC by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice along with a detailed explanation to AHC. Notification to AHC must occur within 48 hours of AHC notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his or her credentialing file. Upon receipt of notification from the practitioner, AHC will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via letter or fax that the correction has been made to his or her credentials file. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department will so notify the practitioner via letter or fax.

The practitioner may then provide proof of correction by the primary source body to AHC's QM Department via letter or fax at the address above within 20 working days. The Credentialing Department will re-verify primary source information if such documentation is provided. If, after 10 working days, primary source information remains in dispute, the practitioner will be subject to Adverse Action, up to administrative denial/termination.

NOTE: *AHC may delegate the primary source verification process to a Credentials Verification Organization (CVO) and provide appropriate oversight of that function.*

Primary Source Verification for Credentialing
For non-delegated credentialing, the Credentialing Department obtains and reviews information on the application and verifies the information from primary sources.

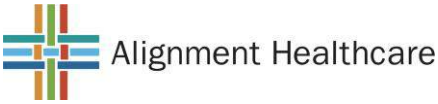
Applicant Office Site Evaluation
AHC does not have a policy that routinely conducts an office site evaluation for each applicant PCP or OB/GYN or high volume practitioner as a condition of credentialing or re-credentialing, but those visits may be conducted in response to a complaint about the specific facility. If a site visit is conducted, a corrective action plan (CAP) may be requested at the time of visit detailing any non-compliance. Applicants considered non-compliant in any critical criteria do not pass the site evaluation and an action plan is implemented. A second site evaluation is scheduled to

ensure implementation of the action plan. Applicants who refuse to allow an office site evaluation, who fail to provide corrective documentation as needed, or who fail two consecutive site evaluations do not meet AHC standards for participation and are referred to AHC's Medical Services Committee (MSC) for suspension from the provider network.

Re-credentialing Application
The re-credentialing process provides a mechanism for updating and re-verifying a practitioner's license and professional status every three years.

Providers Rights Notification Form – Exhibit 12.1

Exhibit 12.1
Providers Rights Notification Form



I. Right of Review

A practitioner has the right to review information obtained by the Alignment Healthcare (AHC) for the purpose of evaluating that practitioner's initial credentialing or re-credentialing 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 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 **Credentialing Department, Alignment Healthcare, 1100 W. Town & Country Rd., Suite #1600, Orange, CA 92868. Ph: 323-728-7232, ext 2272; Fax: 562-206-4617.**

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 his/her 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 letter or fax) along with a detailed explanation to **Credentialing Department, 1100 W. Town & Country Road, Suite #1600, Orange, CA 92868. Ph: 323-728-7232, ext. 2272; Fax: 562-207-4617.**

Upon receipt of notification from the practitioner, the primary source information in dispute will be re-reviewed. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via letter or fax, that the correction has been made to his/her credentials file. If, upon re-review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via letter or fax. The practitioner may then provide proof of correction by the primary source body to the Credentialing Department via letter or fax at the address above within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided. If, after 10 working days, primary source information remains in dispute, the practitioner will be subject to action under **Alignment Healthcare's policy**, up to administrative denial/termination.

Physician Signature:_____**Date:**_____
(Stamped Signature is not acceptable)
Print Name:_____