2014 Provider Handbook

AlphaCare
855-652-5742
www.alphacare.com

AlphaCare
Your Care Comes First

2014 Provider Handbook

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SECTION 1: Introduction

1.1 - Welcome

AlphaCare of New York (ACNY) believes quality health care starts with the provider patient relationship. AlphaCare carefully selects the best physicians and is pleased to welcome you as a participating provider. We are committed to ensuring that our members receive easily accessible, high-quality, comprehensive healthcare services. The AlphaCare provider network is a key partner in achieving this goal. This Provider Handbook has been developed to assist our participating providers in understanding the administrative policies and procedures that govern AlphaCare. It is designed to provide you with easy access to information that will enable you and your office staff to care for AlphaCare members within administrative guidelines.

1.2 - Mission and Values

AlphaCare of New York (ACNY) is a locally-based health plan dedicated to serving the needs of the chronically ill, elderly and disabled members of our community. Our mission is to promote the delivery of high quality, person-centered, culturally sensitive care to our members in a community-based setting. Through the establishment of timely communications and support to our providers, we strive to create a true partnership between AlphaCare and our participating provider network in the service of our members/your patients.

- We offer a full range of programs in the New York Area (Bronx, Brooklyn, Queens, Manhattan and Westchester), including Medicaid Managed Long Term Care (MLTC) and Medicare Advantage Plans.
- Our programs engage the member, care givers, providers and families in the development of care plans to consider their unique needs, preferences and competencies and to provide a full continuum of supports to promote wellness and patient satisfaction.
- We look to our primary care providers to partner with us in serving our members by providing high quality and cost effective care.

1.3 - Purpose of the Manual

AlphaCare's Provider Handbook ("Manual") is an extension of the provider participation agreement ("Agreement") between ACNY and all provider types including, but not limited to, physicians, hospitals and ancillary health care providers (hereinafter collectively and/or individually, as the context requires, referred to as "Provider(s)"). This Manual furnishes all such participating Providers and their office staff with important information concerning ACNY's policies and procedures, claims submission and adjudication requirements, and guidelines used to administer ACNY Benefit Plans. This Manual replaces and supersedes any and all other previous versions and is available on www.alphacare.com. A paper copy may be obtained at any time upon written request to ACNY. Any capitalized terms not otherwise defined herein shall have the meaning as set forth in the Agreement.

1.3.1 - Updates and Revisions

In accordance with the Policies and Procedures clause of the provider contract Agreement, Providers are contractually required to abide by all provisions contained in this Manual, as applicable. Revisions to this Manual constitute revisions to AlphaCare's policies and procedures. Revisions shall become binding ninety (90) days after the date indicated on any notice that is provided by mail or electronic means, or such other period of time as necessary for AlphaCare to comply with any statutory, regulatory and/or accreditation requirements.

As policies and procedures change, updates will be issued in the form of Provider Bulletins and may be incorporated into the electronic version and subsequent paper versions of this Manual. Any changes in policies and procedures must be implemented according to the time frame included in the Agreement.

Variations in applicable laws, regulations and governmental agency guidance, including, but not limited to state or federal laws, regulations, and/or changes to such laws, regulations or guidance may create certain requirements related to the content in this Manual that are not expressly set forth in this Manual. Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this Manual shall be incorporated herein by this reference and shall apply to Providers and/ or ACNY where applicable. Such laws and regulations, if more stringent, take precedence over the content in this Manual. Providers are responsible for complying with all laws and regulations that are applicable.

1.4 - Product Overview

AlphaCare of New York is contracted with CMS to provide several Medicare Advantage products:

- AlphaCare Renew HMO (Medicare Advantage Part D) – Medicare Eligible Beneficiaries
    - » Medicare beneficiaries who have Parts A, B and D who reside in our service area
- AlphaCare Total HMO (Special Needs Plan) – Dual Eligible Beneficiaries
    - » Medicare beneficiaries who have Medicare Parts A, B and D as well as NYS Medicaid who reside in our service area
- AlphaCare Resilience HMO (Special Needs Plan) – Institutional Medicare Beneficiaries
    - » Medicare beneficiaries who have Parts A, B and D who reside in a contracted nursing home in our service area
- AlphaCare Signature – Fully Integrated Dual Advantage (FIDA) (Effective Oct. 1, 2014; see separate manual)
    - » Medicare beneficiaries with Parts A, B and D, as well as full Medicaid benefits, who also meet long-term care criteria and reside in our service area

The above four (4) Medicare plans offer full Medicare Part D prescription drug coverage, as well as supplemental benefits covering other health care services beyond those offered by Original fee-for-service Medicare. However, not all plans offer the same supplemental benefits. Please reference the appropriate Summary of Benefits document online at www.alphacare.com/medicare for more information.

1.5 - Provider Services

AlphaCare considers Participating Providers as partners and we are committed to developing productive relationships to ensure that AlphaCare's members receive the highest quality of care. The AlphaCare Network and Provider Relations (NPR) Department serves as the link between Participating Providers and AlphaCare.

NPR department works with Participating Providers to ensure they are informed of the responsibilities and standards to which they are held. Provider education and training is available for new and established Participating Providers to assist in the development and refinement of their managed care knowledge and to acquaint them with AlphaCare policies and procedures. NPR Account Managers conduct initial orientation sessions for new Participating Providers and their staff and hold additional trainings as needed. They also make regular office visits to Participating Providers.

Provider Services responds to inquiries and requests for information from Participating Providers and assists in the resolution of Participating Provider complaints. Provider Services staff respond to all verbal, telephonic or written inquiries.

AlphaCare has a dedicated phone unit available to assist providers with questions regarding AlphaCare policies and procedures, member care, reimbursement, claim information or general information about AlphaCare and its products. If you have any questions or need more information about AlphaCare and its products, please contact Member Provider Services at 1-855-652-5742.

1.6 - Resources for Provider on the AlphaCare Website

The AlphaCare web site, www.alphacare.com, is another way providers can access up to date information on AlphaCare. The web site provides the following information:

- Provider search and provider directories
- Provider manual
- Provider orientation
- Provider and member newsletters
- Provider bulletins
- Formularies
- Quick reference guide
- AlphaCare health plan descriptions, qualification tools, member handbooks , Evidence of Coverage and Summary of Benefits
- Clinical Practice Guidelines
- Provider Forms

Section 2: Participating Provider Administrative Information

2.1 - Primary Care Provider (PCP) Role

Members are asked to select a PCP when enrolling in AlphaCare plans and may change their selected PCP at any time. AlphaCare contracts physicians that members may choose as their PCP. These providers may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining prior authorization for covered services for members. Please refer section 5 for services that require prior authorization. Medicare participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners or geriatricians. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may be included as PCPs.

The PCP is a network physician that strives to do what's best for his/her patients by delivering high quality care and appropriate care coordination. When coordinating member care, the PCP should refer the member to a participating provider within the AlphaCare network.

Any referral to a nonparticipating provider will require prior authorization from AlphaCare, or the services may not be covered. Contact Customer Service at 1-855-652-5742 for questions or more information.

2.2 - The Specialist Role

A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from AlphaCare before performing specific procedures or when referring members to non-contracted providers. Please refer section 5 for services that require prior authorization. Providers can review prior authorization requirements in the Summary of Benefits or the Evidence of Coverage or call Customer Services at 1-855-652-5742.

After performing the initial consultation with a member a specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up with the PCP
- Send the PCP the consultation report, including medical findings, test results assessments, treatment plan and any other pertinent information
- If a specialist needs to refer a member to another provider, the referral should be to another AlphaCare participating provider. Any referral to a non-participating provider will require prior authorization from AlphaCare.

2.3 - Specialist as a PCP

With approval, a Specialist may act as the PCP for a member with a life threatening, degenerative and/or disabling condition, or a disease requiring prolonged specialized medical care. The member's PCP is responsible for requesting that a SCP assume the PCP function. Such requests should be made to the Utilization/Care Management Department and approved by the Medical Director.

2.4 - Responsibility of all Providers

All AlphaCare participating professionals, facilities, agencies and ancillary providers agree to:

COMPLIANCE WITH CONTRACTUAL REQUIREMENTS

Provider must comply with all contractual, administrative, medical management, quality management, and reimbursement policies as outlined in the ALPHACARE provider contract, provider manual and updates.

NON-DISCRIMINATION

a. Provider must not differentiate or discriminate in accepting and treating patients on the basis of race, color, creed, national origin, ancestry, disability, type of illness or condition, sex, age, religion, sexual orientation, marital status, place of residence, actual or perceived health status or source of payment.

b. ACNY and its contracted providers shall ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal Funds.

CULTURAL SENSITIVITY

AlphaCare members come from very diverse backgrounds. The provider ensures that members of various cultural, ethnic and religious backgrounds; as well as disabled individuals are communicated with in an understandable manner, accounting for

different needs. All efforts are made to speak with the member in their primary language. It is the provider's responsibility to ensure the member clearly understands the diagnosis and treatment options that are presented, and that language, cultural differences, or disabilities are not posing a barrier to communication.

ETHICAL MEDICAL PRACTICE

a. Provider agrees to provide services within the scope of the provider's license and/or specialty.

b. Provider agrees to adhere to established standards of medical practice and the customary rules of ethics and conduct of the American Medical Association and all other medical and specialty governing bodies.

c. Provider agrees to report to ALPHACARE any reports or sanctions against them for failure to provide quality care, negligence determinations or licensing terminations imposed upon them.

2.5 - Continuity and Coordination of Care

AlphaCare maintains and monitors a panel of PCPs from which the member may select a personal PCP. All members may select and/or change their PCP to another participating AlphaCare Medicare PCP without interference. AlphaCare requires members to obtain a referral before receiving specialist services and has a mechanism for assigning PCPs to members who do not select one. AlphaCare will also:

- Provide or arrange for necessary specialist care and in particular, give female members the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. AlphaCare will arrange for specialty care outside of AlphaCare's provider network when network providers are unavailable or inadequate to meet a member's medical needs;
- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. AlphaCare utilizes the provision of translator services and interpreter services;
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations;
- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services; and
- Have in effect procedures that:
  - » Establish and implement a treatment plan that is appropriate;
  - » Include an adequate number of direct access visits to specialists;
  - » Are time-specific and updated periodically;
  - » Facilitate coordination among providers; and
  - » Considers the member's input.

2.6 - Access and Availability Standards

AlphaCare is required to adhere to patient care access and availability standards as required by the NYDOH and CMS. AlphaCare will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the need of the population served. These standards ensure that ALPHACARE members can get an appointment for care on a timely basis, can reach the provider over the phone and do not experience excessive wait times during their scheduled appointments.

Participating providers must:

- Provide coverage for members 24 hours a day, 7 days a week
- Ensure another on-call provider is available to administer care when the PCP is not available
- Nor substitute hospital emergency room or urgent care centers for covering providers
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (e.g., emergency cases) and offer an alternative appointment
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to an urgent phone call with one (1) hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency

services from the nearest emergency room

- Ensure that services are provided in a culturally competent manner to all enrolled including those with limited English proficiency or reading skills.

Contracted physicians are expected to comply with these appointment, telephone access and practitioner availability service standards. ALPHACARE monitors its providers for compliance with these standards. ALPHACARE will develop a corrective action plan for providers and health networks that do not meet these standards.

The following appointment availability goals should be used to ensure timely access to health care services:

TYPE OF APPOINTMENT	AVAILABILITY STANDARD
Life threatening, Emergent problem	Immediately
Urgent care	Within 24 hours
Non-urgent "sick" visit	Within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated
Routine non-urgent, preventive appointments	Within seven (7) days of request
Specialist referrals (not urgent)	Within two (2) to four (4) weeks of request
Non-urgent mental health or substance abuse visits with a Participating Provider	Within two (2) weeks of request

All providers and hospitals are expected to treat AlphaCare members in a manner consistent with professionally recognized standards of Health Care Conduct.

2.7 - Enrollment and Eligibility Verification

Please remember that the ID card does not guarantee eligibility, as a member's eligibility can change at any time for a number of reasons. Therefore, AlphaCare recommends that providers verify eligibility and coverage before providing services (except in the case of an emergency). In an emergency, eligibility should be determined as soon as possible after a member's condition is stabilized. To verify eligibility, deductible, coinsurance amounts, co-pays or other benefit information, call AlphaCare at 1-855-652-5742.

2.8 - Provider Rights and Responsibilities

- Provider shall perform all services in compliance with applicable Federal and State requirements, laws, rules, regulations, and in compliance with all agency bylaws, rules, regulations, policies and procedures with respect to service delivery, participant rights, quality assessment and performance improvement activities. Provider must commit to providing high quality services in an ethical and responsible manner. Comply with NYSDOH guidelines, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested, and maintain records for a minimum of ten (10) years. Comply with all applicable federal and state laws regarding confidentiality of patient records.
- The Provider shall participate in and comply with quality assurance and utilization review programs, including grievance and appeal procedures, and the monitoring and evaluation of the Plan Program, and continuing education and other similar programs established by AlphaCare of NY.
- Provider agrees to report to AlphaCare of NY any reports or sanctions against them for failure to provide quality care, negligence determinations or licensing terminations imposed upon them.
- The Provider will protect all confidential information received consistent with applicable legal and ethical standards. Provide all services ethically, legally and in a culturally competent manner meeting the unique needs of the full member population.

- Provide coverage 24 hours a day, 7 days a week; regular hours of operation must be clearly defined and communicated to members.
- Manage the medical and health care needs of members, including monitoring and following up on care provided by other health care providers, providing coordination necessary for services provided by a specialists and ancillary providers (both in and out of network).
- Make provisions to communicate in the primary language or fashion used by his or her members. Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Agree NOT to balance bill members for balance that are not their responsibility or that are the responsibility of another carrier
- Establish an appropriate mechanism to fulfill obligations under the American with Disabilities Act of 1990 (ADA).
- Support, cooperate and comply with AlphaCare of NY Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost effective and reasonable manner.
- Notify AlphaCare of NY if a member objects to the provisions of any counseling, treatments or referral services for religious reasons.
- Manage a member's transition of care when the provider is the transferring provider:
  - » Notify the member in advance of a planned transition
  - » Provide adequate documentation of the care plan to the receiving institution or provider within one (1) business day of the transition.
  - » Communicate with the member about the transition process.
  - » Communicate with the member about his or her health status and plan of care.
  - » Notify the member's usual practitioner of the transition within three (3) business days after the notification of the transition.
  - » Provide a treatment plan and discharge instructions to the member prior to being discharged.
- Nothing herein prohibits or restricts you from disclosing to any Member, prospective Member, or designated representative any information that you deem appropriate regarding:
  - » A condition or course of treatment including the availability of other therapies, consultations, or tests; or
  - » The provisions, terms, or requirements of AlphaCare's products.

2.9 - Prohibition against Discrimination

As a participating provider, you are prohibited from discriminating against a Member based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

In addition, you are required to be in compliance with Title VI of the Civil Rights Act of 1975, the Age Discrimination Act of 1975, the Americans with Disabilities Act ("ADA") and other laws applicable to recipients of federal funds. The New York State Department of Health ("DOH") has adopted specific guidelines for ADA compliance by managed care organizations including their affiliated provider networks. The scope of the guidelines includes ensuring appropriate access to services through physical access to the site of care (e.g., wheelchair accessibility), access within the site (e.g., exam rooms, tables and medical equipment) and access to appropriate assessment and communications tools that enable disabled individuals to receive needed services and to understand and participate in their care. AlphaCare has developed a plan for achieving full compliance with these requirements, and may request information from your practice as part of this program.

2.10 - Cultural Competency

All AlphaCare members should be treated with dignity and respect by the provider and their staff. AlphaCare providers are prohibited from discriminating against different types of patients based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, source of payment or health status. AlphaCare providers are required to participate in the Cultural Competency Program in order to ensure that culturally competent and linguistically appropriate services are delivered throughout the network.

Providers are expected to deliver care in a culturally competent and sensitive way. Cultural competency

must be embedded in all levels of care in order to meet the needs of the community and members, respect their values, and combat the residual effects of stigma and discrimination. In order to achieve this in communities we serve, AlphaCare promotes robust, comprehensive cultural competency throughout the provider network. AlphaCare makes certain that cultural competency is embedded in all levels of service so that high-quality care that respects individuals' race, ethnicity, culture, and language is available to all members where they live, work and play. Our aim is to increase the level of member engagement and satisfaction through the delivery and monitoring of services that reflect the dignity, values, culture, and privacy needs of each individual.

Participants who are hearing impaired or have speech impairment have access to the TTY/TDD service line by calling 711. Participants who do not have TTY can communicate with a TTY user through Message Relay Center (MRC). MRC has TTY operators available to send and interpret TTY messages.

Participants with a specific language requirement or request can contact 1-855-652-5742 to request interpretation services.

Section 3: Member Rights

3.1 - Member Rights

Throughout your participation, you must allow members to:

- Obtain complete current information concerning a diagnosis, treatment, prognosis in terms the member can understand. When it is not advisable to give such information the member, the information must be made available to an appropriate person acting on the member's behalf;
- Receive information as necessary to give informed consent prior to the start of any procedure or treatment; and
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

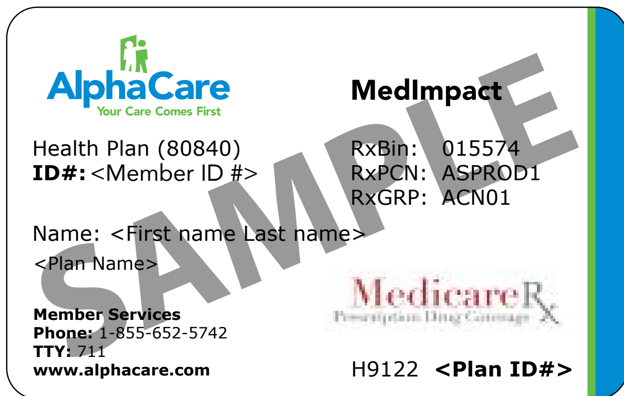
Members have certain rights by virtue of their enrollment in AlphaCare. These include, but are not limited to, the rights to:

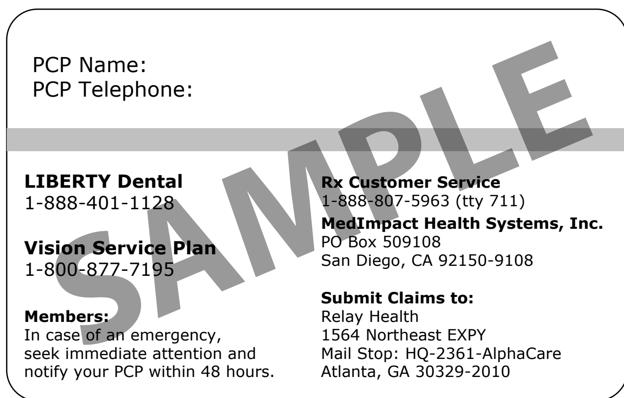
- Receive medically necessary care;
- Timely access to care and services;
- Privacy about their medical record and when they get treatment;
- Get information on available treatment options and alternatives presented in a manner and language they understand;
- Be treated with respect and dignity;
- Obtain a copy of their medical records and ask that the records be amended or corrected;
- Take part in decisions about their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to get the services needed, including how you can get covered benefits from out-of-network providers if they are not available in the plan network;
- Complain or express grievances, use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate;
- Appoint someone to speak about care and treatment; and
- Know what rules and regulations apply to your conduct.

As a participating provider you are expected to not only respect these rights, but assist members in leveraging these rights.

3.2 - Member Identification Cards

Member identification cards are issued to all Members upon enrollment and contain information such as Plan name, important phone numbers, the Member's PCP and RX information. See a copy of the card attached.





3.3 - Changing Primary Care Providers

Members may change their PCP for any reason, at any time by calling AlphaCare at 1-855-652-5742.

3.4 - Hearing-Impaired, Interpreter and Sign Language Services

AlphaCare will provide interpreter access for members from culturally and linguistically diverse backgrounds and people with hearing, speech and communication impairments. Participants who are hearing impaired or have speech impairment have access to the TTY/TDD service line by calling 711. Participants who do not have TTY can communicate with a TTY user through Message Relay Center (MRC). MRC has TTY operators available to send and interpret TTY messages.

Participants with a specific language requirement or request can contact 1-855-652-5742 to request interpretation services.

Section 4: Compliance

4.1 - Fraud, Waste and Abuse

Healthcare fraud, waste, and abuse affects everyone (e.g., Members, providers, taxpayers, AlphaCare, etc.). As a result, and pursuant to applicable requirements, we operate a comprehensive fraud and abuse program. You have a duty to support this program by reporting questionable activities and potentially fraudulent/abusive actions.

4.1.1 - Definitions

Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste – Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program, Medicaid program, or AlphaCare. Waste is generally the misuse of resources.

Abuse — Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

4.1.2 - Examples of Fraud, Waste and Abuse

The following are examples of member fraud, waste, and abuse:

- Members suspected of switching providers in an effort to obtain prescriptions for controlled substances;
- Prescription forging or prescription modification to obtain controlled substances, other medications, or more medication than prescribed;
- Members sharing their ID cards with non-members;
- Non-disclosure of other health insurance coverage; and
- Obtaining unnecessary equipment and supplies.

The following are examples of provider fraud, waste, and abuse:

- Lack of medical necessity for medical services, home health care, durable medical equipment, and prescription drugs billed;
- Services not provided, but billed;
- Upcoding of CPT and DRG codes to obtain a higher rate of reimbursement;
- Inappropriate use of CPT codes and/or modifiers to seek higher reimbursement;
- Unbundling CPT codes to obtain higher reimbursement;
- Not checking member ID's resulting in claims submitted for non-covered persons;
- Scheduling more frequent return visits than are needed to increase reimbursement;
- Billing for services outside of your medical qualifications;
- Using Member lists for the purpose of submitting fraudulent claims;
- Duplicate billings for services rendered;
- Payments stemming from kickbacks or Stark Violations; and
- Retaining overpayments made in error.

4.1.3 - Avoiding Fraud, Waste and Abuse

The Office of the Inspector General ("OIG") has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste, and abuse. This information can be found on the Office of Inspector General's website at:
http://oig.hhs.gov/compliance/101/.

4.1.4 - Training

AlphaCare requires that a First Tier, Downstream, and Related Entity ("FDR"), including providers, vendors, and business partners, receive fraud, waste, and abuse training as outlined by the Centers for Medicare and Medicaid Services ("CMS"). This training is mandatory and must occur annually. The training covers federal requirements FDRs must know about the detection, prevention, and correction of fraud, waste, and abuse for organizations providing health, prescription drug, or administrative services to Medicare Advantage or Prescription Drug Plan members on behalf of AlphaCare.

4.1.5 - Reporting

Reporting fraud, waste, and abuse can be anonymously or directly to AlphaCare.

Options for reporting anonymously:

- Calling the compliance hotline at (888) 770-7814; or
- Visiting www.alphacare.com and clicking "Report Compliance Issue".

Options for reporting directly:

- Calling our Compliance Department at (718) 673-2414; or
- Emailing compliance@alphacare.com.

4.2 - Confidentiality

Medical records must be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations including the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as may be amended. All consultations or discussions involving the member or her or his case should be conducted discreetly and professionally. Practice personnel should be trained on confidentiality requirements and adequate procedures to protect against unauthorized/inadvertent disclosures must be implemented. Be advised that information involving the provision of substance abuse services, mental health treatment, and the presence of HIV-related illness are governed by a special set of confidentiality rules and the release of these records requires a special authorization. They should not be released to anyone other than the member except under tightly defined and controlled circumstances.
All providers rendering healthcare services must maintain a member health record in accordance with standards adopted by AlphaCare and in compliance with applicable guidelines/regulations. Further, providers should be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical record information. Periodically, AlphaCare may request medical records and conduct reviews to evaluate practice patterns, identify opportunities for improvement, and to ensure compliance with quality standards. Providers must make medical records available upon request by AlphaCare or by CMS, DOH, or any other regulatory agency with jurisdiction

over AlphaCare's programs.

4.3 - Marketing

Under its contracts with CMS and the New York State Department of Health, AlphaCare is held responsible for advertising, enrollment, and outreach activities undertaken by any individual or entity on its behalf. This applies regardless of whether AlphaCare directly employs the involved party or if that party is affiliated by subcontract or through a participating provider agreement. Therefore, all providers participating with AlphaCare are bound by the requirements of these contracts (including the laws and guidelines referenced therein or associated therewith) and all marketing activities must be conducted in a responsible manner so that potential Members receive the most accurate and complete information possible. Providers should familiarize themselves with the regulations in the CMS (Chapter 3) Managed Care Manual at www.cms.gov. Below is a non-exhaustive list of marketing responsibilities:

Providers may:

- Advise their patients of the managed care plans with which they participate, so long as all plans are listed and one plan is not promoted over another;
- Give permission to AlphaCare marketing representatives to conduct activities at their facilities;
- Notify patients of a plan disaffiliation and the impact of this change of status on their care;
- Refer patients interested in or eligible for an AlphaCare product to AlphaCare's customer service department so that AlphaCare may assist with the application process and/or serve as a liaison with enrollment agencies.

Providers may not:

- Conduct "cold call" telephone solicitations;
- Provide mailing lists of their patients to AlphaCare;
- Market in a hospital emergency room, treatment room, hospital patient room, medical professional office, nursing home or adult care facility resident room, adult day health care program or social day care sits;
- Develop or use any materials that market AlphaCare without the prior written approval of AlphaCare;
- Accept applications; or
- Offer inducements to enroll in AlphaCare.

Section 5: Utilization Management, Case Management and Disease Management

5.1 - Utilization Management

The role of utilization management (UM) services is to ensure consistent delivery of high-quality, cost-effective health care services to our members through AlphaCare of New York's affiliated providers. Health care services are delivered through our provider network, which is structured to provide a continuum of care including but not limited to preventive services, diagnostic testing, medical and dental treatments, and pharmacy, vision and radiology services. UM functions include authorization of non emergency inpatient and outpatient procedures, home health, inpatient concurrent reviews, discharge planning, and retrospective reviews.

AlphaCare of New York makes utilization management decisions only on appropriateness of care and service, based on the current evidence of coverage and evidence based standards of care. AlphaCare of New York does not reward its providers for issuing denials of coverage or care. There are no financial incentives that would encourage UM decision makers to render decisions that would result in under-utilization of services.

5.1.1 - Medically Necessary Services and Medical Criteria

AlphaCare of New York uses medical necessity criteria, including Milliman Care Guidelines, the United States Preventive Services Task Force Standards, AlphaCare of New York approved Clinical Practice Guidelines, and CMS Federal and State Coverage Determinations that are based on current scientific evidence and clinical consensus. These criteria are used in making medical necessity determinations. We review the criteria annually, taking into consideration current scientific evidence and provider feedback, and revise them as needed. AlphaCare makes utilization management criteria available to practitioners upon request.

Services that include medical or allied care, goods, or services furnished or ordered must be provided under the following conditions:

- Necessary to protect life, to prevent significant illness or significant disability and alleviate severe pain
- Individualized, specific and consistent with symptoms or to confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
- Consistent with the generally accepted professional medical standards as determined by the Centers for Medicare & Medicaid Services (CMS), and not be experimental or investigational
- Furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.

Services that are described as medically necessary to be furnished in a hospital on an inpatient basis must be 1) consistent with the provisions of appropriate medical care, and 2) be effectively furnished more economically than on an outpatient basis.

Medical necessity decisions are objective, based on medical evidence and applied according to the individual needs of the member and an assessment of the local delivery system. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with the medical director or physician advisor. All denial decisions are made by appropriately licensed and qualified physicians. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in and of itself, make such care, goods or services medically necessary, a medical necessity, or a covered service/benefit.

5.1.2 - Prior Authorization/Admission Review

To view a list of services requiring prior authorization, please visit the website www.alphacare.com. AlphaCare of New York requires that the primary care provider be responsible for referring our members to a specialist, ancillary provider and/or elective procedures performed in an ambulatory surgical center or hospital. If a provider has questions regarding to whom referral requests should be submitted, please contact AlphaCare of New York Member Services or the UM department for clarification.

Prior authorization must be requested through AlphaCare's utilization management department, which is available 8 a.m. to 5 p.m. Monday through Friday. Requests for authorization can be made 24 hours a day via fax. Please utilize the prior authorization form enclosed in this manual. Services that require a prior authorization that are rendered without authorization will be denied for payment.

AlphaCare of New York may allow a standing authorization to be approved for members with chronic or disabling conditions. Providers should specifically request these authorizations when working with AlphaCare of New York Care Managers on plans of care for their patients.

5.1.3 - Self-Referral

Alphacare encourages our members to coordinate all of their care with their primary care physicians, but allow self referral for a range of services that includes preventive care as well as routine acute care. AlphaCare members may self-refer for the following services:

- Screening for breast, cervical and colorectal cancerSelect Outpatient Behavioral health
- Influenza and pneumococcal vaccinations
- Routine physical examinations, prostate cancer screening and preventive women's health services

In general, Medicare members must use plan providers except in emergency or urgent care situations, or for out of area renal dialysis. If a member obtains routine care from out of network providers, neither Medicare nor AlphaCare New York will be responsible for the costs

5.1.4 - Referral Guidelines

Primary care providers (PCPs) are responsible for providing all routine health care services, including preventive care, to their enrolled members. However, AlphaCare New York recognizes that in many circumstances, members may require care that is outside the scope of their PCP and must be rendered by qualified specialists. A referral is required from the PCP for an initial visit to a specialist. Refer to prior authorization guidelines to determine if prior authorization is required for that specialty.

To refer a member to the specialist, the PCP provides

his or her NPI number to the specialist, and that specialist must submit the claim with the PCP's NPI in the referring physician box.

In circumstances where medically necessary care cannot be provided by in-network providers, care can be provided by an out-of-network provider. In these exceptional cases, the authorization request must be submitted by the PCP. All non-emergent out-of-network services require a prior authorization.

The PCP must establish office procedures to facilitate follow-up on member referrals and consultations. The PCP is responsible for obtaining and maintaining, in the integrated medical record, the results of findings of consultant referrals. If findings were communicated through telephonic consultation, a summary of the findings and name of the specialist must be documented.

Providers may refer members to our Care Management Program or they may refer themselves. The member has the right to opt out of the program. If you would like to refer a member to the Care Management program or need additional information, please use our online Referral Form found at www.alphacare.com or call 1-855-652-5742 for more information or assistance.

There are separate prior authorization guidelines for AlphaCare New York members. Please be sure to verify a members' eligibility and refer to the appropriate prior authorization guidelines for prior authorization requirements. You may contact Provider Network Management for a copy to be sent to your practice, or go to our website at:

www.alphacare.com

Primary Care Provider(PCP) Referral to a Contracted Specialist

If prior authorization is NOT required from AlphaCare of New York for the referral, the provider may fax the completed prior authorization/referral form (on page xx of this manual) along with pertinent documentation, contact name and phone number directly to the contracted specialist, and notify the member that they may schedule an appointment.

If prior authorization is required, you may get the authorization form from our website, call our prior authorization department during business hours, or fax the completed prior authorization form to the prior authorization department. Please include ICD-9 (or its successor) and CPT code(s), pertinent documentation, and a contact name and phone and fax numbers with area code.

If the request is approved, an authorization is issued Once authorization is obtained, fax the prior authorization form with the authorization number to the contracted specialist and notify the member that they may schedule an appointment.

Note: It is the responsibility of the specialist to verify member eligibility at each appointment, prior to rendering services. Services will not be reimbursed if a member is not eligible on the date of service.

Specialists must refer to the prior authorization guidelines to determine what services may be rendered without obtaining prior authorization.

If follow-up visits are needed, refer to the prior authorization guidelines to determine if an authorization is required for additional visits to the selected specialty.

If prior authorization is NOT required, the specialist may proceed with scheduling follow-up visits to see the member.

If prior authorization is required, the specialist or PCP must request a prior authorization. A legible consult note or clearly written documentation must also be attached to support the request, along with appropriate ICD-9 (or its successor) and CPT code(s) and a contact name and phone number with area code. A list of services requiring prior authorization can be found at www.alphacare.com

The specialist or PCP may request an authorization for the entire treatment plan as long as the consultation notes have been submitted.

If surgery or a special procedure is required, the specialist or PCP must request a prior authorization using the prior authorization form. A legible consult note or clearly written documentation must also be attached to support the request, along with appropriate ICD-9 (or its successor) and CPT code(s), the name of the contracted facility where services will be rendered and a contact name and phone number with area code.

Prior authorization requests for surgery must be

completed at least 14 days prior to the date of the surgery unless it is an emergency situation.

Copies of the consultation and any follow-up notes must be provided to the member's PCP.

5.1.5 - Concurrent Review

Concurrent review is the evaluation by utilization management nurses and care managers of medical necessity for continued admission and/or the appropriateness of services provided during a member's stay in an inpatient setting, including, but not limited to, Skilled Nursing Facility ("SNF"), Long Term Acute Care Hospital ("LTAC") and Inpatient Rehabilitation facility. The nurses and care managers will also assist with continuity of care between health settings.

Concurrent review decisions are made utilizing the following criteria:

- MCG (Milliman Care Guidelines) criteria;
  - » Milliman guidelines provide evidence-based guidance to AlphaCare staff and providers and help drive effective care. Milliman provides access to globally sourced, clinically validated best practices that support clinical decision-making. These guidelines help drive effective care for AlphaCare members, resulting in better outcomes and contained costs.
- CMS National Coverage Guidelines
- NY State Department of Health Guidelines

These review criteria are utilized as a guideline. Decisions will take into account the member's medical condition and co-morbidities. The review process is performed under the direction of AlphaCare's Medical Director.

The concurrent review process includes:

- Obtaining necessary information from appropriate facility staff and providers regarding the clinical status, progress and care being provided to members
- Assessing the clinical status and the ongoing delivery of medical services and treatments to members to determine benefits coverage
- Notifying health care and behavioral health providers of coverage determinations in the appropriate manner and within the appropriate time frame
- Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting and an effective transition in care
- Identifying members for referral to additional programs, including AlphaCare's Care Management program and Chronic Condition Improvement Program.

Concurrent review may be conducted by phone, fax or onsite at the facility where care is delivered.

Discharge planning is an integral part of inpatient concurrent review. Recognizing and planning for discharge needs and transitions of care begin at the time of notification and continue throughout the hospital stay. When members are ready for discharge, a member of the AlphaCare of New York health services team will reach out to the member to support a successful transition in care.

Frequency of the reviews will be based on the clinical condition of the member. The frequency of the reviews for extension of initial determinations is based on the severity/complexity of the patient's condition, necessary treatment, and discharge planning activity including possible placement in a different level of care.

The treating provider and the facility utilization review staff will provide review information that is collected telephonically or via fax.

When a hospital determines that a member no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a Quality Improvement Organization (QIO) review. Prior to requesting a QIO review, the hospital should consult with the AlphaCare Utilization Management nurse.

5.1.6 - Discharge Planning

The goal of the discharge planning process is to follow members through the continuum of levels of care until they are returned to their previous living condition or lowest level of care possible prior to hospitalization. If the PCP was not the attending physician for the member while hospitalized, all efforts will be made to notify him/her of any arrangements made for the member. This may be done by one of the following mechanisms:

- Dictated hospital summary note

from the attending physician

- Phone call from the attending physician
- Phone call from the AlphaCare of New York UM nurse or Nurse Case Manager
- Inpatient Hospital Notification Form faxed by the hospital case manager.

AlphaCare works with the treating physicians and hospital staff to plan discharges and to identify and provide the appropriate level of care as well as medically necessary support services for members upon discharge from an inpatient setting. Discharge planning begins upon notification of the member's inpatient status to facilitate continuity of care, post-hospitalization services, and referrals to a skilled nursing or rehabilitation facility, evaluating for a lower level of care, identifying and coordinating home care services, and maximizing services in a cost effective manner. As part of the UM process, AlphaCare will provide for continuity of care when transitioning members from one level of care to another. The discharge plan will include a summary evaluation of the member's health need and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional setting. This will be based on the information received from the institution and/or provider caring for the member.

5.1.7 - Retrospective Review

Retrospective review is the medical necessity review performed after services have been rendered. AlphaCare of New York reserves the right to perform a retrospective review of care provided to a member for any reason. There may also be times during the process of concurrent review (especially telephonic) that the UM nurse does not receive sufficient information to meet the criteria (e.g., Milliman Care Guidelines). When this occurs, the case will be pended for a full medical record review to the Medical Director or designated physician reviewer. All retrospective review decisions are to be completed within 30 business days of obtaining all necessary information. Notification of retrospective review denials will be in writing to the member and the provider. When a retrospective UM review indicates that there has been an inappropriate provision of care, the case will be referred to the Quality Management department for further investigative review and follow-up.

Retrospective reviews may also be conducted to support our claims department. Retrospective reviews are performed after healthcare services have been provided. AlphaCare conducts retrospective reviews of inpatient admissions that were not reviewed concurrently if all of the conditions listed below are met. Retrospective review is a conditional evaluation of the medical necessity for services that were not pre-authorized or failure to provide clinical information. As long as all of the conditions listed below are met, AlphaCare will perform Medical Management review activities that afford timely, comprehensive retrospective review based on the AlphaCare clinical criteria. AlphaCare will make retrospective determinations within thirty (30) days of receiving the necessary information.

AlphaCare may deny coverage on medical necessity grounds for a previously authorized service only if any of the following conditions have been met:

- The medical information presented upon retrospective review is materially different from the information presented at the time of prior authorization
- The medical information presented at retrospective review existed at the time of prior authorization but was not provided at the time
- AlphaCare was not aware of the additional information at the time of prior authorization; and had AlphaCare been aware of the additional information, it would have not authorized the service

5.1.8 - Criteria for Utilization Management Determinations

UM utilizes review criteria that are recognized and based on sound scientific medical experience. Providers with an unrestricted license, professional knowledge and/or clinical expertise in the area actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

The UM program uses numerous sources of information including, but not limited to the following list when making coverage determinations:

- Member Benefits
- Milliman
- CMS National Coverage Guidelines
- NY State Department of Health Guidelines

The nurse reviewer and/or Medical Director apply

medical necessity criteria in the context of the member's individual circumstances and capacity of the provider delivery system.

5.1.9 - Organization Determinations

For all organization determinations, providers may contact AlphaCare by mail, phone, or fax.

AlphaCare requires prior authorization and/or pre-certification for:

- All non-emergent and non-urgent inpatient admissions except for normal newborn deliveries;
- All non-emergent or non-urgent, out-of network services (except out-of-area renal dialysis);
- Outpatient surgery; and
- Service requests identified in the AlphaCare Authorization Guidelines that are maintained within the UM Department. Refer to AlphaCare Quick Reference Guide on AlphaCare's website at https://www.alphacare.com

For initial and continuation of services, AlphaCare has appropriate mechanisms to ensure consistent application of review criteria for authorization reviews, which include:

- Medical Necessity – approved medical review criteria will be referenced and applied;
- Inter-rater reliability – a process that evaluates the consistency of decisions made by licensed staff when making authorization decisions and ensures the consistent application of medical review criteria; and
- Consultation with the requesting provider when appropriate.

Standard Organization Determination – An organization determination will be made as expeditiously as the member's health condition requires, but no later than 14 calendar days after AlphaCare receives the request for service. An extension may be granted for 14 additional calendar days if the member requests an extension, or if AlphaCare justifies a need for additional information and documents how the delay is in the interest of the member.

Expedited Organization Determination – A member or any provider may request that AlphaCare expedite an organization determination when the member or his or her provider believes that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The request will be made as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the member's or provider's request.

AlphaCare's organization determination system provides authorization numbers, effective dates for the authorization, and specifies the services being authorized. The requesting provider will be notified verbally via telephone or fax of the authorization.

In the event of a favorable or an adverse determination, AlphaCare will notify the member and the member's representative (if appropriate) in writing and provide written notice to the provider. Written notification to providers will include the Utilization Management Department's contact information to allow providers the opportunity to discuss the adverse determination decision. The provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Utilization Management Department. The member may request a copy of the criteria used for a specific determination of medical necessity by contacting Member Services.

5.1.10 - Reconsideration Requests

AlphaCare provides an opportunity for the provider to request a reconsideration of an adverse determination within three (3) business days of the decision. The requesting provider will have the opportunity to discuss the decision with the clinical peer reviewer making the denial determination or with a different clinical peer if the original reviewer cannot be available within one business day of the provider request. AlphaCare will respond to the request within one (1) business day.

5.1.11 - Transition of Care

If a new member has an existing relationship with a provider who is not part of AlphaCare's provider network, AlphaCare will permit the member to continue an ongoing course of treatment by the non-participating provider during a transitional period.

AlphaCare will honor any written documentation of prior authorization of ongoing Covered Services for a period of 60 calendar days after the effective date of enrollment.

For all members, written documentation of

prior authorization of ongoing services includes the following, provided that the services were prearranged prior to enrollment with AlphaCare:

- Prior existing orders;
- Provider appointments (e.g., dental appointments, surgeries, etc.); and
- Prescriptions (including prescriptions at non-participating pharmacies).

AlphaCare cannot delay service authorization if written documentation is not available in a timely manner. Contact the Claims Department for claims payment or claims resolution issues and The Network Provider Relations Department for rate negotiations.

Members who are inpatient at the time of disenrollment from AlphaCare will be covered by AlphaCare throughout the acute inpatient stay, however, AlphaCare will not be responsible for any discharge needs the member may have. For members admitted under coverage of another health plan, Alphacare will not be responsible for the inpatient stay, but will participate in the discharge planning process when notified of the admission.

AlphaCare will take immediate action to address any identified urgent medical needs.

Continued Care with a Terminated Provider

When a provider terminates or is terminated without cause, AlphaCare will allow members in active treatment to continue either through the completion of their condition (up to 90 calendar days) or until the member selects a new provider.

AlphaCare will inform the provider that care provided after termination shall continue under the same terms, conditions and payment arrangements as they existed in the terminated contract. If an obstetrical provider terminates without cause and requests approval for treatment for a pregnant member who is in treatment, the member will be allowed to, when medically necessary, continue care according to the state regulations. Under Medicare guidelines, the member will be permitted to continue care until the member's post-partum visit is completed.

If a provider is terminated for cause, AlphaCare will direct the member immediately to another participating provider for continued services and treatment.

5.2 - Care Management Programs

AlphaCare offers care management services to facilitate patient assessment, care coordination, care planning and advocacy to improve health outcomes for patients. AlphaCare supports the treatment plans developed by the providers and the interdisciplinary care team and relies on its providers to help coordinate the placement and cost-effective treatment of patients who are eligible for AlphaCare's Care Management Programs.

AlphaCare's Care Management teams are led by specially trained Registered Nurses, and Licensed Clinical Social Worker Case Managers who assess the member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan.

The Care Managers work collaboratively with PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

AlphaCare's Care Management teams also support the PCP and/or Behavioral Healh provider and assist in actively linking the member to other providers, medical services, residential, social and other support services, as needed. Providers may request care management services for any member.

The Care Management process begins with member identification and follows the member until discharge from the Program. Members may be identified for Care Management in various ways, including:

- a referral from a member's PCP;
- self-referral;
- referral from a family member;
- after completing a Health Risk Assessment; and
- data mining for members with high utilization, high risk conditions and gaps in care.

AlphaCare's belief is that the Care Management Program is an integral management tool in providing support for members across the continuum of care. Key elements of the Care Management process include:

- **Clinical Assessment and Evaluation** – a comprehensive assessment of the member is completed to determine where she or he is in the health continuum. This assessment gauges the member's support

systems and resources and seeks to align them with appropriate clinical needs;

- **Care Planning**
– collaboration with the member and/ or caregiver as well as the PCP to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the provider's plan of care;
- **Service Facilitation and Coordination**
– working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/ or caregiver or as complex as arranging services, transportation and follow-up; and
- **Member Advocacy**
– members are a key participant in the inter-disciplinary care team. The Care Management process advocates on behalf of the member within the health care system. Care Managers engage members in their health and treatment plan and assist them with seeking the services to optimize their health status. Care Management emphasizes continuity of care for members through the coordination of care among physicians and other providers.

Members commonly identified for AlphaCare's Care Management Program include:

- Multiple Chronic Conditions – multiple co-morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple barriers to quality health care (i.e., transportation, lifestyle risks, poor social connectivity, etc.);
- Transplantation – organ failure, donor matching, post-transplant follow-up; and
- Complex Discharge Needs - members discharged home from acute inpatient or SNF with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.
- Multiple ER visits
- Multiple hospitalizations
- Members requiring skilled nursing care
- Acute behavioral health issues

Care Managers work closely with the provider regarding when to discharge the member from the Care Management Program. Reasons for discharge from the Care Management Program may include:

- The member is meeting primary care plan goals;
- The member has declined additional case management services;
- The member has disenrolled from AlphaCare; and/or
- The member is unable to be located by AlphaCare.

In addition to the care management activities described above, AlphaCare has a Chronic Care Improvement Program (CCIP) for Cardiovascular Disease. This program is offered to all eligible members identified with CHD risk factors and diagnosed with coronary heart disease (CHD)/ coronary artery disease (CAD)   Our Cardiovascular Disease CCIP incorporates education, motivational and emotional support, easy to read materials, and group and individual resources in alignment with the member's conditions, needs, and readiness for behavior change. Interventions vary based on member stratification.

Members are identified for participation in the program through several avenues, one of which is provider referrals. If you have a patient who you believe may benefit from the program, please complete the referral form located on the AlphaCare website at alphacare.comand fax to the number on the form. If you have any questions about the Cardiovascular Disease CCIP program, please contact us at use AC's member service number

5.2.1 - Provider Access to Care Management

AlphaCare's Member Outreach Program assists new members in their transition from Medicare or another managed care organizations to AlphaCare. The program involves outreach to these members prior to their effective date, or within the first 30 days, of their enrollment. During this outreach, members are gauged for their health care needs including, but not limited to, their primary and specialist providers, current prescriptions, DME and home health. Members are also screened for eligibility for AlphaCare's Care Management Programs, and any additional behavioral health care needs.

If you would like to refer an AlphaCare member as a potential candidate to our Care Management Program or would like more information, you may

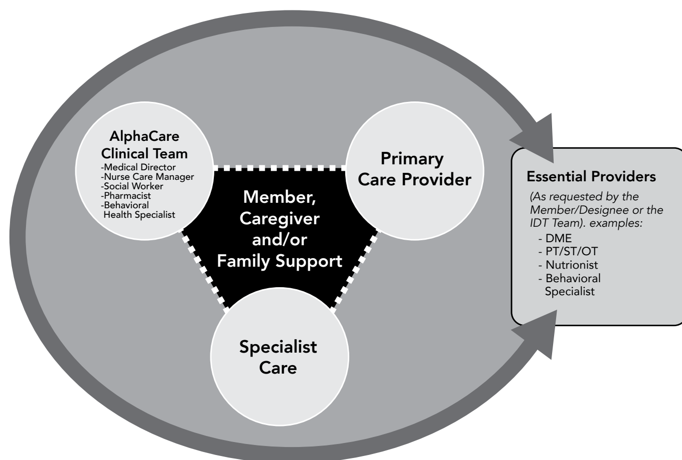
call our Care Management Line or complete the Care Management Referral form located on our website and on page xx of this manual.

5.2.2 - Interdisciplinary Care Team (AlphaCare Signature)

The FIDA interdisciplinary team (IDT) provides the framework to develop, coordinate and deliver the plan of care and to provide appropriate staff and program oversight to achieve the SNP goals. The Care Management staff assumes an important role in developing and implementing the individualized care plan, coordinating care and sharing information with the interdisciplinary care team and with the member, their family or caregiver.

Practitioners providing care to our SNP members are important members of the SNP interdisciplinary team. As such, they participate in one of our regularly scheduled care coordination or case rounds meetings to discuss their plan of care and the health status of the SNP-enrolled patient. These practitioners also share their progress with the team to ensure we are meeting our SNP program goals.

The graphic below describes the AlphaCare Signature IDT team:



To ensure collaboration between all parties involved with the member's care, the members of the IDT can and will change, if a member's medical and/or behavioral health status shifts, a change in housing status occurs, or a change has occurred in the member's home or community supports. The Care Manager, in conjunction with the member and the PCP, determine the need for additional professional participants and extends an invitation to participate in the IDT Care Plan review. These practitioners may include, but are not limited to:

Long term support service providers involved in the member's care including, but not limited to:

- Adult day health care providers, home health agency staff, personal care
- attendants and other behavioral health specialists
- AlphaCare Care Management staff
- PCPs and midlevel practitioners
- Medical specialist(s)
- Rehabilitation therapists (OT,PT and ST)
- Nutritionists
- Other providers as neededInterpreters to accommodate member language needs
- The specific goals of the AlphaCare Signature plan are to:
- Improve member access to medical, behavioral health and social services
- mprove member access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and providers
- Improve access to preventive health services
- Assure appropriate utilization of services
- Improve beneficiary health outcomes

5.2.3 - Model of Care SNPs Meet Our Members' Special Needs

Medicare Special Needs Plans (SNPs) are special Medicare plans with custom designed benefits to serve a specific segment of the Medicare population. Enrollment in a SNP is limited to Medicare beneficiaries who meet the medical or situational criteria for that SNP. AlphaCare offers two types of SNPs – one that serves individuals who are eligible for and enrolled in Medicare and Medicaid (D-SNP), and a SNP that serves individuals who reside in nursing homes (I-SNP).

AlphaCare's SNPs are named as follows:

D-SNP: AlphaCare Total
I-SNP: AlphaCare Resilience

Our SNP Model of Care Includes:

- Comprehensive Provider Network
- Multi-channel Communication with providers and members (e.g. digital, face to face, written, online and telephonic)
- Additional Benefits (e.g. OTC medication stipend, routine annual eye exam, one routine hearing exam every year, etc.)
- Case Management
- Annual Health Risk Assessments
- Individualized Care Plans for Each Member
- A care team, called an interdisciplinary care team (IDT) to Coordinate Care
- Management of Care Transitions
- Coordination of Medicare and Medicaid Benefits
- Quality Improvement Program

The SNP Model of Care requires that all SNP members receive an initial Health Risk Assessment (HRA) within 60 days of enrollment and that a Care Plan (CP) be created for each member. The purpose of the CP is to encourage the early identification of the member's health status, and allow coordinated care to improve the member's overall health.

Health Risk Assessment (HRA): All SNP members receive an initial Health Risk Assessment within 60 days of enrollment and are annually assessed within one year of the last assessment. The HRA is used in care plan development and member risk stratification. AlphaCare team members and/or the member are responsible for obtaining the HRA.

Care Plan (CP): All SNP members have an individualized Care Plan that address the member's particular needs and is shared with the member, the member's primary care provider, and others who are involved in the member's care, such as behavioral health providers and the member's Interdisciplinary Care Team. The CP for each member is developed based partially on the answers to the HRA.

Interdisciplinary CareTeam (IDT): All SNP members are assigned to an Interdisciplinary Care Team that will coordinate the delivery of services and benefits. Based on the HRA and the member's primary behavioral and physical health conditions and risk factors, the composition of the care team is identified. The IDT comprises the member and/or designated representative, primary treating providers, AlphaCare of New York care manager and a care coordinator who helps the member navigate through the physical and behavioral health delivery systems. The AlphaCare care management teams help ensure that the member receives all necessary health services in order to live independently in the community.

Participating providers are the key to our success in meeting the needs of our members. Our model is built to meet the medical and behavioral health care needs of our members. The level of support and coordination provided depends on the needs of the individual members. Our IDT deploys a broad set of tools, resources and reports.

Our model of care process begins with the completion of a health assessment within 60 days of a member's enrollment. The IDT, including the primary care provider, is expected to meet within 30 days of completion of the health assessment to develop a coordinated, individualized plan of care for each member.

AlphaCare of New York care managers and care coordinators work collaboratively to coordinate care with member, the primary care provider and other providers to ensure that all care and services are coordinated and integrated into the member's comprehensive treatment plan.

Working with our providers, AlphaCare of New York believes we can leverage our strength, experience and expertise to improve health outcomes for AlphaCare members in our community.

The AlphaCare Model of Care is Member Centric:

- Member may opt out of program at any time
- Member participates in a Health Risk Assessment and development of their individualized Care Plan
- Member agrees to the goals and interventions of their Care Plan
- Member informed of interdisciplinary team members and meetings
- Member either participates in the IDT meeting or provides input through the Care Manager or their designee and is informed of the outcomes

The IDT meets regularly to manage the medical, cognitive, psychosocial, and functional needs of the member. The member is included on the IDT

whenever possible:

- Required Team Members
  - » Member or Member Designee
  - » Care Manager
  - » Primary Care Provider
  - » Home Health Aide/ PCA
  - » Social Services Expert
  - » Mental/Behavioral Health Expert – when indicated
- Additional Team Members
  - » Pharmacist
  - » Health Educator
  - » Pastoral Specialist
  - » Nutrition Specialist
  - » Nursing/Disease Management
  - » Restorative Specialist
  - » Provider Specialists

5.2.3.1 - Provider Responsibility

The Provider Role in the IDT is to:

- Participate in IDT meetings and other care coordination activities
- Communicate with the IDT including the member's assigned Care Manager, specialty providers, members and caregivers
- Support the transitions in care process after hospitalization
- Support medication reconciliation. Review and respond to patient – specific communication
- Maintain the Interdisciplinary Care Plan in the member's record

Section 6: Quality Improvement

6.1 - Quality Improvement Activities

AlphaCare's Quality Improvement program is designed to continually monitor, evaluate and improve the quality and accessibility of the health care received by our members.
Providers in the AlphaCare network are expected to take an active role in the Quality Improvement Program, by supporting medical record documentation as requested for HEDIS/STARs/QUARR data collection, for adverse event and incident investigation, and for other treatment record review procedures, including Medicare Risk Adjustment (MRA) documentation.
QI works to:

- Ensure the maintenance of appropriate clinical practice and preventive health guidelines.
- Monitor provider compliance and establish AlphaCare standards
- Track adverse events and assure their timely resolution
- Compliance with the QI activities and reporting requirements of federal, state and local regulatory agencies.

6.2 - Clinical Practice Guidelines

AlphaCare adopts validated evidence-based Clinical Practice Guidelines and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede CPGs, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual members and populations. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the Quality Improvement Committee. CPGs are available upon request and may be requested through the Utilization Management Department.

6.3 - Healthcare Effectiveness Data and Information and Coding

Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90% of America's managed care organizations to measure performance on important dimensions of care and service. The tool comprises 80 measures across five domains of care, including:

- Effectiveness of Care;
- Access and Availability of Care;
- Experience of Care;
- Health Plan Descriptive Information; and
- Utilization and Relative Resource Use.

The collection of HEDIS measures is a mandatory process that occurs annually. It is an opportunity

for AlphaCare and providers to demonstrate the quality and consistency of care that is available to members that can be compared to national and local benchmarks and relative performance across providers. Medical records and claims data are reviewed to capture required data. Compliance with HEDIS standards is reported on an annual basis with results available to providers upon request. Through compliance with HEDIS standards, members benefit from the quality and effectiveness of care received and providers benefit by delivering industry-recognized standards of care to achieve optimal outcomes.

6.4 - Medicare Star Rating System

The Medicare Star Rating System is the CMS rating system for evaluating the relative quality of private plans offered to Medicare beneficiaries through the MA program. Plans are measured on a 1 – 5 star scale. Star ratings exist for both Part C and Part D and focus on a variety of quality and service metrics.

Star scores are published on the CMS website, http://www.medicare.gov/index.html, for members to evaluate health plans during the Annual Enrollment Period (AEP). Plans with a five-star rating receive a “High Performing Icon” on the website and plans with less than a three-star rating for the past three years receive a “Low Performing Icon” on the website. Plans are also eligible for a bonus in premium from CMS if they have a four-star or higher rating.

Key Components:

- HEDIS: Clinical performance indicators (access to care, receipt of preventive services, and management of chronic conditions).
- Consumer Assessment of Healthcare Providers and Systems (CAHPS): Survey to evaluate member satisfaction with providers, health plan, and overall experience.
- Medicare Health Outcomes Survey (HOS): Survey to evaluate physical and mental health and quality of life of Medicare beneficiaries.
- Administrative Measures: Complaints, customer service, appeals, disenrollment, and audit performance.
- Part D (Pharmacy) Measures: Medication adherence and access to affordable drugs.

6.5 - Risk Adjustment: Member Diagnosis Information and Correct Coding

Risk adjustment is a key component for financing health care services for those enrolled in Medicare Advantage (MA) plans. The Centers for Medicare & Medicaid Services (CMS) adjusts premiums paid for members based on their health status. The health status of a member is determined through diagnosis codes. Medicare Risk Adjustment (MRA) is applied to every Medicare Advantage plan and its members.

By providing payment that is based on beneficiary health status, CMS more accurately covers a given member’s anticipated health expenditures by taking into account the variation in per capita cost that occurs, based on the health status of individual beneficiaries. Also, CMS does not overpay for beneficiaries who utilize fewer resources and therefore reduces any incentive for providers or health plans to favor these beneficiaries.

Provider Responsibilities

Providers are responsible for maintaining complete and accurate medical records which are patient specific, person centered and documentation that meets both CMS and industry standards including the American College of Physician documentation conventions for ICD-9 (soon to be ICD-10) convention, CPT 4 procedure codes or other relevant industry norms for documenting clinical information in patient charts and for coding claims and encounter information to AlphaCare regarding services provided to AlphaCare Members. From time to time, AlphaCare will conduct chart reviews, file audits or other quality checks to validate the accuracy, specificity, completeness of the medical record documentation that supports those claims and encounters that have been submitted by providers for services rendered to AlphaCare members. Providers are expected to fully cooperate with the plan or its designee in the conduct of these reviews or in related educational activities designed to educate providers on “best practices” in documentation and coding protocols and in improving areas of documentation deficiencies as may be noted from time to time.

Member Benefits

Accurate and complete diagnosis data assist health plans in identifying members who may benefit from disease and case management programs. More

accurate health status information can be used to match health care needs with the appropriate level of care.

6.6 - Member Satisfaction

AlphaCare periodically surveys members to measure overall customer satisfaction, including satisfaction with the care received from providers. AlphaCare reviews survey information and shares the results with network providers.

Members are also surveyed by CMS twice a year through the CAHPS and HOS surveys. The results of both CMS surveys are part of the Medicare Advantage plans' HEDIS and star ratings. AlphaCare encourages its participating providers to encourage members to actively participate in their health care, to receive preventive services timely and to improve their quality of life by following the provider's treatment plan. See the Centers for Medicare & Medicaid Services Star Ratings section of this manual.

6.7 - Medical Records

AlphaCare requires its practitioners to maintain accurate medical records.

The medical record should be comprehensive and contains information about each member, identifies the patient's complaints/symptoms or lack thereof, contains the diagnosis and basis for the diagnosis, the communication and discussion of treatment options, side effects, decisions made and treatments rendered. The primary purpose of the record is to document the course of the member's health or illness and treatments and serve as a mode of communication between physicians and other professionals participating in the care rendered. The entire medical record of an active member must remain in the primary care physician's office and must be consistent with all relevant local, state and federal laws, rules and regulations.

The following guidelines assist AlphaCare in assuring the appropriate exchange and retention of member medical data and are used to perform clinical audits in conjunction with ongoing quality improvement activities.

Please note that AlphaCare may request a copy of, or make an on-site visit to review, your medical records for internal and regulatory chart audits.

6.7.1 - Member Medical Records Standards

Medical records should be comprehensive and reflect all aspects of care for each member.

Records are to be maintained in a secured, timely, legible, current, detailed and organized manner which conforms to good professional medical practice. Records should be maintained in a manner that permits effective, professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment.

Complete medical records include, but are not limited to:

- medical charts;
- prescription files;
- hospital records;
- provider specialist reports;
- consultant and other health care professionals' findings;
- appointment records;
- and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided.

Medical records must be signed and dated.

6.7.2 - Advance Directives

Advance directives are written instructions, recognized under state law, which relate to the provision of health care when the individual is incapacitated and unable to communicate his/her desires. Examples include such documents as a living will, durable power of attorney for health care, health care proxy or do not resuscitate (DNR) request. AlphaCare counts on its practitioners to honor a member's request regarding the type of care stipulated under an advance directive.

Living Will: The living will is the patient's declaration of how he/she wants to be treated in certain medical conditions, whether he or she wishes to be given life-sustaining treatment and may also express preferences as to treatment when medical conditions render them permanently unconscious, without detectable brain activity.

Health care proxy: This document appoints a person to make medical decisions for the patient in the

event that he or she is unable to do so.

Our practitioners should discuss advance directives with their patients (as appropriate) and file a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should clearly indicate that said document is included.

Section 7: Claims

7.1 - Overview

Clean claims for AlphaCare members are generally adjudicated within 30 calendar days from the date AlphaCare receipt of the claim. Any non-clean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, and the date the claim was received by AlphaCare. AlphaCare produces and mails an Explanation of Payment (EOP) on a weekly basis. The EOP delineates for the provider the status of each claim that has been paid or denied during the previous week.
AlphaCare members must not be balance billed for services rendered as outlined in the participating provider agreement. Reimbursement by AlphaCare constitutes payment in full except for applicable copays, deductibles and coinsurance. These amounts will be indicated on the EOP and direction provided based on whether AlphaCare is responsible for processing both the primary and secondary claims or not. In instances where AlphaCare is only responsible for processing primary claims, the provider should bill the state Medicaid agency, as would be the standard practice in the Medicare fee-for-service program for AlphaCare Total & Signature plan members.

Provider must use HIPAA-compliant billing codes when billing. The provider must also follow Medicare National Correct Coding Initiative guidelines "NCCI" or "CCI"). This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the participating provider agreement will not be required to replace such billing codes. AlphaCare follows Strategic National Implementation Process (SNIP) level 1 through 6 editing for all claims received in accordance with HIPAA. AlphaCare will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim "Corrected Claim." Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim, due to the original claim not being a clean claim.

7.2 - Electronic Claims Submission

Providers are strongly encouraged to submit to AlphaCare using electronic claim processing option. Providers must submit claims within the timely filing limit of 120 days from the date of discharge for inpatient services or from the date of service for outpatient services.

Electronic claims submission is available through:

MDOnline – Claim Payer ID# ALPHA

The advantages of electronic claims submission are as follows:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims

To initiate the electronic claims submission process or obtain additional information, please contact the Provider Services at 1-855-652-5742

7.3 - Paper Claims Submission

Providers also have the option of submitting paper claims. AlphaCare uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures.

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed CMS 1450 (UB-04) or

CMS-1500 (02-12) within 120 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and NUBC, AlphaCare requires the use of the new CMS-1450 (UB-04) for the purposes of accommodating the National Provider Identifier ("NPI").

CMS-1500 (02-12) and CMS-1450 (UB-04) must include the following information (HIPAA-compliant where applicable):

- Patient's Plan ID number
- Patient's name
- Patient's date of birth
- ICD-9 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPCS codes/DRG codes
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician
- NPI of performing provider when applicable
- Coordination of Benefits/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other state-required data

AlphaCare will not accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. AlphaCare will not accept claims from those providers who submit entirely handwritten claims.

7.4 - Encounter Data

We require the submitting entity to submit all professional and institutional claims and/or encounter data for Medicare Advantage Customers:

To comply with regulatory requirements of the Balanced Budget Act (BBA)

- To submit to CMS for risk adjustment reporting and accurate Medicare reimbursement
- To comply with NCQA-HEDIS reporting requirements
- To provide the submitting entity with comparative data
- To produce the Provider Profile and Quality Index
- To facilitate utilization management oversight
- To facilitate quality management oversight
- To support Services 75 FR 19709 -Maximum Allowable Out-of-Pocket Cost Amount for Medicare Parts A and B
- To comply with CMS regulation 42 CFR 422.111(b)(12) which requires an EOB for Part C benefits
- To facilitate settlement calculations, if applicable

In order for AlphaCare to comply with the CMS regulations to report Customer cost share as well as out-of-pocket maximums, we require contracted providers to submit current, complete and accurate encounter data, including Customer cost share/revenue, to us within the CAS segment of the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned Medicare Advantage Customers.

Part C benefits, all encounter submissions from contracted providers with dates of service of January 1, 2014 and later must include all data fields contained in an ANSI ASC X12N 837 Health Care Claims transaction and follow guidance specified in the technical report document for the ANSI ASC X12N 837 Health Care Claims transaction implementation guide.

We will continuously monitor encounter data submissions for quality and quantity. Submission

levels below the desired monthly threshold of 100% will be considered non-compliant. The capitated medical group/IPA, or other submitting entity, must correct any encounter errors identified by a clearinghouse or trading partner on a monthly basis at a minimum. As a capitated delegated entity processing claims on our behalf, it is our expectation that all encounter submissions are accurate reflection of the original claim received without exception. All encounter data submitted to AlphaCare is subject to federal audit. We have the right to perform routine medical record chart audits on any or all participating providers at such time or times as we may reasonably elect to determine the completeness and accuracy of encounter data ICD-9 and CPT coding. The participating shall be notified in writing of audit results pertaining to coding accuracy. As outlined in your participation agreement, the participating providers may be subject to financial consequences if it or another submitting entity fails to submit or meet the encounter data element requirements. In addition, the participating providers may be required to perform a complete medical record chart audit of its participating physicians with notice from AlphaCare.

7.5 - Coordination of Benefits

AlphaCare and its providers agree Medicare coverage is primary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When AlphaCare is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if AlphaCare does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post-payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

AlphaCare will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, AlphaCare will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers.

AlphaCare requires members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at 1-855--652-5742.

7.6 - Claims Adjudication

AlphaCare is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-9 manuals. Institutional claims should be submitted using EDI submission methods or CMS-1450 (UB-04) and provider claims using the CMS-1500.

Providers must use HIPAA-compliant billing codes when billing AlphaCare. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. AlphaCare will not pay any claims submitted using noncompliant billing codes.

AlphaCare reserves the rights to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria are applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within 120 days from the date the service is rendered, or for inpatient claims filed by a hospital, within 120 days from the date of discharge.
- In the case of other insurance, submit the claim within 18 months from the date of service after receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system

- must be received within 120 days from the date the eligibility is added and AlphaCare is notified of the eligibility/enrollment.
- Claims submitted after the timely filing deadline will be denied. And subject to the provider dispute process.

After filing a claim with AlphaCare, review the EOP. If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by calling Provider Services at 1-855-652-5742. If the claim is not on file with AlphaCare, resubmit your claim within 120 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted in a timely manner
- Is accurate in services rendered and coding used to request for payment
- Is submitted on a HIPAA-compliant standard claim form, including a CMS-1500 or CMS-1450 or successor forms thereto or the electronic equivalent of such claim form
- Requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by AlphaCare

Clean claims are typically adjudicated within 30 calendar days of receipt. If AlphaCare does not adjudicate the clean claim within the time frames specified above, AlphaCare will pay all applicable interest as required by law.

AlphaCare produces and mails an EOP on a weekly basis, which delineates for the provider the status of each claim that has been adjudicated during the previous payment cycle. Upon receipt of the requested information from the provider, AlphaCare must complete processing of the clean claim within 30 calendar days.

Paper claims determined to be unclean will be returned to the billing provider along with the reason for the rejection. Electronic claims determined to be unclean will be returned to the AlphaCare contracted clearinghouse that submitted the claim.

In accordance with CMS requirements, AlphaCare will pay at least 95 percent of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 30 calendar days of the date of receipt. AlphaCare will pay or deny all other claims within 60 calendar days of the receipt of the request. The date of receipt is the date AlphaCare receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

7.7 - Claims Status

Providers should call Provider Services at 1-855-652-5742 to check claim status.

7.8 - Overpayment Status

Refund notifications may be identified by either, AlphaCare or the provider. The AlphaCare researches and notifies the provider of an overpayment by requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by AlphaCare, we will notify the provider of the overpayment. The provider will submit a Refund notification along with the refund check. If a provider identified the overpayment and returns the AlphaCare check, please include a completed explanation specifying the reason for the return. Once the AlphaCare has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the refund notification procedure, please call Provider Services at 1-855-652-5742.

7.9 - Claims Dispute Process

AlphaCare uses an automated claims auditing system, to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control

improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

Administrative Disputes

Please reference the explanation of payment received for the proper dispute/appeal process to submit your request. Note the process for appeals is different depending on whether or not the member can be held liable for any payments (member liability).

Member Liability Appeals

If a provider appeals a decision rendered with member liability, then the appeal follows the CMS Member Liability Appeals process and is processed by the Appeals and Grievance department. Add web address

Provider Liability Appeals

A provider liability appeal is a request for AlphaCare to review a decision by AlphaCare Health Services to deny payment (without member liability) for services already rendered. To submit a request, send in a copy of the original denial letter received along with all medical records. The provider is responsible for sending in all necessary information, and the appeal will be reviewed and a determination rendered based on the information provided.

Provider Payment Disputes

If you believe AlphaCare has not paid for your services according to the terms of your provider agreement, submit a request an Appeal. Providers will not be penalized for filing an appeal or payment dispute.

Submit provider liability appeals/payment disputes to:

Provider Liability Appeals/Payment Disputes
AlphaCare of New York
335 Adams Street, Ste 2600
Brooklyn, NY 11201

Provider Claims Adjudication Appeals

Should you disagree with non-clinical/administrative decisions related to a claim, you may avail yourself of our administrative appeal process. An "Administrative Appeal" is a request by a provider on his/her own behalf to reverse an administrative claim determination, including, but not limited to: a) payment amount; and b) denials in whole or in part due to scope of benefit coverage, Member eligibility, lack of authorization/referral, payor appropriateness, and late claim submission. Requests by providers on behalf of a Member and requests to reverse determinations governed by Article 49 of New York Public Health Law (i.e., clinical/utilization review determinations) are excluded from this definition and are addressed elsewhere in this manual.

Participating providers have sixty (60) days from receipt of an Explanation of Payments ("EOP") to submit an Administrative Appeal related to a claim contained therein. A separate Administrative Appeal must be submitted for each claim. To be accepted for consideration, the Administrative Appeal must (in addition to being timely):

- Be in writing;
- Contain sufficient information to conduct a review; and
- Include a copy of the EOP.

If an Administrative Appeal fails to include all required elements or is not received at the following address by the submission deadline, AlphaCare's payment of the claim will not be revisited:

AlphaCare of New York, Inc.
ATTN: Provider Appeals Unit
335 Adams Street, 26th Floor
Brooklyn, New York 11201

We make a decision on Administrative Appeals within forty five (45) days of receipt, although this timeframe may be extended for any particular appeal in AlphaCare's sole discretion (e.g., to account for complexity, additional documentation, etc.). The only written notice of our Administrative Appeal

decision will be either an updated EOP or a letter upholding the initial determination/original claim decision. Such notice constitutes our final internal decision related to the claim and no further internal review is available. Should a participating provider wish to challenge our Administrative Appeal decision, further appeal rights, if any, are as dictated by the provider's participation agreement (e.g., dispute resolution process, arbitration, etc.).

Pursuant to Section 3224 a(h)(1) of New York Insurance Law, should we receive an Administrative Appeal from a participating provider regarding a claim that was denied exclusively because it was submitted untimely, the denial will be reversed, subject to a potential twenty five (25%) reduction, if the provider is able to demonstrate that: a) his/her non-compliance with the applicable claim submission timeframe was the result of an unusual occurrence; and b) he/she has a pattern/practice of timely submitting claims. The foregoing will apply only if the claim had been submitted within one (1) year of the date of service.

7.10 - Benefits during Disaster and Catastrophic Events

Section 1135 of the Social Security Act authorizes the Health and Human Services Secretary to temporarily modify or waive certain requirements applicable to public health insurance programs to ensure that sufficient health care services are available to meet the needs of enrollees whenever and wherever an emergency is experienced. If a Section 1135 waiver is issued, AlphaCare will adhere to its scope to ensure that providers, who in good faith are unable to comply with certain requirements, are nonetheless reimbursed for services rendered. In the event of a Presidential emergency declaration, a Presidential disaster declaration, a declaration of emergency or disaster by the Governor, or other announcement of a public health emergency absent a 1135 waiver – AlphaCare will adhere to regulatory guidance received at the time. Action taken may include:

- Allowing members to receive services at specified non-contracted facilities;
- Waiving requirements for pre-authorization or pre-notification;
- Temporarily reducing out-of-network cost sharing to in-network cost sharing amounts; and/or
- Waiving the requirement that we notify members at least 30 days in advance of a change to their plan as long as the change (such as reduction of cost sharing and waiving authorization) benefits the member.

Typically, the agency that made the declaration will clarify when the disaster or emergency is over and plans will receive specific instructions as to how to process claims and communicate with providers and members. If, however, the disaster or emergency timeframe has not been closed within 30 calendar days from the initial declaration, and no end date has been indicated, AlphaCare may resume normal operations.

Section 8: Appeals and Grievances

8.1 - Appeals

8.1.1 - Provider Retrospective Appeals Overview

A provider may appeal a claim or utilization review denial on his or her own behalf by mailing or faxing AlphaCare a letter of appeal or an appeal form with supporting documentation such as medical records.

Providers have 90 calendar days from AlphaCare's original utilization management review decision or claim denial to file a provider appeal. Appeals after that time will be denied for untimely filing. If the provider feels that the appeal was filed within the appropriate timeframe, the provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of AlphaCare, a similar receipt from other commercial delivery services or an AlphaCare date and time stamped fax receipt.

Upon receipt of all required documentation, AlphaCare has 30 calendar days to review the appeal for medical necessity and conformity to AlphaCare guidelines and to render a decision to reverse or affirm. Expedited appeals will be reviewed in 72 hours. Required documentation includes the member's name and/or identification number, date of services, and reason why the provider believes the decision should be reversed. Additional required information varies based on the type of appeal being requested. For example, if the provider is requesting a medical necessity review, medical records should

be submitted. If the provider is appealing a denial based on untimely filing, proof of timely filing should be submitted. If the provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

Appeals received without the necessary documentation will not be reviewed by AlphaCare due to lack of information. It is the responsibility of the provider to provide the requested documentation within 60 calendar days of the denial to review the appeal. Records and documents received after that time will not be reviewed and the appeal will remain closed.

Medical records and patient information shall be supplied at the request of AlphaCare or appropriate regulatory agencies when required for appeals. The provider is not allowed to charge AlphaCare or the member for copies of medical records provided for this purpose.

8.1.2 - Provider Appeals Decisions

Reversal of Initial Denial

If it is determined during the review that the provider has complied with AlphaCare protocols and that the appealed services were medically necessary, the initial denial will be reversed. The provider will be notified of this decision in writing.

The provider may file a claim for payment related to the appeal, if one has not already been submitted. After the decision to reverse the denial has been made, any claims previously denied will be adjusted for payment.

AlphaCare will ensure that claims are processed and comply with federal and state requirements, as applicable.

Affirmation of Initial Denial

If it is determined during the review that the provider did not comply with AlphaCare protocols and/or medical necessity was not established, the initial denial will be upheld. The provider will be notified of this decision in writing.

For denials based on medical necessity, the criteria used to make the decision will be provided in the letter. The provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

8.1.3 - Member Reconsideration Process

Overview

A member reconsideration, also known as an appeal, is a formal request from a member for a review of an action taken by AlphaCare. A reconsideration may also be filed the member's behalf by an authorized representative or a provider with the member's written consent. The member appeals rights apply to members will also apply to the member's authorized representative or a provider acting on behalf of the member with the member's consent.

To request an appeal of a decision made by AlphaCare, a member may file a reconsideration request orally or in writing within 60 days from the date of the Notice of Action. If the member's request is made orally, AlphaCare will mail an acknowledgment letter to the member to confirm the facts and basis of the appeal.

Examples of actions that can be appealed include, but are not limited to:

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service; and/or
- The failure to provide services in a timely manner, as defined by CMS.

AlphaCare gives members reasonable assistance in completing forms and other procedural steps for a reconsideration, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability. AlphaCare ensures that decision-makers assigned to reconsiderations were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the reviewers will be health care professionals with clinical expertise in treating the member's condition/disease or will seek advice from providers with expertise in the field of medicine

related to the request.

AlphaCare will not retaliate against any provider acting on behalf of or in support of a member requesting a reconsideration or an expedited reconsideration.

Appointment of Representative

If the member wishes to use a representative, she or he must complete a Medicare Appointment of Representative (AOR) form. The member and the person who will be representing the member must sign the AOR form.

Prior to the service(s) being rendered, providers may appeal on behalf of the member if they have the member's consent in their records.

Types of Appeals

A member may request a standard pre-service, retrospective, or an expedited appeal.

Standard pre-service appeals are requests for services that AlphaCare has determined are not Covered Services, are not medically necessary, or are otherwise outside of the member's benefit plan.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the member has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review. These are the only appeals that may be made by the provider on his or her own behalf.

Only pre-service appeals are eligible to be processed as an expedited appeal.

Appeal Decision Timeframes

According to CMS guidelines, AlphaCare will issue a decision to the member or the member's representative within the following timeframes:

- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **30 or 60 calendar days** as applicable
- Expedited Request: **72 hours**

8.1.4 - Standards Pre-Service and Retrospective Reconsiderations

A member may file a reconsideration request either verbally or in writing within 60 calendar days of the date of the adverse determination by contacting the Customer Service Department.

After filing a written reconsideration, a member may present his or her appeal in person. To do so, the member must call AlphaCare to advise that the member would like to present the reconsideration in-person or via the telephone. If the member would like to present her or his appeal in-person, AlphaCare will arrange a time and date that works best for the member and AlphaCare. A member of the management team and an AlphaCare Medical Director will participate in the in-person appeal.

After the member presents the information, AlphaCare will mail the decision to the member within the timeframe specified above, based on the type of appeal.

If the member's request for reconsideration is submitted after 60 calendar days, then good cause must be shown in order for AlphaCare to accept the late request. Examples of good cause include, but are not limited to:

- The member did not personally receive the adverse organization determination notice or received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits; and/or
- The member had incorrect or incomplete information concerning the reconsideration process.

8.1.5 - Expedited Reconsiderations

To request an expedited reconsideration, a member or a provider (regardless of whether the provider is affiliated with AlphaCare) must submit a verbal or written request directly to AlphaCare. A request to

expedite a reconsideration of a determination will be considered in situations where applying the standard review procedure could seriously jeopardize the member's life, health or ability to regain maximum function, including cases in which AlphaCare makes a less than fully favorable decision to the member. In light of the short timeframe for deciding expedited reconsiderations, a provider does not need to be an authorized representative to request an expedited reconsideration on behalf of the member. However, the provider must have the member's consent on file.

A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration.

If a reconsideration is expedited, AlphaCare will complete the expedited reconsideration and give the member (and the provider involved, as appropriate) notice of the decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving a valid and complete request for reconsideration.

If AlphaCare denies the request to expedite a reconsideration, AlphaCare will provide the member with verbal notification within 24 hours. Within three calendar days of the verbal notification, AlphaCare will mail a letter to the member explaining:

- That AlphaCare will automatically process the request using the 30 calendar day timeframe for standard reconsiderations;
- The member's right to file an expedited grievance if he or she disagrees with AlphaCare's decision not to expedite the reconsideration and provides instructions about the expedited grievance process and its timeframes; and
- The member's right to resubmit a request for an expedited reconsideration and that if the member gets any provider's support indicating that applying the standard timeframe for making a determination could seriously jeopardize the member's life, health or ability to regain maximum function, the request will be expedited automatically.

8.1.6 - Member Reconsideration Decisions

Reconsideration Levels

There are five levels of reconsideration available to Medicare beneficiaries enrolled in Medicare Advantage plans after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of adverse organization determination by AlphaCare;
2. Reconsideration of adverse organization determination by the Independent Review Entity (IRE);
3. Hearing by an Administrative Law Judge (ALJ), if the appropriate threshold requirements set forth in §100.2 have been met;
4. Medicare Appeals Council (MAC) Review; and
5. Judicial Review, if the appropriate threshold requirements have been met.

Standard Pre-Service or Retrospective Reconsideration Decisions

If AlphaCare reverses its initial decision, AlphaCare will either issue an authorization for the pre-service request or send payment if the service has already been provided.

If AlphaCare affirms its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 30 days from receipt of the appeal to issue a final determination; and
- Notify the member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and AlphaCare. In the event the IRE agrees with AlphaCare, the IRE will provide the member further appeal rights.

If the IRE reverses the initial denial, the IRE will notify the member or representative in writing of the decision. AlphaCare will also notify the member or member's representative in writing that the services are approved along with an authorization number.

Expedited Reconsideration Decisions

If AlphaCare reverses its initial action and/or the denial, it will notify the member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

If AlphaCare affirms its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination; and
- Notify the member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and AlphaCare. In the event the IRE agrees with AlphaCare, the IRE will provide the member further appeal rights. If the IRE reverses the initial denial, the IRE notifies the member or representative in writing of the decision.

8.2 - Grievance

8.2.1 - Provider

Medicare Advantage providers are not able to file a grievance per CMS guidance.

8.2.2 - Member

The member may file a grievance. A grievance may also be filed on the member's behalf by an authorized representative or a provider with the member's written consent. If the member wishes to use a representative, then she or he must complete a Medicare Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement.

Examples of issues that may result in a grievance include, but are not limited to:

- Provider Service including, but not limited to:
  - » Rudeness by provider or office staff;
  - » Refusal to see member (other than in the case of patient discharge from office); or
  - » Office conditions.
- Services provided by AlphaCare including, but not limited to:
  - » Hold time on telephone;
  - » Rudeness of staff;
  - » Involuntary disenrollment from AlphaCare; or
  - » Unfulfilled requests.
- Access availability including, but not limited to:
  - » Difficulty getting an appointment;
  - » Wait time in excess of one hour; or
  - » Handicap accessibility.

A member or a member's representative may file a standard grievance request either orally (via Customer Service or in person) or in writing within 60 calendar days of the date of the incident or when the member was made aware of the incident.

8.2.3 - Grievance Resolution

Standard

A member or member's representative shall be notified of the decision as expeditiously as the case requires, based on the member's health status, but no later than 30 calendar days after the date AlphaCare receives the verbal or written grievance, consistent with applicable federal law. Unless an extension is elected, AlphaCare will send a closure letter upon completion of the member's grievance.

An extension of up to 14 calendar days may be requested by the member or the member's representative. AlphaCare may also initiate an extension if the need for additional information can be justified and the extension is in the member's best interest. In all cases, extensions must be well-documented. AlphaCare will provide the member or the member's representative prompt written notification regarding AlphaCare's intention to extend the grievance decision.

The Grievance Department will inform the member of the determination of the grievance as follows:

- All grievances submitted, either verbally or in writing, will be responded to in writing; and
- All grievances related to quality of care will include a description of the member's right to file a written complaint with the Quality Improvement Organization (QIO). For any complaint submitted to a QIO, AlphaCare will cooperate with

the QIO in resolving the complaint.

AlphaCare provides all members with written information about the grievance procedures/process available to them, as well as the complaint processes. AlphaCare also provides written information to members and/or their appointed representative(s) about the grievance procedure at initial enrollment, upon involuntary disenrollment initiated by AlphaCare, upon the denial of a member's request for an expedited review of a determination or appeal, upon the member's request, and annually thereafter. AlphaCare will provide written information to members and/or their appointed representatives about the QIO process at initial enrollment and annually thereafter.

The facts surrounding a complaint will determine whether the complaint is for coverage determination, organization determination or an appeal and will be routed appropriately for review and resolution.

Expedited

A member may request an expedited grievance if AlphaCare are makes the decision not to expedite an organizational determination, expedite an appeal, or invoke an extension to a review. AlphaCare will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review timeframe or extend a review timeframe does not jeopardize the member's health.

AlphaCare will contact the member or the member's representative via telephone with the determination and will mail the resolution letter to the member or the member's representative within three business days after the determination is made. The resolution will also be documented in the member's record

Section 9: Credentialing and Recredentialing

9.1 - Credentialing Requirements

To become a participating AlphaCare practitioner/provider, you must hold, if applicable, a current, unrestricted license issued by the New York State and not be subject to any Medicare or Medicaid sanctions. You must also comply with New York State, CMS and AlphaCare's credentialing criteria and submit all additionally requested information. A complete Credentialing Application short form (practitioners) or an AlphaCare Ancillary/Facility Application and all required attachments must be submitted to initiate the process.

AlphaCare is one of over 600 participating health plans, hospitals and health care organizations that currently use the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data Source (UPD) for gathering credentialing data for physicians and other health care professionals. Under this program, practitioners use a standard application (state-mandated applications are included in the UPD) and a common database to submit an electronic application. For those practitioners who are not participating with CAQH, AlphaCare will assist you with the process to create a CAQH profile. This is the only application which AlphaCare accepts for practitioners.

Ancillary and/or Facility applicants must submit the AlphaCare applicable application, completed in it's entirety and submitted along with ALL requested information. Incomplete applications cannot be processed and will be returned.

9.2 - Credentialing Procedures

AlphaCare credentialing requirements apply only to those with whom AlphaCare enters in to or plans to contract for health care services rendered independent of professional oversight. Except as may be required by state or federal regulations, this policy does not apply to practitioners who practice exclusively within the setting of an institution or organizational setting.

AlphaCare credentials the following practitioners/providers, at a minimum: Physicians, Podiatrists, Chiropractors, Physician Assistants, Optometrists, Dentists, Nurse Practitioners, Certified Curse Midwives, Licensed Professional Counselors, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Advanced Registered Nurse Practitioners, Licensed Chemical Dependency Counselors, Psychologists, Physical Therapists, Speech/Language Therapists and allied service (ancillary) providers.

AlphaCare credentials the following organizational providers and all practitioners associated with them, Durable Medical Equipment Prosthetic and Orthotic

Services, Home Health Services, Adult Social and Health Day Care,
AlphaCare credentials all Hospitals, Skilled Nursing Facilities and Residential Treatment Facilities to the CMS and New York State Department of Health standards.

We use a credentialing committee comprised of licensed practitioners to review credentialing and recredentialing applicants, delegated groups and sanction activity related to applying and/or existing network participants. The credentialing committee is also responsible for the creation and regular review of all policies and procedures relevant to the credentialing program.

We review and/or revise our credentialing policy periodically, and no less frequently than annually, based on input from:

- Credentialing committees
- Chief medical officers
- State and federal requirements
- Credentialing Department
- Providers

By signing the application, credentialing applicants must attest to the accuracy of their credentials. If there are discrepancies between the application and the information obtained during the external verification process, the AlphaCare's credentialing department will investigate them. Discrepancies may be grounds for our denial of network participation or the termination of an existing contractual relationship.

Applicants will be notified by telephone or in writing if any information obtained during the process varies substantially from what was submitted.

The following elements are reviewed in the course of credentialing. Most of these elements are also included at the time of recredentialing:

1. Board certification: Acceptable sources of verification include, but are not limited to:
   - » American Medical Association Provider profile
   - » American Osteopathic Association
   - » American Board of Medical Specialties
   - » American Board of Podiatric Surgery
   - » American Board of Podiatric Orthopedics and Primary Podiatric Medicine
2. Education and training: Education and training will be verified for all practitioners at the time of initial credentialing. Acceptable sources of verification include but are not limited to:
   - » Board certification
   - » State-licensing agency
   - » Educational institution
3. Work history: A full work history, documenting at least the prior five years, must be submitted at the time of practitioner credentialing. Any gaps in work history greater than six months must be explained in written format
4. Hospital affiliations and privileges: Network practitioners must have clinical privileges, as appropriate to their scope of practice, in good standing at an AlphaCare contracted hospital.
5. State licensure or certification: Initial credentialing applicants must have a current, legal state license or certification if applicable to their field of practice. This information will be verified by referencing data provided to us by the state via:
   - » Roster
   - » Telephone
   - » Written verification
   - » Internet
6. Drug Enforcement Administration (DEA) number: Initial practitioner applicants must provide their current DEA numbers, if applicable, to AlphaCare for verification.
7. Evidence of professional and general liability coverage: A copy of the malpractice face sheet will provide evidence of coverage. In addition, an attestation which includes the following information may be used:
   - » Name of the carrier
   - » Policy number
   - » Coverage limits
   - » Effective and expiration dates of such malpractice coverage
8. As a practitioner or a provider, you must maintain professional and general liability insurance in specified amounts in accordance with your AlphaCare contract.
9. Professional liability claims history: Initial credentialing applicants will be asked to provide

a full professional liability claims history. This information will be assessed along with a query of the National Practitioner's Data Bank (NPDB).

10. Provider Sanctions History: All initial credentialing practitioner and provider applicants must not have any sanctions by Medicare, Medicaid, or any federal or state exclusions lists. This information is verified by accessing the NPDB, OIG, NYS OMIG, SDN, SAM and NSOR.
11. Disclosures — attestation and release of information: All initial credentialing applicants must respond to questions, including within the application regarding the following:
    - Reasons for being unable to perform the essential functions of the position with or without accommodation
    - History or current problems with chemical dependency, alcohol or substance abuse
    - History of license revocations, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
    - History of conviction of any criminal offense other than minor traffic violations
    - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
    - History of complaints or adverse action reports filed with a local, state or national professional society, licensing board or accrediting bodies
    - History of refusal, cancellation or non renewal of professional liability insurance
    - History of suspension or revocation of a DEA or CDS certificate
    - History of any Medicare or Medicaid sanctions
    - Applicants must also provide a/an:
        - ◊ Attestation of the correctness and completeness of the application
        - ◊ Explanation in writing of any identified issues
12. Disclosure of ownership: CMS requires the collection of certain information regarding the ownership and control of entities with which we contract for services for federal employees or federal health plans. This information is required for participation in the AlphaCare network. All individuals and entities included on the form must be clear of any sanctions or exclusions by Medicare and Medicaid or any federal health care programs
13. License history: The appropriate state-licensing board/agency is queried, along with the National Practitioner Databank (NPDB), as part of the credentialing process

The credentialing committee approves or denies the credentialing request based on information presented in the provider's application and any additional documentation provided in the course of the credentialing process. AlphaCare notifies the applicant either by telephone, email or in writing if any information obtained in support of the credentialing or recredentialing process varies substantially from the information submitted by the provider/practitioner. Each applicant has the right to review all information used in reaching the decision and may appeal a denied application.

9.3 - Timing and Frequency of Credentialing

Unless otherwise mandated by state regulation, the requirement for timeliness of credentialing a practitioner/provider is 180 calendar days from the date the applicant signs an attestation to the date of the credentialing committee's final decision. The AlphaCare recredentialing cycle is a 36-month (three-year) cycle. All providers/practitioners will be recredentialed at least every 36 months.

9.4 - Sanctioned Providers

AlphaCare is required to review the sanctions and exclusions on a monthly basis. AlphaCare is prohibited from employing or contracting with any individual who is excluded from participation in any federal or state healthcare or contracting programs. Providers identified as being excluded will be denied participation or terminated from participation in AlphaCare and will not be considered for participation or reinstatement until the exclusion is lifted and reinstatement is verified. Reinstatement is not automatic. A new application must be submit and the credentialing process begun again. Excluded providers may not receive any payments from federal or state healthcare programs. There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room.

9.5 - Sanctions under Federal Health Programs and State Laws

Providers must ensure no management staff or other persons who have been excluded by Medicaid, Medicare or other federal health care programs are employed or subcontracted by the provider.

Providers must disclose to AlphaCare whether they, a staff member or subcontractor have any prior violation, fine, suspension, termination or other administrative action taken by any of the following:

- Medicare or Medicaid laws
- The rules or regulations of the state
- The federal government
- Any public insurer

Providers must immediately notify AlphaCare of any imposed sanction or adverse action taken on them or any staff.

9.6 - Opt-out Providers

Section 4507 of the Balanced Budget Act of 1997 permits a provider to opt out of Medicare for at least a two-year period. For a provider to opt out of Medicare, he or she must file an opt-out affidavit with his or her local Medicare Part B carrier. If the provider wishes to render services to Medicare beneficiaries, he/she must sign a private contract with each patient. When a provider opts out of Medicare, health care services rendered by the opt-out provider are not covered by Medicare, and no payments can be made to the provider or to the beneficiary, except for services for emergent and/or urgent care situations. Medicare will pay for covered, medically necessary services ordered by an opt-out provider but only if the provider has obtained a unique provider identifier number from Medicare and if the service is rendered by a provider who has not opted out. AlphaCare reserves the right to not contract with any provider who has "Opted Out" of the Medicare program.

9.7 - Organizational Provider Credentialing

AlphaCare credentials organizational providers in accordance with NCQA, CMS and state-specific requirements. The following providers require assessments:

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities
- Assisted Living Facilities
- Nursing Homes
- Ambulatory Surgical Centers
- Behavioral Health Facilities
- Durable Medical Equipment, Prosthetic and Orthotic Services Providers
- Adult Social and Health Day Care Centers

Additional providers may also be required to following the credentialing process.

The following steps are included in the AlphaCare's Organizational Provider Credentialing process:

- A review and primary source verification of a current copy of the state license
- A review of any restrictions to a license are investigated and could impact your participation in the network
- A review and primary source verification of any Medicare or Medicaid sanctions
- A review and verification of nationally recognized accreditation organizations including but not limited to:
  - » Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  - » Health Care Facilities Accreditation Program
  - » American Osteopathic Association
  - » The Commission on Accreditation of Rehabilitation Facilities
  - » Community Health Accreditation Program
  - » Accreditation Association for Ambulatory Health Care

If your facility, ancillary or hospital is not accredited, a copy of a recent state or CMS review may be submitted in lieu of performing an onsite review. If there is no current accreditation or a recent state or CMS review, AlphaCare will conduct an onsite review.

Evidence of malpractice insurance, in amounts specified in the provider contract and in accordance with AlphaCare's policy, must also be included at the time of credentialing.

AlphaCare will track an organization's recredentialing date and recredential every 36 months or sooner, as applicable. The requirements for recredentialing are

the same as they are for the initial credentialing. The organizational provider will:

- Be notified either by telephone, email or in writing if any information obtained in support of the credentialing or recredentialing process varies substantially from the information submitted
- Have the right to review the information submitted in support of the credentialing process and to correct any errors in the documentation

9.8 - Recredentialing

Recredentialing is required every three years by AlphaCare as guided by the NCQA standards. In some instances, there is a requirement to recredential every year due to CMS requirements. AlphaCare will perform recredentialing at least every 36 months, if not earlier. Network practitioners and providers will receive requests for recredentialing applications and supporting documentation in advance of the 36-month anniversary of their original credentialing or last credentialing cycle. Information from quality improvement activities, performance profiles and member complaints will be assessed, along with the assessments and verifications listed above. In addition, AlphaCare will request an updated Disclosure of Ownership and Controlling Interest Statement at the time of recredentialing, in accordance with CMS requirements and any state-specific required documents.

9.9 - Practitioners Rights to Review Credentialing Information

You can request the status of your application through your local Provider Relations team via:

- Telephone
- Fax
- Mail
- Email

Credentialing applicants have the right to:

- Review information submitted to support your credentialing application
- Explain information obtained that may vary substantially from what you provided
- Provide corrections to any erroneous information submitted by another party by submission of a written explanation or by appearance before the credentialing committee

AlphaCare's medical director has authority to approve clean files without input from the credentialing committee; all files not designated as clean will be sent to the credentialing committee for review and a decision regarding network participation.

We will inform you of the credentialing committee's decision in writing within 60 days. If your continued participation is denied, you can appeal this decision in writing within 30 days of the date of the denial letter.

9.10 - Credentialing Appeals Process

Credentialing/recredentialing applicants will be notified of a denial or limitation and/or restriction of credentials, or a decision of termination for cause. Applicants will have 30 calendar days to appeal this decision in writing. The appeals process, as defined by the AlphaCare's Appeals Policy, includes the right to a fair hearing when there has been termination for cause. If the written appeal is not submitted within the 30 calendar day time frame, the appeal right will expire, and the initial determination will stand.

- If the credentialing/recredentialing applicant has a current AlphaCare participation agreement that specifies a different time frame, the current contract language shall govern.
- The request for an appeal must set forth in detail those matters the credentialing/recredentialing applicant believes were improperly determined by the health plan credentialing committee and/or medical director, as well as the specific reasons why the applicant believes the decision to be improper. The applicant may include any statement, documents or other materials to be considered by the hearing committee or appointed hearing officer prior to rendering a final decision.
- When a determination would lead to a contract termination, the hearing committee or appointed hearing officer shall meet within 30 calendar days of receipt of the appeals request to consider the appeal, unless a time extension is requested and mutually agreed upon by both parties, in accordance with AlphaCare's policy.
- The credentialing/recredentialing applicant shall be informed when the request for appeal has been received; if an informal hearing is being offered, the time, date and location of the informal hearing will also be communicated to the physician/practitioner no less than 14

calendar days prior to the date of the informal hearing; the physician/practitioner has the right to be represented by an attorney or other representative of his or her choice.

- The appeals process provides the right of the credentialing/recredentialing applicant to appear in person before the hearing committee or appointed hearing officer, at which time the provider has the right to present his or her case.
- The credentialing/recredentialing applicant will be notified in writing of the final decision, setting forth the reasons for the decision, within 15 days of the hearing committee or appointed hearing officer meeting.
- If the hearing committee or appointed hearing officer upholds a denial, the recommendation would be made to initiate termination procedures for the credentialing/recredentialing applicant's participation with AlphaCare.

9.11 - Peer Review

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are to:

- Participate in the implementation of the established peer review system
- Review and make recommendations regarding individual provider peer review cases
- Work in accordance with the medical director

If an investigation of a member grievance results in concern regarding a provider/practitioner's compliance with community standards of care or service, the elements of peer review will be followed. Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of provider/practitioner's actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the provider/practitioner and consults and peer review committee as appropriate. The medical director informs the provider/practitioner of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, including the Quality Management Committee.

The peer review process is a major component of the Medical Advisory Committee's monthly agenda. The peer review policy is available upon request.

9.12 - Delegation of Credentialing

Provider groups with strong credentialing programs that meet AlphaCare's credentialing standards may be evaluated for delegation. As part of this process, we will conduct a pre-delegation assessment of a group's credentialing policy and program, as well as an onsite evaluation of credentialing files. A passing score is considered to be an overall average of 90 percent compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation.

We may waive the need for the pre-delegation onsite audit if the group's credentialing program is NCQA or URAC certified for all credentialing and recredentialing elements.

AlphaCare is responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

Section 10: Dual-Eligible Members

10.1 - Overview

Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of NYS Medicaid benefit are often referred to as "dual-eligible members." These benefits are sometimes referred to as Medicare Savings Programs (MSPs). Dual-eligible members are eligible for some form of Medicaid benefit, whether that Medicaid coverage is limited to certain costs, such as Medicare premiums, or the full benefits covered under the state Medicaid plan.

10.2 - Types of Dual-eligible Members

The state administers MSPs for Medicare- and Medicaid-eligible members with limited income and resources to help pay for their Medicare cost-sharing. There are multiple MSP categories and the categories are based upon the beneficiary's income and asset levels as well as "medically needy" status. Members learn of their MSP assistance from an

award letter they receive from the state Medicaid agency.

In general, QMB, QMB+, SLMB+ and FBDE beneficiaries are considered "zero cost-share" dual-eligible members since they pay no Part A or Part B cost-share. Please note, the state Medicaid agency defines all optional MSP levels and those levels.

Please contact the NYS Medicaid for full MSP information.

Payments and Billing

For all zero cost-share dual-eligible members (QMB, QMB+, SLMB+ and FBDE), Medicaid is responsible for deductible, coinsurance, and co-payment amounts for Medicare **Parts A and B Covered Services.** The filed cost-sharing amounts related to supplemental benefits (e.g. hearing, vision and extra dental) are the responsibility of the member.

Providers may not "balance bill" these members. This means providers may not bill these members for either the balance of the Medicare rate or the provider's customary charges for Part A or B services. The member is protected from liability for Part A and B charges, even when the amounts the provider receives from Medicare and Medicaid are less than the Medicare rate or less than the provider's customary charges. Providers who bill these members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

Providers agree to accept AlphaCare's payment as payment in full or will bill the appropriate state source for the cross-over cost-sharing payment. To bill the state, the provider will submit the EOP provided by AlphaCare to the state.

Referral of Dual-Eligible Members

When a participating provider refers a dual-eligible member to another provider for services, the provider should make every attempt to refer the dual-eligible member to a provider who participates with both AlphaCare and the state Medicaid agency. Providers who participate with the state Medicaid plan can be located at the applicable state's Medicaid website. The AlphaCare Provider Directory displays an indicator when the provider participates in Medicaid.

10.3 - Special Needs Plans Case Management Program

10.3.1 - Overview

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) became law in July of 2008. MIPPA mandates a health risk assessment, care plan, interdisciplinary care team for members, and an evaluation of care effectiveness by the health plan.

AlphaCare's Model of Care (MOC) is tailored specifically to the dual-eligible members in an effort to meet the populations' functional, psychosocial and medical needs in a member-centric fashion.

Health Risk Assessment: Conducted by AlphaCare

- AlphaCare's Case Management MOC begins with the HRA. The HRA assesses member risk in the following areas: functional, psychosocial, and medical. Once completed, the HRA is stratified and then reviewed by a Case Manager. The stratification/acuity of the HRA is an indicator of the needs of the member and is verified with the comprehensive medical assessment. The dual-eligible member is then contacted so Case Management process can begin.

Comprehensive Medical Assessment: Conducted by AlphaCare

- The Case Manager conducts the comprehensive medical assessment with the dual-eligible member and/or caregiver, if appropriate, in order to collect additional social, medical, and behavioral information to generate a member-centric Individualized Care Plan (ICP). The comprehensive medical assessment is based on Clinical Practice Guidelines and allows the care plan to be generated utilizing these guidelines. Also

Individualized Care Plans: Generated by AlphaCare

- Once the Case Manager, the member, and/or caregiver complete the comprehensive medical assessment, an ICP is generated that reflects the member's specific problems, prioritized goals, and interventions. The Case Manager and the member and/or caregiver, if appropriate, agree on the care plan and set goals. The ICP generated tracks dates and goal progress. The frequency of contact will vary depending on the stratification/acuity of the member and specific goal timeframes. The ICP is shared with all members of the Interdisciplinary Care Team (IDT)

for input and updates.

Interdisciplinary Care Team: AlphaCare and Providers

- The Case Manager shares the ICP with all the members of the IDT in an effort to provide feedback and promote collaboration regarding the member's goals and current health status. At a minimum, the IDT includes the member, the member's caregiver (if appropriate), the member's PCP and AlphaCare Case Manager. Other members of the IDT can include specialists, social service support, behavioral health specialists, and/or caregiver and others depending on the member's specific needs. The Case Manager communicates and coordinates with the members of the IDT to educate the member, provide advocacy, and assist them as they navigate the health care system.

Care Transitions: AlphaCare and Providers

- The Case Manager is responsible for coordinating care when members move from one setting to another and facilitates transitions through communication and coordination with the member and their usual practitioner. During this communication with the member, the Case Manager will discuss any changes to the member's health status and any resulting changes to the care plan. The Case Manager will notify the member's usual provider of the transition and will communicate any needs to assist with a smoother transition process.

10.3.2 - Provider Required IDT Participation

To meet the intent of the MIPPA legislation, providers are required to participate in the MOC for all DSNP plan members. The expectations for participation are as follows:

- Complete the required MOC training. AlphaCare offers an online training module and a printable self-study packet. If providers opt to use the self-study packet, AlphaCare requests you return the attestation for reporting purposes. Providers may return the attestation via fax. The self-study packet can be accessed at https://www.alphacare.com. If providers would like to request a copy mailed, at no cost, contact Provider Services;
- Familiarize yourself with our Clinical Practice Guidelines which are based on nationally-recognized evidence-based guidelines;
- Read newsletters that feature articles regarding the latest treatments for patients;
- Review and update the member care plan faxed by the Case Management Department; and
- Participate in the IDT for all DSNP members in your membership panel and give feedback as appropriate. The Case Manager will communicate with the members of the IDT for any updates to the ICP and will be available to assist the dual-eligible member to meet the goals of the ICP.

Re-cap of the benefits of the DSNP Case Management Program:

- All members receive a Health Risk Assessment.
- Members are stratified according to the severity of their disease process, functional ability, and psychosocial needs.
- A Comprehensive Medical Assessment is completed by the Case Manager and is the basis for the ICP.
- The ICP is generated by the Case Manager in collaboration with the member and the Care Team.
- The ICP is shared with the IDT for review and comments as needed.
- The Case Manager continues to monitor, educate, coordinate care and advocate on behalf of the member.

Section 11:Behavioral Health

11.1 - Overview

AlphaCare maintains a whole person, integrated approach for members who have behavioral health issues. AlphaCare administers all covered inpatient and ambulatory behavioral health services and incorporates behavioral health concerns into our member's plan of care.

11.2 - Behavioral Health Program

AlphaCare's Care Management teams serve as facilitators for connecting members to mental health and substance abuse services and as a coordinator of member's care based upon recovery and resilience principles.

Prior approval is not required for Behavior Health:

- Outpatient initial consultation
- Outpatient medication management
- Outpatient psychotherapy

AlphaCare will, however, contact providers when there are questions regarding member's clinical treatment.

Prior approval is required for:

- Inpatient behavioral health treatment
- Ambulatory detoxification treatment
- Outpatient or inpatient Electro-Convulsive Treatment (ECT)
- Partial Hospitalization

To obtain a prior approval, please fill and submit the AlphaCare Prior Authorization Request Form (available at our website www.alphcare.com) to AlphaCare Health Services at:

- Email: Authorizations@alphacare.com or
- Fax: (718) 878-5173

Expedited requests may be emailed, faxed or submitted telephonically by calling 1-855-OK-ALPHA (1-855-652-5742)

11.3 - Coordination of Care between Medical and Behavioral Health Providers

PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if, and when, they are licensed to do so within the scope of their practice. Behavioral providers are required to use the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) multi-axial classification when assessing the member for behavioral health services and document the DSM-V diagnosis and assessment/outcome information in the member's medical record.

Behavioral health providers are encouraged to submit, with the member's or the member's legal guardian's consent, an initial and quarterly summary report of the member's behavioral health status to the PCP. The Behavioral Health- PCP Communication Form may be used for this purpose (See section 11.5). Communication with the PCP should occur as clinically indicated. AlphaCare encourages behavioral health providers to pay particular attention to communicating with member's PCP's at the time of discharge from a Behavioral Health inpatient stay, AlphaCare recommends faxing the discharge instruction sheet or a letter summarizing the hospital stay, including prescribed behavioral health medications, to the PCP. Any changes in the treatment plan should be noted. The PCP is also encouraged to share changes in the treatment plan and summary of hospitalization with the behavioral health providers.

Fostering a culture of collaboration and cooperation helps maintain a seamless continuum of care between medical and behavioral health and positively impact member outcomes. AlphaCare's Care Management program is based upon integrated health approaches and open communication between medical care and behavioral health providers. If a member's medical or behavioral health condition or medication regimen changes, AlphaCare expects that both PCPs and behavioral health providers will communicate those changes to each other. The care management team, including the nurse care manager, is available to help maintain continuity of care and coordination of members with complex needs by supporting communication between behavioral health and medical providers.

11.4 - Responsibilities of Behavioral Health Providers

AlphaCare promotes the use of best practices and monitors providers against standards to ensure members can obtain needed health services within the acceptable appointments waiting times. The following access to care standards are applicable to behavioral health providers. Provider not in compliance to these standards will be required to implement a corrective action plan set forth by AlphaCare:

Type of Appointment	Access Standard
Behavioral Health Crisis Line	Member may call the NYC crisis line: 1-800-543-3638
Behavior Health Life Threatening Emergency	Call 911

Type of Appointment	Access Standard
Behavioral Health Provider – Urgent	Within 48 hours
Behavioral Health Provider – Post Inpatient discharge	Within 7 Days
Behavioral Health Provider – Routine	Within 10 business days

All members receiving inpatient behavioral health services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, prior to discharge, which includes the specific time, date, place, and name of the provider to be seen. The outpatient treatment must occur within seven days from the date of discharge.

In the event that a member misses an appointment, the behavioral health provider must contact the member within 24 hours to reschedule.

Behavioral health providers are expected to assist members in accessing emergent, urgent, and routine behavioral services as expeditiously as the member's condition requires. Members also have access to a toll free behavioral crisis hotline that is staffed 24 hours per day.

11.5 - Behavioral Health PCP Communication Form

As reference in section 11.3 of this manual, AlphaCare encourages behavior health providers to regularly update the member's PCP regarding the member's behavioral health status. The form below illustrates the type of information to provide and can be found in the appendices of this manual in a printable format.

Behavioral Health PCP Communication Form

Patient Name: ______________________________ Patient Date of Birth: ____________________

Behavioral Health Clinician Name: ____

Clinician Address: ____

____

Clinician Phone/Fax: ____

Dear Colleague:

I saw the above-named patient, who gave an authorization to release the following information,

on ______________________ for____
(Date) (Reason/Diagnosis)

Brief Summary (if indicated):

____

____

____

____

Current Treatment (interventions by sending practitioner):

Psychotherapy Patient Refused Medication

Medication(s) Prescribed: ____

____

____

____

The patient has has not received a copy of this form. If you have any questions or would like additional information, please contact me. Thank you.

Clinician Signature: __________________________________ Date Sent/Faxed: ______________

Phone #: ____________________________________

11.6 - Principles of Adult Recovery

1. Respect: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. Persons in recovery choose services and are included in program decisions and program development efforts: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. Focus on individual as a whole person, while including and/or developing natural supports: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. Integration, collaboration, and participation with the community of one's choice: A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. Persons in recovery define their own success: A person in recovery -- by their own declaration --discovers success, in part, by quality of life outcomes, which may include an improved sense of well being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.
9. Hope is the foundation for the journey towards recovery: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

Section 12: Supplemental Benefits

12.1 - Dental Services

Dental Services are provided and managed to AlphaCare members through a contract with Liberty Dental, the plan's benefit manager. Liberty Dental is responsible for providing all dental benefits based on the plan that the member is enrolled.

Phone: 1-877-550-4437

Website: www.libertydentalplan.com/alphacare

Liberty Dental's programs are based on the prevention of dental disease. AlphaCare members

eligible for dental benefits are covered oral exams, cleanings and dental X-rays. Any additional dental benefits are based upon the plan the member is enrolled. Members must utilize participating providers for all dental services.

12.2 - Vision Services

Vision Services are provided and managed to AlphaCare members through a contract with Liberty Dental, the plan's benefit manager. Liberty Dental is responsible for providing all dental benefits based on the plan that the member is enrolled.

Phone: 1-800-877-7195

Website: www.vsp.com

12.3 - Hearing Services

Hearing Aide Services are provided to all AlphaCare members through a contract with HearUSA.

Phone: 1-800-700-3277

Website: www.hearusa.com

Hear USA operates more than 1,500 audiology center nationwide. HearUSA has a long-standing commitment to enhance the quality of life in the individual communities in which we serve. HearUSA pledges to:

- Provide personal care and attention by qualified staff that is experienced in providing clinically appropriate hearing care.
- Follow the belief that hearing loss is a condition deserving quality providers, products and services.
- Continuously seek improved performance and positive outcomes.

12.4 - Non-emergent Transportation Services

Non-emergent transportation Services are provided to all AlphaCare members through a contract with National MedTrans.

Phone: 1-800-558-1638

Section 13: Prescription Drugs

All AlphaCare plans except for AlphaCare MLTC offer prescription drug coverage. These benefits include the coverage of Medicare Part D prescription drugs, as well as those covered under Medicare Part B.

The prescription benefits services are provided and managed to AlphaCare members through a contract with MedImpact, the plan's benefit manager. MedImpact is responsible for providing all Part D and Part B prescription drug benefits based on the plan that the member is enrolled.

Phone: 1-888-807-5963

Website: www.medimpact.com

13.1 - Formulary

The formulary is a published prescribing reference and clinical guide of prescription drug any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

The P&T Committee's selection of drugs is based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature, and cost-effectiveness profile. The medications on the formulary are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, prior authorization and step therapy).

The formulary is located on AlphaCare's website at https://www.alphacare.com

Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to providers via the following:

- Quarterly updates in provider and member newsletters;
- Website updates; and/or
- Pharmacy and provider communication that detail any major changes to a particular therapy or therapeutic class.

13.2 - Step Therapy

Step Therapy programs are developed by the QM Department. These programs encourage the use of therapeutically equivalent, low-cost medication alternatives (first line therapy) before stepping up to less cost-effective alternatives. Step therapy

programs are intended to be safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven safe and cost-effective therapy is attempted before progressing to a more costly option. First line drugs are recognized as a safe, effective and economically sound treatments. The first-line drugs on our formulary have been evaluated through the use of clinical literature and are approved by our Quality Committee.

Part D Drugs requiring Step Therapy are clearly designated in our formulary.

13.3 - Prior Authorization

Prior authorization protocols are developed and reviewed annually. Prior authorizations protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s)).

Part D Drugs requiring authorization are clearly designated in our formulary.

13.4 - Part B Prescription Drugs

Prescription drugs covered under the Medicare Part B benefits are very limited. These include the following:

- Injectable medications provided incidental to a physician's service
- Drugs administered through covered durable medical equipment, such as a nebulizer or infusion pump in the home
- Certain oral cancer medications
- Antiemetic drugs administered within 48 hours of chemotherapy
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant
- Erythropoietin for individuals undergoing chronic renal dialysis
- Parenteral nutrition for members with a permanent dysfunction of the digestive tract
-

Other drugs may be covered under Part B in certain limited situations. Many Part B drugs and injectable medications provided incidental to a physician's service require precertification from AlphaCare. Please visit the website or call Provider Services at the 1-855-652-5742 for additional information.

13.5 - Over-the-Counter Medications

Over-the-Counter Medications available to the member without a prescription are not eligible for coverage under the member's Medicare Part D benefit.

AlphaCare offers an OTC Benefit according the member's benefit plan by Medagate. Please refer the member's Summary of Benefit for plan specific coverage amounts.

Section 14: Glossary of Terms

ACSCs: Ambulatory Care Sensitive Conditions are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

ADA: The Americans with Disability Act

Appeal: Appeals are any of the procedures that deal with the review of adverse organization or coverage determinations on the health care services or prescription drug benefits a member is entitled to receive or any amounts the member must pay for a covered service. These procedures include reconsiderations by AlphaCare of NY, hearings before an administrative law judge, reviews by the Medical Appeals Council and federal judicial reviews. This process is separate from the provider administrative appeals/dispute process.

Authorization Number: A unique number generated by the Care Management department when a request for authorization of services has been approved. Authorization numbers are communicated to the provider of service and should be referenced on all claims and correspondence related to those services.

Authorized Services: Medical, ancillary or behavioral healthcare services that require authorization beyond a routine referral from the Care Management department. Authorizations should generally be obtained in advance of services in order for the provider to receive reimbursement.

Balance Billing: A provider billing a member for the difference between the amount the provider charges for the services rendered and the amount the provider has been reimbursed from the health plan.

Basic Benefits: services covered for all Medicare beneficiaries under Medicare Part A and Part B. All Medicare Advantage members receive all basic benefits, including all health care services covered under Medicare Part A and B programs, except for hospice services. AlphaCare of NY Medicare also provides supplemental benefits not covered by fee-for-service Medicare.

Behavioral Health Services: Services to address mental health disorders and/or chemical dependency.

Beneficiary: An individual person who the Center for Medicare & Medicaid Services (CMS) determines to be eligible for Medicaid or Medicare and who meets all the other conditions for enrollment in the health plan.

Benefits: The services to which health plan members are entitled under their designated AlphaCare of NY program.

Capitation Payment: A fixed amount of money paid to a provider, hospital, or other provider per-member-per-month to cover the cost of a specific scope of services which must be provided or arranged for by the provider pursuant to the provider's contract with AlphaCare of NY.

Care Management: The process of planning for treatment and services, assessing the appropriateness of services, and following up to review the effectiveness of services to ensure the members receive efficient, effective, high quality care that meets their healthcare needs in a cost effective manner.

Claim Review/Reconsideration: The process by which a claim is reviewed at the provider's request to reconsider the payment determination made when the claim was processed.

Clean Claim: A claim for services that includes all required information and documentation, passes all system edits and does not require any additional review to determine the medical necessity and appropriateness of services provided.

CMS: Centers for Medicare & Medicaid Services; the federal agency responsible for administering the Medicare program and certain aspects of the State Medicaid programs.

Coinsurance: A fixed percentage of the total amount paid for the healthcare service that can be charged to a member on a pre-service basis.

Concurrent Review: An assessment of inpatient hospital care or ambulatory service by trained clinical review staff, during the period that those services are being provided, to assess the appropriateness and duration of care, treatment plans and to facilitate discharge planning.

Contracting Hospital: a hospital that has a contract to provide services and/or supplies to Medicare members.

Contracting Medical Group: a group of physicians organized as a legal entity for the purpose of providing medical care with a contract to provide medical services to Medicare members.

Contracting Pharmacy: a pharmacy that has a contract to provide Medicare members with medications prescribed by their providers in accordance with the AlphaCare of NY contract.

Co-payment: A fixed amount that can be charged to a member on a per service basis.

Cost Sharing: The amount of deductibles, coinsurance and copayments that the member is responsible for paying on a per-service basis.

Coverage Determination: the first decision made by a plan regarding the benefits an enrollee is entitled to receive under the plan.

Covered Services: those benefits, services or supplies that are:

- Provided or furnished by providers or authorized by AlphaCare of NY or its providers.
- Emergency services and urgently needed services that may be provided by non-providers.
- Renal dialysis services provided while members are temporarily outside the service area.
- Basic and supplemental benefits.

Credentialing: This process reviews and verifies a provider's credentials and experience prior to the provider's being approved for participation in a health plan.

Cultural Competence: A provider's effective method of communicating with members who have limited proficiency in English or limited reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities, in order to facilitate the member's decision making regarding medical treatment option. This also includes offering the option of receiving no treatment.

Culturally and Linguistically Appropriate Services (CLAS): health care services that are respectful of, and responsive to, a member's cultural and linguistic needs.

Current Procedural Terminology (CPT): A recognized industry standard of descriptive terms and code identifiers for reporting medical services and procedures performed by physicians and other healthcare providers. CPT codes are used in conjunction with ICD-9 diagnostic codes for claims data and other reporting of services provided.

Custodial Care: Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by a person without professional skills or training. Custodial care is not covered unless provided in conjunction with Skilled Nursing Care.

Disenrollment: The process by which a member's entitlement to receive services from a health plan is terminated and the member is removed from the plan. Reasons for disenrollment may include but not be limited to loss of eligibility as well as disenrollment 'for cause'.

Discharge Planning: The planning and arranging for post-hospital services to ensure members are discharged from inpatient care with timely arrangements in place for all necessary and appropriate post-hospital care.

Drug Formulary: A continuously updated list of preferred prescription medications. This list contains FDA approved brand name and generic drugs.

Dually Eligible Beneficiaries (AlphaCare Total HMO SNP): Medicare beneficiaries with Parts A, B & D and New York State Medicaid who reside in the service area. This is a special needs plan for dual eligible beneficiaries.

Dual Eligible Beneficiaries with MLTC Benefits (AlphaCare Signature - FIDA): Medicare beneficiaries with Parts A and B, dually eligible for Medicare and Medicaid, eligible for Medicare Part D, live in the service area and require one of the following three (Require community based long-term services & services (LTSS) for more than 120 days; OR Are Nursing Facility Clinically Eligible (NFCE) and receiving facility based long-term services and supports; OR are eligible for the Nursing Home Transition and Diversion (NHTD) 1915© waiver.

Durable Medical Equipment (DME): Equipment that can withstand repeated use by one (1) member, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the member's home.

Effective Date of Enrollment: The date on which a health plan member can begin to receive services from the health plan.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient

severity (including severe pain) 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 or, in the case of a pregnant woman, the health of the woman and/or her unborn child.
» Serious impairment to the bodily functions.
» Serious dysfunction of any bodily organ or part.

Emergency Services: covered inpatient or outpatient services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition in accordance with the prudent layperson standard.

Enrollment Roster: A report circulated each month to participating primary care providers to identify and provide demographic information on the health plan members who are in that provider's panel for that month.

Evidence of Coverage (EOC): The contract between the member and AlphaCare of NY putting forth the terms of coverage for medically necessary healthcare services.

Explanation of Payment (EOP): A form report providing detailed explanation of the payment determination in response to a provider's claim for reimbursement of services rendered.

Experimental Procedures and Items: procedures and items determined by AlphaCare of NY and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, AlphaCare of NY will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare.

Exceptions: An exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the AlphaCare of NY tiered cost-sharing structure or an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or precertification requirement).

Fee-for-Service: Traditional healthcare payment system under which providers receive a payment for each service provided based upon a contractually agreed upon fee schedule.

Grievance: A grievance is any complaint or dispute other than one involving an organization determination. Examples of issues involving a complaint that is resolved through the grievance rather than the appeal process are waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

Healthcare Proxy: A formal document that enables a health plan member to designate a trusted individual to make healthcare decisions on his/her behalf should the member lose the capacity to make decisions on his/her own.

Health Plan Employer Data and Information Set (HEDIS): A set of standardized performance measures designed to ensure consumers, purchasers and the general public can access information that allows for reliable comparison of the performance of different healthcare plans.

HIPPA: Health Insurance Portability and Accountability Act of 1996.

Home Health Agency: a Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member's home when medically necessary, when members are confined to their home and when authorized by their primary care physician.

Home Health Care: Skilled nursing care, rehabilitation therapies and certain other health care services that the member receives in the home for treatment of an acute illness or injury.

Hospice: a Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families.

Hospital: a Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Hospitalist: a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists complete education and training in internal medicine. As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient's primary care physician during the member's inpatient stay.

HRA: Health Risk Assessment, completed with new members within 90 days to identify those with ongoing needs and annually thereafter.

IDT: Interdisciplinary Team, made up of the participant and/or his/her designee, Designated Care Manager, PCP, Behavioral Health Professional(s), Participant's Home Care Aide and other providers as requested by the participant/ designee or recommended by the Care Manager or PCP.

Independent Practice Association: a group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices.

International Classification of Diseases, 9th Edition (ICD9-CM): Industry standard listing and coding system used by providers for reporting medical conditions and diagnoses. ICD-9 codes are used in conjunction with CPT-4 codes for claims data and other clinical data reporting.

In-Network: The designation given to medical care services provided by physicians, hospitals and other healthcare providers that have participation agreements with the health plan.

Managed Care: A comprehensive and coordinated approach to the provision of healthcare services that combines medical services with administrative procedures to ensure timely access to high quality, medically appropriate and cost effective care. Managed care emphasizes primary and preventive care and focuses on the appropriate utilization of specialty care, emergency room services and inpatient hospital care.

Medicaid: Medicaid is the federal health insurance program established in 1965 by Title XIX, Medical Assistance of the Social Security Act and administered and operated by states for eligible persons who meet set income or medical need criteria.

Medically Necessary: medical services or hospital services determined by AlphaCare of NY to be:

- Rendered for the diagnosis or treatment of an injury or illness.
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards.
- Not furnished primarily for the convenience of the member, the attending provider or other provider of service.

Medical necessity determinations are made based on peer reviewed medical literature, publications, reports and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by AlphaCare of NY. Medical necessity criteria are available to providers on request.

Medical Record: A complete record that documents care received by a member, including inpatient, outpatient and emergency care, in accordance with all applicable laws, rules and regulations, which is signed by the medical

professional rendering the services.

Medicare: the federal health insurance program established by Title XVIII of the Social Security Act and administered by the federal government for elderly and disabled individuals.

Medicare Part A: Medicare Part A covers hospital insurance benefits, including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

Medicare Part A premium: Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island or local government employment to be insured, they do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if they are at least 65 years old and meet certain other requirements.

Medicare Part B: optional, supplemental medical insurance requiring a monthly premium. Medicare Part B covers physician (in both hospital and nonhospital settings) and certain non-physician services. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood products not covered under Part A.

Medicare Part B Premium: a monthly premium paid to Medicare (usually deducted from a member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services, whether members are covered by a Medicare Advantage plan or by original Medicare.

Medicare Part C: Medicare Part C is optional coverage that can be elected by the Medicare beneficiary. Coverage under Part C is provided by health maintenance organizations (HMO) or by select preferred provider organizations (PPO). The HMO or PPO must provide all Part A and B services in its plan and may offer additional benefits to the beneficiary.

Medicare Part D: the prescription drug coverage provided by a Medicare Advantage (MA) plan or by a stand-alone Prescription Drug Plan (PDP) contracted with CMS. The MA plan or PDP may charge the beneficiary premiums and cost sharing for this coverage. AlphaCare of NY offers a MAPD plan.

Medicare Advantage (MA) agreement: the agreement between AlphaCare of NY and the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Part C and other health plan services to AlphaCare of NY members.

Medicare Advantage (MA) plan: a policy or benefit package offered by a Medicare Advantage Organization (MAO) in which a specific set of health benefits are offered at a uniform premium level of cost sharing to all Medicare beneficiaries residing in the corresponding service area. An MAO may offer more than one benefit plan in the same service area. The AlphaCare of NY MAPD plan is a kind of MA plan.

Medicare Eligible Beneficiary (AlphaCare Renew HMO): Medicare beneficiaries with Parts A and B who reside in our service area.

Medicare Eligible Beneficiaries (AlphaCare Resilience HMO SNP): Medicare beneficiaries with Parts A and B who reside, long-term, in a contracted nursing home within the service area. This is a special needs plan for institutional beneficiaries.

Member: A person covered by AlphaCare of NY and enrolled in benefit programs offered by AlphaCare of NY.

MLTC: Managed Long Term Care

Nonparticipating Provider: A provider of medical care and/or services with which the health plan has no Provider Agreement.

Participating Provider: a professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish health care services and has a contract directly or indirectly with AlphaCare of NY to provide services directly or indirectly to members pursuant to the terms of the participating provider agreement.

PHI: Protected Health Information.

PQIs: Prevention Quality Indicators are a set of measures developed by the Federal Agency for Healthcare Research and Quality (AHRQ) for use in assessing the quality of outpatient care for "ambulatory care sensitive conditions" (ACSCs).

Primary Care Provider (PCP): a participating provider selected by a member to coordinate the member's health care. The PCP is responsible for providing covered services for Medicare members and coordinating referrals to specialists. PCPs usually practice internal medicine, family practice or general practice medicine.

Prior Authorization: The process whereby a provider must receive approval from the Care Management department prior to rendering services.

Provider Agreement: Any written contract between the health plan and a participating provider to provide medical care and/or services under this agreement.

Provider payment dispute: a request for AlphaCare of NY to review the claim adjudication as the provider feels payment was not rendered as per the contractual agreement between AlphaCare of NY and the provider.

Qualified Medicare Beneficiary (QMB): an individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the FPL and whose resources do not exceed twice the SSI limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance and copayments (except for Medicare Part D). Collectively these benefits (services) are called QMB Medicaid benefits (services).

RAF: Risk Adjustment Factor, is a score dependent on how thoroughly physicians document all of a patient's pertinent medical condition at least once a year during a face-to-face visit.

Service area: a geographic area where members reside and the health plan is authorized to operate. Approved by New York State and CMS within which an eligible individual may enroll in an AlphaCare of NY plan.

Skilled Nursing Facility (SNF): A facility that provides inpatient Skilled Nursing Care, rehabilitation services or other related health services. This term does not apply to convalescent nursing homes, rest homes, or facilities for the aged that primarily furnish custodial care including the training in routines of daily living.

Urgently needed services: those covered services provided when the member is temporarily absent from the Medicare Advantage service area, or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member's PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.

Section 15: Appendices

Appendix I – Appointment Availability and 24HR Access Standards

AlphaCare of NY maintains provider access, visit scheduling and waiting time standards in compliance with NYS regulations, which are actively monitored in conjunction with NYSDOH. AlphaCare of NY conducts audits of provider appointment availability, office waiting times and 24HR access and coverage.

All participating providers are held to these standards in providing care for AlphaCare of NY members.

Emergency Care: an emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the person afflicted with such condition in: A) serious jeopardy, impairment, dysfunction, disfigurement, or; placing the health of others in serious jeopardy, in the case of a behavioral condition.	Care must be provided immediately upon the presentation at the service delivery site.
Urgent Care: Urgent conditions are defined as those illnesses and injuries of a less serious nature than emergencies that require services to prevent serious deterioration of a member's health, which cannot be delayed without imposing undue risk to the patient's well-being, until the patient either returns to the health plan's service area or until the patient can secure services from his/her primary care physician.	Urgent medical or behavioral problems must be seen within 24hrs of request.
Non-urgent Sick Visits: These are visits for symptomatic conditions, which are neither of an emergency nor an urgent nature.	Visit must be scheduled within 48-72hrs of request as indicated by the nature of the clinical problem.
Routine Care: These are visits for routine management of clinical conditions or other follow-up care as is clinically appropriate.	Appointment must be scheduled within 4 weeks of request.
Non-urgent Referred Specialist Visit	Appointments must be scheduled within 4 to 6 weeks of request.

Physicians must practice a minimum of 16hrs per week. To qualify as a primary care provider, the practitioner must be available at a minimum of two (2) days or 16hrs per week at each practice site.

Appendix II – Credentialing Requirements

AlphaCare credentialing requirements apply only to those with whom AlphaCare directly enters in to or plans to contract for health care services rendered independent of professional oversight. Except as may be required by state or federal regulations, this policy does not apply to practitioners who practice exclusively within the setting of an institution or organizational setting.

AlphaCare credentials the following practitioners/providers, at a minimum: Physicians, Podiatrists, Chiropractors, Physician Assistants, Optometrists, Dentists, Nurse Practitioners, Certified Nurse Midwives, Licensed Professional Counselors, Licensed Clinical and Master Social Workers, Licensed Marriage and Family Therapists, Advanced Registered Nurse Practitioners, Licensed Addiction Treatment Counselors, Psychologists, Psychoanalysts, Physical Therapists, Occupational Therapists, Speech/Language Therapists and allied service (ancillary) providers.
AlphaCare credentials the following organizational providers and all practitioners associated with them, Durable Medical Equipment Prosthetic and Orthotic Services, Home Health Services, Adult Social and Health Day Care,
AlphaCare credentials all Hospitals, Skilled Nursing Facilities and Residential Treatment Facilities to the

CMS and New York State Department of Health standards.

The following elements are reviewed in the course of credentialing. Most of these elements are also included at the time of recredentialing:

1. Board certification: Acceptable sources of verification include, but are not limited to:
    - American Medical Association Provider profile
    - American Osteopathic Association
    - American Board of Medical Specialties
    - American Board of Podiatric Surgery
    - American Board of Podiatric Orthopedics and Primary Podiatric Medicine
2. Education and training: Education and training will be verified for all practitioners at the time of initial credentialing. Acceptable sources of verification include but are not limited to:
    - Board certification
    - State-licensing agency
    - Educational institution
3. Work history: A full work history, documenting at least the prior five years, must be submitted at the time of practitioner credentialing. Any gaps in work history greater than six months must be explained in written format
4. Hospital affiliations and privileges: Network practitioners must have clinical privileges, as appropriate to their scope of practice, in good standing at an AlphaCare contracted hospital.
5. State licensure or certification: Initial credentialing applicants must have a current, legal state license or certification if applicable to their field of practice. This information will be verified by referencing data provided to us by the state via:
    - Roster
    - Telephone
    - Written verification
    - Internet
6. Drug Enforcement Administration (DEA) number: Initial practitioner applicants must provide their current DEA numbers, if applicable, to AlphaCare for verification.
7. Evidence of professional and general liability coverage: A copy of the malpractice face sheet will provide evidence of coverage. In addition, an attestation which includes the following information may be used:
    - Name of the carrier
    - Policy number
    - Coverage limits
    - Effective and expiration dates of such malpractice coverage
8. As a practitioner or a provider, you must maintain professional and general liability insurance in specified amounts in accordance with your AlphaCare contract.
9. Professional liability claims history: Initial credentialing applicants will be asked to provide a full professional liability claims history. This information will be assessed along with a query of the National Practitioner's Data Bank (NPDB).
10. Provider Sanctions History: All initial credentialing practitioner and provider applicants must not have any sanctions by Medicare, Medicaid, or any federal or state exclusions lists. This information is verified by accessing the NPDB, OIG, NYS OMIG, SDN, SAM and NSOR.
11. Disclosures — attestation and release of information: All initial credentialing applicants must respond to questions, including within the application regarding the following:
    - Reasons for being unable to perform the essential functions of the position with or without accommodation
    - History or current problems with chemical dependency, alcohol or substance abuse
    - History of license revocations, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
    - History of conviction of any criminal offense other than minor traffic violations
    - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
    - History of complaints or adverse action reports filed with a local, state or national professional society, licensing board or accrediting bodies
    - History of refusal, cancellation or nonrenewal

of professional liability insurance

» History of suspension or revocation of a DEA or CDS certificate

» History of any Medicare or Medicaid sanctions

» Applicants must also provide a/an:

» Attestation of the correctness and completeness of the application

» Explanation in writing of any identified issues

12. Disclosure of ownership: CMS requires the collection of certain information regarding the ownership and control of entities with which we contract for services for federal employees or federal health plans. This information is required for participation in the AlphaCare network. All individuals and entities included on the form must be clear of any sanctions or exclusions by Medicare and Medicaid or any federal health care programs
13. License history: The appropriate state-licensing board/agency is queried, along with the National Practitioner Databank (NPDB), as part of the credentialing process

The credentialing committee approves or denies the credentialing request based on information presented in the provider's application and any additional documentation provided in the course of the credentialing process. AlphaCare notifies the applicant either by telephone, email or in writing if any information obtained in support of the credentialing or recredentialing process varies substantially from the information submitted by the provider/practitioner. Each applicant has the right to review all information used in reaching the decision and may appeal a denied application.

Appendix III – Medical Record Standards

AlphaCare of NY providers are required to maintain member's medical records of members in a manner that is current, detailed, organized and comprehensive that will permit effective patient care and quality review.

- Patient's name and ID number on each page.
- Personal biographical data including the patient's date of birth, address, employer (if applicable), telephone numbers and marital status.
- Problem List that is updated regularly to reflect current medications, allergies, surgeries, significant illnesses, and medical conditions.
- Patient's medical history including serious accidents, operations and illnesses.
- Laboratory and other studies are ordered as appropriate including results.
- Working diagnoses are consistent with treatment plans.
- Unresolved problems from a previous visit addressed in subsequent visits.
- Evidence of preventive screening and services being offered.
- Record of emergency room visits, hospitalizations.
- All entries are signed, dated and stamped.
- The record itself is legible to those other than the writer.
- The member's consent to disclose PHI to AlphaCare of NY.

Behavioral Health PCP Communication Form

Patient Name: ________________________________ Patient Date of Birth: ____________________

Behavioral Health Clinician Name: ____

Clinician Address: ____

____

Clinician Phone/Fax: ____________________________________

Dear Colleague:

I saw the above-named patient, who gave an authorization to release the following information,

on ________________ (Date) for________________________________ (Reason/Diagnosis)

Brief Summary (if indicated):

____

____

____

____

Current Treatment (interventions by sending practitioner):

Psychotherapy Patient Refused Medication

Medication(s) Prescribed: ____

____

____

____

The patient has has not received a copy of this form. If you have any questions or would like additional information, please contact me. Thank you.

Clinician Signature: ________________________________ Date Sent/Faxed: ______________

Phone #: ________________________________

AlphaCare
855-652-5742
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