ALTERWOOD HEALTH
Quality Care. Better Health.

2025 Provider Manual

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Section 1: Welcome to Alterwood Health

Alterwood Health is a health insurance organization formed in Maryland in 2021 by a team of individuals with significant managed care experience. Alterwood Health's organizational structure includes a management company known as Alterwood Health Management Company, Inc. and a number of affiliated Medicare Advantage Organizations (MAOs) that serve as licensed Health Maintenance Organizations (HMOs). The affiliated MAOs' Benefit Plans offer benefits and services to Medicare eligible beneficiaries and certain individuals who are dual-eligible for Medicare and Medicaid. Alterwood Health's corporate office is located in Baltimore County, Maryland.

Purpose of this Manual

This Manual is intended for Providers who have contracted to participate in Alterwood Health's network to deliver quality healthcare services to Members enrolled in a Medicare Advantage (MA) Benefit Plan. This Manual serves as a guide to Providers and their staff to comply with the policies and procedures governing the administration of Alterwood Health's MA Benefit Plans and is an extension of, and supplements, the contract (the "Agreement") under which a Provider participates in Alterwood Health's network for MA Benefit Plans.

A paper copy of this Manual is available at no charge to Providers, upon request. In accordance with the Agreement, Participating Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to Alterwood Health's policies and procedures. As policies and procedures change, updates will be issued by Alterwood Health in the form of Provider Bulletins and will be incorporated by reference into subsequent versions of this Manual. Unless otherwise provided in the Agreement, Alterwood Health will communicate changes to the Manual through a Table of Revisions in the front of the Manual; Provider Bulletins posted to the Provider Portal on Alterwood Health's website; or in a Provider Newsletter.

Alterwood Health will abide by any additional requirements in the Agreement regarding communication of changes, if required by the Agreement. Alterwood Health may release Provider Bulletins that are state-specific and may override the policies and procedures in this Manual for that specific state only.

Alterwood Health Medicare Advantage

Alterwood Health, via its licensed MAOs, administers coverage that includes all of the benefits traditionally covered by Medicare plus additional benefits identified in the Benefit Plan's coverage documents. Such additional benefits may include, but are not limited to:

- No or low monthly health plan premiums with predictable co-pays for in-network services;
- Outpatient prescription drug coverage;
- Routine dental, vision, and hearing benefits;
- Over the counter (OTC) benefits; and
- Non-emergency medical transportation

Additional benefits may vary by plan and county and are governed by the applicable Benefit Plan.

Alterwood Health Products

Alterwood Health's products are designed to offer enhanced benefits to its Members as well as cost-sharing alternatives. Alterwood Health's products are offered in selected markets to allow flexibility and offer a distinct set of benefits to fit Member needs in each area. For more information on Alterwood Health's products, visit www.AlterwoodAdvantage.com.

Below is a list of Alterwood Health's MA products. The list may change from time to time.

Health Maintenance Organization (HMO) - Traditional MA plan. All services must be provided within the Alterwood Health network unless an emergency or urgent need for care arises, or such service is not available in-network. Some services require prior authorization by Alterwood Health or its designee.

Dual-Eligible Special Needs Plan (D-SNP) - A special type of plan that provides more focused healthcare for people who have Medicare and Medicaid and live within the plan service area. Like all Medicare Advantage plans, it is approved by CMS. These plans provide a coordinated Medicare and Medicaid benefit package that offers more integrated or aligned care than regular Medicare Advantage plans or Original Medicare. All services must be provided within the network unless an emergency or urgent need for care arises, or such service is not available in-network. Some services require prior authorization by Alterwood Health or its designee.

Provider Services Phone Number

The Provider Services toll-free number is 866-274-3265.

Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

In accordance with generally accepted professional standards and Alterwood Health procedures, participating Providers must:

- Meet the requirements of all applicable state and federal laws and regulations including, without limitation, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973
- Agree to cooperate with Alterwood Health in its efforts to monitor compliance with its MA contract(s) and/or MA rules and regulations, and assist Alterwood Health in complying with corrective action plans necessary to comply with such rules and regulations
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to Alterwood Health Members as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of healthcare
- Respond within the identified time frame in the Agreement to Alterwood Health's requests for medical records in order to comply with regulatory requirements
- Maintain a member medical record that accurately reflects the preventive, routine, and specialty care provided. All records pertaining to a member's care must be in one central medical record. The member's name must be on each page of notes, lab results, and consults, and the provider must initial and date each test or lab result indicating it has been reviewed
- Cooperate and comply with Alterwood Health's utilization management procedures, quality management procedures, and quality improvement activities
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen
- Not differentiate or discriminate in the treatment of members on the basis of source of payment for covered services, gender, age, race, color, religion, origin, place of residence, economic or health status, disability, or medical condition, including mental as well as physical condition, claims experience or medical history
- Freely communicate with and advise Members regarding the diagnosis of the Member's condition and advocate on the Member's behalf for the Member's health status, medical care, and available treatment or non-treatment options, including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services

Responsibilities of All Providers

The following is a summary of the responsibilities of all Providers who render services to Alterwood Health Members.

Maximum Out-of-Pocket

For MA Benefit Plans, Member Expenses are limited by a maximum out-of-pocket (MOOP) amount. If a Member has reached the maximum out-of-pocket amount for that particular Member's Benefit Plan, a Provider should not collect any additional out-of-pocket amounts from the Member for Medicare Covered Services and should not apply or deduct any Member Expenses from that Provider's reimbursement. Providers may determine a Member's accumulated out-of-pocket amount via the Alterwood Health provider portal or by contacting Alterwood Health's Provider Services Department. In the event a Provider collects an out-of-pocket amount that causes a Member to exceed his or her annual maximum out-of-pocket, Alterwood Health will notify the Provider that the amount collected from the Member was in excess of the maximum out-of-pocket, and the Provider shall promptly reimburse the Member for that amount.

Member Hold Harmless

Participating providers are prohibited from balance billing Alterwood Health members including, but not limited to situations involving non-payment by Alterwood Health, Alterwood Health's breach of its Agreement, or insolvency of Alterwood Health. Providers cannot bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against members or persons other than Alterwood Heath, acting on behalf of members for covered services pursuant to the Participating Provider's Agreement. The provider is not prohibited from collecting copayments, coinsurances, or deductibles for covered services in accordance with the terms of the applicable member's Benefit Plan.

Confidentiality

Providers are expected to maintain policies and procedures within their offices to prevent the unauthorized or inadvertent disclosure of confidential information.

At Alterwood Health, we know our members' privacy is extremely important to them, and we respect their right to privacy when it comes to their personal information and health care. We are committed to protecting our members' personal information. Alterwood Health does not disclose member information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law. Because you are a valued provider to Alterwood Health, we want you to know the steps we have taken to protect the privacy of our members. This includes how we gather and use their personal information. Alterwood Health's privacy practices apply to all of Alterwood Health's past, present, and future members.

When a member joins an Alterwood Health Medicare Advantage plan, the member agrees to give Alterwood Health access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium.

Access to PHI allows Alterwood Health to work with providers, like yourself, to decide whether a service is a Covered Service and pay your clean claims for Covered Services using the members' medical records. Medical records and claims are generally used to review treatment and to do quality assurance activities. It also allows Alterwood Health to look at how care is delivered and carry out programs to improve the quality of care Alterwood Health's members receive. This information also helps Alterwood Health manage the treatment of diseases to improve our members' quality of life.

Alterwood Health's members have additional rights over their health information. They have the right to:

- Send Alterwood Health a written request to see or get a copy of information about them or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer Alterwood Health's member to the source of the information.
- Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.
- Receive an accounting of Alterwood Health's disclosures of their medical information, except when those disclosures are for treatment, payment, or health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect member PHI.

Access Standards

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member's needs.

Service	**Appointment Wait time (*not more than*)**
PCP Routine/Preventive Care	30 calendar days
PCP Non-Urgent (Symptomatic)	Seven (7) calendar days
PCP Urgent Care	Immediate/Same Day
PCP Emergency Services	Immediate/Same Day
Specialist Routine	30 calendar days
Specialist Non-Urgent (Symptomatic)	Seven (7) calendar days
Behavioral Health Routine Initial	10 business days
Behavioral Health Routine Follow-up	30 calendar days
Behavioral Health Urgent	48 hours
Behavioral Health Emergency	6 hours
Office Wait Time	30 minutes

Eligibility Verification

A Member's eligibility status can change at any time. Therefore, all Providers should request and make a copy of the Member's identification card, along with additional proof of identification such as a photo ID, and file them in the patient's medical record.

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment.

Provider Billing and Address Changes

Providers are required to give prior notice for any of the following changes. Please contact Alterwood Health to report changes to your:

- 1099 mailing address
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and fax number
- Panel status (open/closed)

Advance Directives

The Federal Patient Self-Determination Act ensures the patient's right is to participate in health care decision-making, including decisions about withholding resuscitative services, and declining or withdrawing life sustaining treatment. In accordance with guidelines established by CMS, and our own policies and procedures, Alterwood Health requires all participating providers to have a process in place pursuant to the intent of the Federal Patient Self-Determination Act.

The member may inform all providers contracted directly or indirectly with Alterwood Health that the member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his or her medical record.

If the PCP or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he or she must advise the member and Alterwood Health. Alterwood Health and the PCP and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in The Federal Patient Self Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience.

To make sure that providers maintain the required processes regarding Advance Directives, Advantage MD conducts periodic patient medical record reviews to confirm that the required documentation exists.

Responsibilities of Primary Care Providers

PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week. To ensure access and availability, PCPs must provide one of the following:

- Answering service with specific instructions on how the member can reach the provider directly for urgent services and how to access emergency services
- Pager service to gain access to the provider with specific instructions on how the member can reach the provider directly for urgent services and how to access emergency services

- Answering machine with specific instructions on how the member can reach the provider directly for urgent services and how to access emergency services

Covering Physicians/Providers
In the event that a PCP's covering Provider is temporarily unavailable, the PCP should make arrangements with another Provider who participates in Alterwood Health's MA program. In the event of an emergency, Members may seek care from any Provider – regardless of whether the Provider is contracted with Alterwood Health. In non-emergency cases, Providers should contact Alterwood Health for approval of any covering physician/Provider who is not contracted with Alterwood Health or has not been credentialed by Alterwood Health.

Assignment of Primary Care Provider
Most Members will choose a PCP or one will be assigned to the Member by Alterwood Health.

Closing of Provider Panel
When requesting closure of their panel to new Members and/or transferring Alterwood Health Members, PCPs must:

- Submit the request in writing at least 30 days prior to the effective date of closing the panel
- Keep the panel open for Alterwood Health Members who were provided services before the closing of the panel
- Notify Alterwood Health when reopening the panel and provide the effective date

Termination of a Member
A PCP may not seek or request to terminate his or her relationship with a Member or transfer a Member to another Provider based on the Member's medical condition, amount or variety of care required or the cost of Covered Services required by the Member.

Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. In the event that a Provider desires to terminate his or her relationship with a Member, the Provider must complete a PCP Request for Transfer of Member form and attach documentation of the Member's non-compliance with treatment or uncooperative behavior that is impairing the ability to care for and treat the Member effectively. The form should be faxed or emailed to Alterwood Health's Provider Services Department.

Once the form has been submitted, the Provider shall continue to provide medical care for the Member until such time that written notification is received from Alterwood Health confirming that the Member has been successfully transferred to another Provider.

Annual Wellness Visit
An annual wellness visit should be completed to assess the health status of all Alterwood Health MA Members. The adult Member should receive an appropriate assessment and intervention as indicated or upon request.

Member Administrative Guidelines

Alterwood Health will make information available to Members on the role of the PCP, how to obtain care, what to do in an emergency or urgent medical situation as well as Members' rights and responsibilities. Alterwood Health will convey this information through various methods including an Evidence of Coverage.

Evidence of Coverage Booklet

All Members receive an Evidence of Coverage, which is shared on Alterwood Health's website at www.AlterwoodAdvantage.com.

Enrollment

Alterwood Health must obey laws that protect from discrimination or unfair treatment. Alterwood Health does not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin.

Upon enrollment with Alterwood Health, Members are provided the following:

- Terms and conditions of enrollment
- Description of covered non-emergency services in-network and out-of-network, if applicable
- Information regarding coverage of out-of-network emergency/urgent care services
- Information about PCPs, such as location, telephone number and office hours
- Grievance and disenrollment procedures
- Brochures describing certain benefits not traditionally covered by Medicare and other value-added items or services, if applicable

Member Identification Cards

Member identification cards are intended to identify Alterwood Health Members, including the type of plan they have, and facilitate their interactions with healthcare providers. Information found on the Member identification card may include the Member's name, identification number, plan type, PCP's name and telephone number, co-payment information, health plan contact information, and claims filing address. Possession of the Member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

Member Rights and Responsibilities

Alterwood Health Members have specific rights and responsibilities when it comes to their care. The Member rights and responsibilities are provided to Members in the Member's Evidence of Coverage and are outlined below. Providers will deliver care to Members in accordance with these rights and responsibilities. In the case of a conflict between the Evidence of Coverage applicable to a given Member and the provisions below, the Evidence of Coverage governs.

Members have the right to:

- Have information provided in a way that works for them, including information that is available in alternate languages and formats.
- Be treated with fairness, respect, and dignity.
- See in-network Providers, get Covered Services, and get prescriptions filled in a timely manner.

- Privacy and to have their protected health information (PHI) protected,
- Receive information about Alterwood Health, its network of Providers and practitioners, their Covered Services, and their rights and responsibilities.
- Know their treatment choices and participate in decisions about their healthcare
- Use advance directives (such as a living will or a durable healthcare power of attorney).
- Make complaints about Alterwood Health or the care provided and feel confident it will not adversely affect the way they are treated.
- Appeal medical or administrative decisions Alterwood Health has made by using the grievance process.
- Make recommendations about Alterwood Health's Member rights and responsibilities policies.
- Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. The information must be given to Members in a way they understand.

Members also have certain responsibilities. These include the responsibility to:

- Become familiar with their coverage and the rules they must follow to get care as a Member.
- Tell Alterwood Health and Providers if they have any additional health insurance coverage or prescription drug coverage.
- Tell their PCP and other healthcare Providers that they are enrolled in Alterwood Health.
- Give their PCP and other Providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their Providers agree upon.
- Understand their health problems and help set treatment goals that they and their doctor agree to.
- Ask their PCP and other Providers questions about treatment if they do not understand.
- Make sure their Providers know all of the drugs they are taking, including over-the-counter drugs, vitamins and supplements.
- Pay their plan premiums and any co-payments or coinsurance they owe for the Covered Services they get. Members must also meet their other financial responsibilities as described in the Evidence of Coverage booklet.
- Inform Alterwood Health if they move.
- Inform Alterwood Health of any questions, concerns, problems or suggestions by calling the Member Services Department listed in their Evidence of Coverage booklet.

Changing Primary Care Providers
Members may change their PCP selection at any time by calling Alterwood Health's Member Services Department.

Women's Health Specialists
PCPs may also provide routine and preventive healthcare services that are specific to female Members. If a female Member selects a PCP who does not provide these services, she has the right to direct, in-network access to a women's health specialist for Covered Services related to this type of routine and preventive care.

Hearing-Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to Members through Alterwood Health Member Services. PCPs should coordinate these services for Members and contact Member Services if assistance is needed.

Section 3: Health & Quality: Advancing Population Health

Alterwood is advancing population health by integrating the services of care management, pharmacy management, utilization management, and quality improvement and leveraging data to drive our decisions. We have implemented a member and population centered model to promote continuity and coordination of care, remove barriers to care, prevent complications/adverse events and improve our populations' quality of life; one member at a time.

We value our partnership and hope you will engage with us to improve your patients' lives.

Quality…

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage organizations to have an ongoing Quality Improvement (QI) program to ensure health plans have the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The requirements for the QI program are based in regulation at 42 CFR§ 422.152. At Alterwood, we have incorporated quality in everything we do.

Purpose of the QI Program

The primary objective of the Quality Improvement program (QIP) is to promote and build quality into the organizational structure and develop a systematic plan for monitoring, evaluating, and improving the quality of care and services for MAPD and D-SNP enrollees. Prioritizing and monitoring of the most vulnerable individuals in these populations, which include those who are frail, disabled, near the end of life and with multiple or complex chronic conditions.

The QIP provides guidance for the management and coordination of all quality improvement and quality management activities throughout the organization, its affiliates, and delegated entities.

The program describes the processes and resources to continuously monitor, evaluate and improve the clinical care and services provided to enrollees for both their physical and behavioral health. The program also defines Alterwood's methodology for identifying improvement opportunities and developing and implementing initiatives to impact members/populations in a positive way.

Examples of quality assessment monitoring activities included in our program:

- Annual collection, validation and evaluation of Health Effectiveness Data and Information Set (HEDIS) measures
- Clinical and non-clinical performance improvement projects including the Chronic Care Improvement Program (CCIP)
- Medicare member satisfaction and functional assessments using NCQA certified CAHPS and Medicare's Health Outcome Survey (HOS)
- Collection and reporting of Part C Reporting Elements
- Collection and reporting of Part D Reporting Elements, including the Medication Therapy Management Program (MTMP)
- Assessment of provider satisfaction using an instrument that is approved by CMS
- Collection and evaluation of specific performance measures as identified by CMS and the States

Scope of the QI Program

Quality is the core concept that drives each department at Alterwood. Everyone has a role and responsibilities in the QIP. The program is comprehensive, systematic, and based on policies, procedures, and clinical practice guidelines. We utilize best practices and standards from CMS, and relevant accreditation entities.

The scope of Alterwood's program includes quality planning, quality control and quality improvement functions.

Quality Planning activities include, but are not limited to:

- Defining and implementing written policies and procedures and assuring regular written updates
- Using current medical necessity criteria, evidence-based clinical practice guidelines and best practice models with providers' input and approval
- Training programs for staff and providers
- Employing qualified staff and effective leaders that promote quality in day-to-day processes
- Utilizing multidisciplinary teams with a combination of front-line staff, management staff and provider representatives
- Establishing annual priorities and a comprehensive quality improvement work plan

Quality Control activities include, but are not limited to:

- Identifying reliable and valid indicators to monitor key processes
- Measuring data at appropriate frequencies to ensure processes are working as intended
- Instituting thresholds and defining acceptable levels of performance
- Utilizing automation and technology to promote consistent performance and reduce variances
- Implementing internal Corrective Action Plans (CAPs) as needed
- Establishing ad hoc quality improvement strategy meetings as needed

Quality Improvement activities include, but are not limited to:

- Defining valid methodologies for data collection
- Collecting and analyzing baseline data
- Establishing ongoing continuous monitoring and evaluation activities, including a combination of process and outcome indicators
- Convening workgroups to plan, implement and evaluate specific quality improvement projects
- Communicating quality improvement data/analyses, action plans and results via the Quality Improvement Committee structure
- Providing feedback to providers and staff and encouraging participation in quality committees and initiatives to promote quality care and service
- Translating quality improvement project findings into innovation and re-measurement cycles and/or integrating successes into existing policies and procedures

Program Evaluation

Annually, Alterwood produces a Quality Improvement Evaluation that evaluates the performance and results of the Quality Improvement Program in the prior year. Based on the results, the program's goals and objectives for the coming year are tracked in the Quality Improvement Work Plan. Examples of these goals include:

- Achieving an overall health plan 5.0 STAR rating.
- Striving for the Triple Aim of improving member experience, improving population health, and reducing health care costs.
- Ensuring compliance with all CMS requirements.

Examples of these objectives include:

- Developing a population health management strategy that closely matches the needs of Alterwood's member population.
- Improving the monitoring of the MAPD and D-SNP health and quality programs and initiatives through a renewed focus on case audits and health outcomes measures.
- Providing culturally competent and sensitive care and service to Alterwood's diverse membership.
- Recognizing and reducing disparities in member health and access to care based on socioeconomic status, race, education level and/or language spoken.
- Protecting patient safety through regular monitoring of the quality of care and services provided by network practitioners.
- Developing mechanisms to increase continuity of care for members between both settings and practitioners. Specifically, target members transitioning out of an inpatient setting to reduce readmissions.
- Increasing outreach, education, and resources available to members with chronic conditions.
- Enhancing the member experience as defined by the CAHPS results through the implementation of targeted initiatives. Specifically, identify member dissatisfaction within the UM process and adjust prior authorization process to improve the experience.
- Continuously monitoring and evaluating new technology and standards of care to safely provide the most advanced care to members.

Quality Committee Structure

Alterwood maintains a committee structure to support the flow of quality information throughout the organization and to the Board of Directors who has the ultimate responsibility for the quality of care and service provided by the organization.

The Corporate Quality Improvement Committee (CQIC) has oversight authority for Quality Improvement activities across the organization and is responsible for ensuring the development and implementation of Medicare's QI program Description, the Annual QI/UM/CM Work Plans, review, and approval of Health Service Policies; monitoring credentialing, delegation oversight, member and provider Appeal activity, and reviewing clinical and service quality initiatives. To monitor and facilitate implementation of the QI program, the CQIC has established appropriate sub-committees that provide oversight of the functions and activities within the scope of the organization's Quality Improvement program. The CQIC may also appoint and convene ad hoc work groups as needed.

Health Care Plan Effectiveness Data and Information Set (HEDIS)

HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) supplemental data (EMR/vendor data), and medical record review data. HEDIS includes measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Controlling High Blood Pressure, Breast Cancer Screening, Medication Reconciliation Post Discharge, and Colorectal Cancer Screening.

HEDIS measures are reported annually in June for the prior year and represent a mandated activity for health plans contracting with the Centers for Medicare and Medicaid Services (CMS). A portion of measures are designated as "hybrid" measures and plans are allowed to collect medical record data for the prior measure year during the annual Medical Record Review (MRR) project. This project typically runs from the end of January until the first week in May. Each spring, Alterwood Representatives collect records from practitioner offices to impact this MRR project and establish final HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections.

All records are handled in accordance with Alterwood's privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506]. Alterwood's HEDIS results are available upon request.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Our Care Model for our Populations…

Our Care Model is focused on our members and how we support them and their providers. Alterwood's Care Model incorporates a cohesive plan of action that addresses members' needs across the continuum of care. The program addresses members' needs in the following focus areas:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety
- Managing multiple chronic illnesses

Alterwood has multiple programs in place to promote continuity and coordination of care, remove barriers to care, prevent complications/adverse events and improve member quality of life. It is important to note that Alterwood treats disease management as a component of the care management continuum, as opposed to a separate and distinct activity. In so doing, we are able to seamlessly manage cases across the care continuum using integrated staffing, content, data resources, risk identification algorithms, and computer applications.

Alterwood employs a segmented and individualized care management approach that focuses on identifying, prioritizing, and triaging cases effectively and efficiently. Our aim is to assess the needs of individual members, to secure their agreement to participate, and to match the scope and intensity of

our services to their needs. Results from health risk assessment surveys, eligibility data, retrospective claims data, and diagnostic values are combined using proprietary rules, and used to identify and stratify members for case management intervention. The plan uses a streamlined operational approach to identify and prioritize member outreach and focuses on working closely with members and family/caregivers to close key gaps in education, self-management, and available resources. Personalized care management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target member groups.

Special Needs Plans (SNP)

In 2008, CMS issued the final regulation "Medicare Improvements for Patients and Providers Act of 2008," known as "MIPPA." This regulation mandated that all Special Needs Plans (SNP) have a filed and approved Model of Care by January 1, 2010. The Patient Protection and Affordable Care Act reinforced the importance of the SNP Model of Care as a fundamental component by requiring NCQA review and approval.

Model of Care (MOC)

The MOC is an evidenced based care management program that facilitates early and on-going assessments of SNP members, including the identification of health risks and major changes in the health status. The SNP MOC provides structure and describes the coordination of care, benefits and services targeted to improve the overall health of our SNP members. The MOC also serves to ensure the unique needs of our SNP members are identified and appropriately addressed.

The SNP MOC identifies the following key care management components:

- SNP population – provides a description of the unique characteristics of our overall and most vulnerable SNP members.
- Care coordination – describes our SNP staff structure, the Health Risk Assessment (HRA), Individualized Care plan (ICP), Interdisciplinary Care Team (ICT) and Care Transition process, all of which identify the services and benefits offered through this plan and are available to our SNP members.
    - The wide range of services is targeted to help our SNP members achieve their optimal health and improve the connection to care.
- Provider Network – describes how providers with specialized expertise correspond to the target population in our SNP program and collaborate with the ICT and contribute to a beneficiary's ICP. It also explains how network providers use evidence-based medicine, when appropriate and care transition protocols. The SNP MOC Training is also addressed in this Section.
    - CMS (Medicare) mandates initial and annual SNP MOC training for staff and providers and documentation to reflect that SNP MOC training was completed. **Completion of training is required.** The SNP MOC Training and attestation can be found under the Provider Tab at www.AlterwoodAdvantage.com.
- MOC Quality Measurement and Performance Improvement – describes the quality improvement plan and identifies goals for the SNP population; this Section of the MOC includes

clinical and member satisfaction goals, as well as on-going performance evaluation of the SNP MOC.

SNP MOC process

Alterwood's SNP MOC care management process focuses on the unique needs of our SNP members with the goal of identifying interventions, care coordination and care transition needs, barrier to care, education, early detection, and symptom management.

The MOC includes key program components, which are benefits and services provided to ensure appropriate care coordination and care management, including the following:

- Health Risk Assessment (HRA) – Alterwood will conduct an HRA to identify care needs. SNP members will have a Health Risk Assessment (HRA) completed within 90 days of enrollment and then annually, within 365 days of the last HRA.
- Individualized Care Plan (ICP) – HRA results, and evidence-based clinical protocols are utilized to develop an ICP. The Interdisciplinary Care Team is responsible for the development of an ICP.
- Interdisciplinary Care Team (ICT) – An ICT is composed of key stakeholders, including the PCP and care managers. The ICT help to develop the ICP.
- Primary Care Providers (PCPs) who treat SNP members are core participants of the ICT as they are the primary care giver. However, ICT participants can also include practitioners of various disciplines and specialties, as well as community resource providers based on the member's individual needs. The member may participate in the ICT meetings, as may health care providers.
- Care Transition – a change in health status could result in new care management needs. As a result, our care management teams provide support to address the specific needs of our SNP population.

As a provider, your participation is required for the coordination of care, care plan management and in identifying additional health care needs for our Special Needs program members.

Your participation is needed at the ICT meetings

The Alterwood Case Manager will invite you to participate in an ICT meeting when your SNP member requires care management. We encourage you to participate in the ICT meeting and to collaborate in the care planning and identification of care planning goals for your SNP member.

The SNP MOC is geared to support our members and you by providing the benefits and services required and by supporting care management and member goal self-management. Additionally, care transitions, whether planned or unplanned, are monitored, and PCPs are informed accordingly. PCP communication to promote continuity of care and ICT involvement is a critical aspect of Cigna's care transitions protocols.

A copy of your members' care plans will be mailed to you. A sample care plan can be found on under the Provider Tab at www.AlterwoodAdvantage.com.

Prescription Drugs…

Prescription drugs, when used under their approved indication(s), are critical to improving and maintaining individual health. Alterwood offers three (3) plans with prescription drug coverage. These plans are:

- Alterwood Advantage Choice
- Alterwood Advantage Choice Plus
- Alterwood Advantage Dual Secure

These plans are Medicare Advantage plus Prescription Drug plans that include medical coverage for medical services such as hospital expenses, doctor visits, and prescription drug coverage.

Some of your patients may be eligible to participate in our Medication Therapy Management program. Engaged members will speak with a pharmacist who will review their medications. If an issue or concern surfaces during this review, the pharmacist will contact you. Please be sure to take these calls and review their recommendations.

Prescription Drug Coverage

Your patient's prescription drug coverage and out-of-pocket copay and co-insurance will vary by plan, drug tier (if applicable), drug supply, and if they reside at home or a long-term care facility. Patients may also receive "Extra Help" to pay for their prescription drugs, which will lower their out-of-pocket copay. You may direct your patients for more information on Extra Help to the local Social Security Administration (SSA) office or call 1-800-772-1213 (TTY 1-800-325-0778 using specialty TTY equipment) between 8:00 AM and 7:00 PM Monday through Friday or visiting https://www.ssa.gov/. They may find the phone number to your local SSA office by using the SSA Office Locator at https://www.ssa.gov/locator. SSA also has a variety of online services at https://www.ssa.gov/onlineservices/.

Formulary

Each plan has a formulary, which is a CMS approved list of medications covered by Alterwood. The formulary drugs covered are similar from plan to plan, but member's out-of-pocket copay or coinsurance for a prescription will vary.

All formularies offer providers a variety of choices to treat your patients' conditions. You may search, view, or download a copy of the formularies by going to www.AlterwoodAdvantage.com.

Some drugs on the formularies are subject to a coverage determination (also known as prior authorization), step-therapy, and or quantity limits. These are utilization management tools we use to ensure appropriate and medically necessary use of these drugs.

When patients transition into our plan, they may be on drug(s) that are not on the Alterwood formulary. We have made arrangements with the network pharmacies to provide your patients with a transition supply that will allow you to transition you patients to similar drug(s) on the formulary that treats the same condition(s).

Transition Supply

When your patients transition into our plan, they may be on drug(s) that are not on the Alterwood formulary. We have made arrangements with the network pharmacies to provide you a transition

supply that will allow you to transition your patients to similar drug(s) on our formulary that treats the same condition(s).

Your patients may be eligible for a temporary transition supply of their current prescriptions. The following is a summary of our transition policy:

- One (1) month drug supply during the first 90 days of membership with Alterwood as a new member OR within the first 90 days of the calendar year if you are a continuing member and your drug has encountered a negative formulary change.
- You may also be eligible for a one-time, temporary one (1) month drug supply if you qualify for an emergency fill while residing in a long-term care (LTC) facility after the first 90 days as a new member or you have encountered a level of care change.
- If your doctor writes your prescription for fewer days, you may refill the drug until you've received one (1) month supply as described in your EOC.

It is important to note that Part B drugs/items and other excluded drugs that are not part of the Part D benefit are not eligible for a transition supply.

If you are working on switching your patient to an alternative formulary drug or in the process of requesting an exception ***and*** find that your patient is out of your medication(s) after receiving a temporary supply, please contact us at 667-261-8050 or 1-866-267-3144 toll-free. TTY: 711. Calls to this number are free. We are available 24 hours a day, seven (7) days a week.

Coverage Determinations (CDs)

There are two types of Coverage Determinations. The first CD type is a prior authorization and the second CD type is an exception. There are also two types of exceptions. The first is a formulary exception and the other is a tier exception.

Alterwood requires prior authorization on certain drugs listed on the formulary to ensure appropriate use.

Alterwood requires an exception when:

- A drug is not listed on the formulary
- Your patient is unable to take formulary drugs on "step 1" due to adverse reactions or treatment failure and needs a "step 2" drug
- You need to exceed the quantity limits outlines in the formulary

Note: Tier exceptions are not applicable to Alterwood Dual Secure members who have a one tier formulary. For Alterwood Choice and Choice Plus members, Tier exceptions are available for drugs in Tier 1 through 4 only. Tier exceptions for Tier 5 and 6, if applicable, are not allowed.

Provider Requests

You may contact us to request a coverage determination or exception using the information below.

Method	**Part D Coverage Determinations and Exception Requests**

Call	667-261-8050 or 1-866-267-3144 toll-free. Calls to this number are free. We are available 24 hours a day, seven (7) days a week.
TTY	711 Calls to this number are free. We are available 24 hours a day, seven (7) days a week.
Fax	1-877-503-7231
Write	Elixir Attn: PA Department 2181 E. Aurora Rd., Suite 201 Twinsburg, OH 440807
Website Select "Prescriber"	https://elixirsolutions.promptpa.com/

Elixir will complete CD reviews within 24 hours for expedite requests and 72 hours for standard requests. CMS does not allow for extensions related to Part D CDs requests.

You and your patients will always receive in the mail a letter notifying you of our coverage and exception decisions. When we do not approve request(s), the letter explains your patients' appeal rights and next steps.

You may contact us to request an appeal using the information below.

Method	**Part D Appeals**
Call	667-261-8050 or 1-866-267-3144 toll-free. Calls to this number are free. We are available 24 hours a day, seven (7) days a week.
TTY	711 Calls to this number are free. We are available 24 hours a day, seven (7) days a week.
Fax	1-877-503-7231
Write	Elixir Attn: Appeals Department 2181 E. Aurora Rd., Suite 201 Twinsburg, OH 440807

Elixir will complete Part D appeal reviews within 72 hours for expedite requests and 7 days for standard requests. CMS does not allow for extensions related to Part D appeal requests.

Network Pharmacies

Alterwood has a national network of pharmacies. The network pharmacies in Maryland are listed in our Provider & Pharmacy Directory and network pharmacies out of state can be found in our searchable pharmacy function at www.AlterwoodAdvantage.com

For chronic medications, we encourage you to utilize our mail order pharmacy **Elixir Pharmacy**, LLC, 7835 Freedom Ave. NW, North Canton, OH 44720. To initiate prescription(s) at mail order, prescribers may call 677-261-8050 or 866-267-3144. We are available 24/7.

Other Coverages

OTC & Other Supplemental Benefits

Over-the-counter (OTC) drugs and products are not covered under the Part D benefit. However, some of our plans do have OTC, hearing, and other supplemental coverages through our vendor partners.

Diabetic Supplies

Diabetic supplies are covered under our members' medical or Part C benefit and are not covered under their Part D benefit. For member convenience, Alterwood is allowing certain diabetic supplies to be available at network pharmacies for greater access.

Alterwood covers certain Abbott and LifeScan diabetic supplies such as blood glucose monitors, blood glucose test strips, and lancets at network pharmacies with a valid prescription. Quantity limits are defined by CMS and more details can be found in your EOC.

Alterwood does not cover other manufacturers of diabetic supplies at network pharmacies. Other brands of diabetic supplies may be available at network DME providers with a valid provider order.

Vaccines

Coverage of vaccines vary depending on the vaccine, what it is being used for, and where you patients get the vaccine.

The following Part D vaccines are available at certain network pharmacies and covered by Alterwood:

- Shingles
- Human papillomavirus (HPV)
- Measles, mumps, rubella (MMR)
- Diphtheria
- Pertussis

Part D vaccinations ***do*** have a cost-share that varies depending on where your patient gets vaccinated. Part D vaccines obtained at a network pharmacy will usually have a lower cost-share amount. If your patient gets a Part D vaccine at your office, your patients' cost-share can vary, and they would need to submit a completed request form and copies of prescription receipts for reimbursement.

E-Prescribing

Alterwood encourages all prescribers to adopt e-prescribing technology to avoid medication errors. This will also facilitate getting the right prescription processed by a network pharmacy. More information on e-prescribing can be found at www.cms.gov/Medicare/E-Health/Eprescribing.

MedWatch Reporting

Healthcare professionals and consumers may report adverse events and product problems to MedWatch by calling 1800-FDA-1088, by submitting the FDA MedWatch 3500 form online at https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home.

Questions – Part D Benefits

Members and providers may contact us at 667-261-8050 or 866-267-3144 (TTY: 711). We are available 24 hours a day, 7 days a week.

Medical Care…

Medical care that is medically necessary should consistently be delivered through a quality network of providers. Our Utilization Management (UM) program incorporates utilization review components such as organization determination (i.e., prior authorization or pre-certification), concurrent review, transition (I.e., discharge planning), and retrospective review activities. Each component is designed to evaluate the use of healthcare services based on Member coverage and the appropriateness of care and services defined by the U.S. Centers for Medicare and Medicaid Services (CMS) National Coverage Determination, CMS Local Coverage Determination, MCG (previously known as Milliman Care Guidelines), other government entity such as the U.S. Food and Drug Administration (FDA), or other supported clinical/practice guidelines adopted by Alterwood. In addition, the UM program supports the delivery of medically necessary care and services at the most economical setting by a qualified network provider.

Alterwood does not provide financial incentives to its employees, providers, or other individuals or entities performing UM activities for rendering denial of coverage or care/service determinations. In addition, Alterwood does not award incentives to promote underutilization.

The UM program is intended to support Members and Providers in the delivery of quality and efficient care while also administering the correct benefits.

Organization Determinations (OD)

Alterwood requires prior authorization or pre-certification on:

- All non-emergent and non-urgent inpatient admissions in-network
- All out-of-network services
- Select outpatient services and medications identified and maintained by the Health Services and Quality department
- Radiological and other services/medications performed in an inpatient setting that can be delivered in an outpatient or home setting
- Biological and specialty medications that have a biosimilar or lower cost alternative

Alterwood also has a retrospective review process available within 30 days of when the service or medication being rendered. However, no denied authorization or claims denial has been issued. This retrospective review is only available in certain documented situations such as:

- Provider is unable to obtain the correct insurance information due to the patient being incapacitated.
- Member gave the Provider incorrect insurance information or misinformation regarding health coverage.

- Member has no identification at the time of admission.
- Family members or appointed representative is unaware of member's current insurance coverage.
- Provider communication medium(s) were hindered by a department/organization barrier (faxes not working, electrical shortage, etc.), natural disaster, or unforeseen situation.
- Within five (5) days of an inpatient (hospital or SNF) admission or continued stay unless CMS' retrospective enrollment into Alterwood is greater.
- CMS retrospective enrollment into Alterwood.

Provider Requests

Prior authorization requests for outpatient services, outpatient medication, and planned inpatient/SNF services should be directed to the UM department using the contact information below. Be sure to fax a completed UM request form and relevant medical records/justification. UM request forms can be downloaded from www.AlterwoodAdvantage.com (Provider tab).

Method	Prior Authorization for Medical Care
FAX	410-801-5701
CALL *(initiation only)*	667-262-9412 or 1-866-675-3944 toll-free We are available 8 a.m. to 5 p.m. local time Monday through Friday.
WRITE	Alterwood Attn: Utilization Management P.O. Box 4175 Timonium, MD 21094

Provider questions regarding the authorization process can be directed to the UM department by calling us at the number above.

Provider Notifications

Providers should notify Alterwood's UM department at the numbers listed above of all unplanned inpatient/SNF admissions and actual inpatient admissions of previously approved authorizations. In addition, Providers should also notify Alterwood's UM department on the anticipated and actual discharge date so Alterwood's transition team can collaborate with you, our members, other providers, and facilities to ensure transitions are as smooth as possible.

Alterwood Health will place a summary of the products and services that will require a OD approximately 30 days in advance to its effective date.

Outreach

Alterwood will make at least one (1) outreach to the requesting provider when additional information is needed to make a decision on a request. If Alterwood does not receive additional information requested, we will make the best decision based on the information available within the decision timeframes - see below.

Decision Makers

Approved decisions are made by a nurse, or other appropriate healthcare professional, who has sufficient medical and other expertise; knowledge of the Medicare coverage criteria, and a current, unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (i.e., Puerto Rico), or the District of Columbia.

Partial or full adverse decisions are made by a physician, or other appropriate healthcare professional, who has sufficient medical and other expertise; knowledge of the Medicare coverage criteria, and a current, unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (i.e., Puerto Rico), or the District of Columbia.

Decision Timeframes

Alterwood will complete organization determination requests as expeditiously has the member's health condition requires, but no later than the following decision timeframes.

Request Type	Medical Services	Part B Drugs
Standard	14 days	72 hours
Expedited*	72 hours	24 hours

*Providers must attest that a member's life, health, or ability to regain maximum function could seriously be jeopardized if the standard timeframe is used.

Extensions of the above timeframes may be granted for 14 additional days on standard and expedited ODs (not medication related) if the member requests an extension or when it is in the member's best interest to gather additional medical documentation from the provider. CMS does not allow for extensions on Part B medication requests.

Although available, Alterwood will not generally or regularly extend the timeframe for an expedited organization determination (not medication related) to seek information or records from a contract provider, but may do so if it is justified in the member's interest and due to extraordinary, exigent, or other non-routine circumstances.

Decision Notifications

Members and providers will be notified of Alterwood's OD review outcome in writing within three (3) calendar days of the decision. Verbal notification to the member and provider may occur prior to issuing the written notification.

Concurrent Reviews

Providers should always notify Alterwood of a planned or unplanned admission. Alterwood conducts concurrent reviews on all inpatient admissions into the hospital (directly into and from the emergency room/observation) and skilled nursing facilities/SNF (directly into or from the hospital). An initial approval for the admission will be issued upon provider or facility notification to the plan and on-going medical necessity monitoring reviews will occur periodically throughout the inpatient stay.

Peer-to-Peer

Prior to a written partial or full denial notification is issued to the member and provider, Alterwood will verbally notify the provider(s) of the potential adverse determination. The requesting or servicing provider may contact Alterwood UM department to request a peer-to-peer review. This peer-to-peer review is between the Alterwood Medical Director and the provider requesting the peer-to-peer. The

discussion will entail the details of a member's care, which may include a collaboration on the medical necessity guidelines and other clinical considerations. The outcome of the peer-to-peer must occur prior to the decision notification being issued.

Transitions

Alterwood's Health Nurses will do our best to obtain the target discharge date anticipated by or actual discharge date from the facility. Prior to a member's actual discharge date from the hospital and/or SNF, Alterwood will contact the provider/facility and our member (and potentially our member's appointed representative) to facilitate the transition to home and coordinate access to needed services/medications. To accomplish this, the UM/CM "coordinators" at the discharging entity will need to notify Alterwood's UM department of the actual discharge date.

Non-Participating Providers

Providers who do not have a contract with Alterwood are considered non-PAR (I.e., not participating). Non-PAR providers may request ODs. However, the UM process includes an assessment of whether the services/medications being requested can be delivered within the Alterwood Provider Network. If it is found that the requested* services/medications can be delivered within the Alterwood Provider Network, the request(s) will be denied or partially approved and arrangements will be made by for the member to receive such services/medications from a provider within the Alterwood network.

Requirements for Submitting Clinical Information for Inpatient and Skilled Nursing Facility (SNF) Admissions

Alterwood Health requires that clinical information is submitted each business day during hospital inpatient and SNF admissions. The clinical information must be submitted during business hours on the following business day.

If a member is admitted over the weekend or a holiday and is discharged prior to the facility's notification of admission to Alterwood, Alterwood Health will treat the request as a current request if the notice of admission is received no later than the first business day following admission.

If a member is admitted on a week day and the facility fails to submit clinical information timely and the member is already discharged prior to Alterwood Health receiving clinical information, Alterwood Health will treat it as a retrospective request and administratively deny all days of the admission. The facility may submit an appeal to receive reconsideration of medical necessity.

Skilled Nursing Facility Specific Requirements:

If Alterwood Health does not receive timely clinical information from a SNF, and upon receipt the clinical information would have resulted in a NOMNC, Alterwood Health will carve out the days from coverage for which clinical was not received timely. This includes timely submission of clinical information during an appeal to the Quality Improvement Organization (QIO).

Clinical information must be received from SNFs by 2:00pm on each business day.

Special Requirements for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Outpatient Rehabilitation Facilities – Notice of Medicare Non-Coverage (NOMNC)

Notice of Medicare Non-Coverage (NOMNC): CMS requires that physicians and other healthcare providers give the Notice of Medicare Non-Coverage (NOMNC) to MA health plan members at least two days prior to termination of Skilled Nursing Facility (SNF), home health agency (HHA) or comprehensive

outpatient rehabilitation facility (CORF) services. Additionally, if the member's SNF services are expected to be fewer than two (2) calendar days, the NOMNC should be delivered at the time of admission. For HHA or CORF services, the notice needs to be given no later than the next-to-the-last time services are furnished. The NOMNC informs members how to request an expedited determination from their QIO if they disagree with the termination.

The form and instructions regarding the NOMNC are available on the CMS website at https://www.cms.gov/medicare/medicare-general-information/bni. Practitioners can also contact their QIO for forms or additional information. Forms can also be obtained from Alterwood's Health & Quality Management department. No modification of the text on the CMS NOMNC is allowed.

For the NOMNC to be valid:

- The member must be able to comprehend and fully understand the notice contents.
- The member or his/her authorized representative must sign and date the notice as proof of receipt.
- The notice must be the standardized CMS NOMNC form.

If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of person who witnessed the refusal and his/her signature must be documented on the NOMNC. Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Any assistance used with delivery of the notice also must be documented. If a member is not able to comprehend and fully understand the NOMNC, a representative may assume responsibility for decision-making on the member's behalf; in such cases, the representative, in addition to the member, must receive all required notifications. The following specific information is required to be given when contacting a member's representative of the NOMNC by phone:
The member's last day of covered services and the date when the beneficiary's liability is expected to begin:

- The member's right to appeal a coverage termination decision
- A description of how to request an appeal by a QIO
- The deadline to request a review, as well as what to do if the deadline is missed
- The telephone number of the QIO to request the appeal

The date when the information is verbally communicated is considered the NOMNC's receipt date. Practitioners must document the telephone contact with the member's representative on the NOMNC on the day that it is made, indicating that all of the previous information was included in the communication. The annotated NOMNC also should include:

- The name of the staff person initiating the contact
- The name of the representative contacted by phone
- The date and time of the telephone contact
- The telephone number called

A dated copy of the annotated NOMNC must be placed in the member's medical file, mailed to the representative the same day as the telephone contact and faxed to **Alterwood's Health & Quality Management department.**

If the provider does not return a timely, valid NOMNC, Alterwood reserves the right to hold the provider responsible for all subsequent days. Alterwood considers a returned NOMNC to be timely and valid if:

- The member's acknowledgment is documented on the day of issuance of the NOMNC
- A completed NOMNC is returned to Alterwood by noon the day after issuance

Right to appeal a NOMNC (Fast-track Appeal): CMS offers fast-track appeal procedures to Medicare enrollees, including MA members, when coverage of their SNF, HHA or CORF services will soon end. CMS contracts with QIOs to conduct these fast-track appeals.
When notified by Alterwood or the QIO that the member has requested a fast-track appeal, SNFs, HHAs and CORFs must:

- Provide medical records and documentation to Alterwood and the QIO, as requested, no later than close of the calendar day on which they are notified. This includes, but is not limited to, weekends and holidays.
- Deliver the Detailed Explanation Non-Coverage (DENC) form that is provided by Alterwood (or that is delegated to the practitioner to complete) to members or their authorized representatives no later than close of the calendar day on which they are notified, including on weekends and holidays. The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

If a member misses the time frame to request an appeal from the QIO, the member still can appeal through Alterwood's appeals department.
For more information about notification of termination requirements, practitioners can visit the CMS website at: https://www.cms.gov/medicare/medicare-general-information/bni.

Other Coverages

Vaccines

The following Part B vaccines are available at certain network pharmacies and covered by Alterwood:

- Influenza (flu shot)
- Pneumococcal pneumonia
- Hepatitis B*

*Subject to a Part B vs. Part D determination through Elixir (see Prescription Drug section) to ensure use for intermediate or high-risk individuals.

Part B vaccinations ***do not*** have a cost-share.

Vaccine Adverse Event Reporting System

Established in 1990, the Vaccine Adverse Event Reporting System (VAERS) is a national early warning system to detect possible safety problems in U.S.-licensed vaccines. VAERS is co-managed by the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA). VAERS accepts and analyzes reports of adverse events (possible side effects) after a person has received a vaccination. Anyone can report an adverse event to VAERS. Healthcare professionals are required to report certain adverse events and vaccine manufacturers are required to report all adverse events that come to their attention. Report vaccine events to the VAERS online at https://vaers.hhs.gov/reportevent.html.

Where can you find us?

Providers can access our Health & Quality department by calling 667-262-9412 or 1-866-675-3944 toll-free. We are available Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

Where can our members find us?

Members can access their Health Nurse by calling 667-262-9412 or 1-866-675-3944 toll-free. We are available Monday through Friday, 8:00 a.m. to 5:00 p.m.

Section 4: Claims

Submitting Claims to Alterwood Health

Overview

As a Participating Provider, you have agreed to a payment arrangement as defined in your Participating Agreement with Alterwood Health. Members may not be balanced billed for the difference between the actual billed amount for covered services and your contracted reimbursement rate.

How to submit claims

Claims for Alterwood Health can be submitted in one of the following methods:

Electronically (preferred method) through our clearinghouse:

Availity: Payor ID - RP016

Or

Paper - using a CMS 1500 or UB04. Mail paper claims to:

Alterwood Health
PO Box 981832
El Paso, TX 79998-1832

All claims, whether paper or electronic, should be submitted using standard clean claim requirements including, but not limited to:

- Member name and address
- Member ID number
- Place of service
- Provider name
- Provider NPI
- Diagnosis (ICD-10) code(s) and description(s)
- Applicable CPT/Revenue/HCPCS codes
- Applicable modifiers

- ✓ All paper claims must be submitted on original (red ink on white paper) claim forms.
- ✓ Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.

Timely Claims Submission Unless otherwise stated in the Agreement, Providers must submit Clean Claims (initial, corrected and voided) to Alterwood Health within 180 calendar days from the date of discharge (for inpatient services) or the date of service (for all other services). The start date for determining the

timely filing period is the "from" date reported on a CMS-1500 or 837-P for professional claims or the "through" date used on the UB-04 or 837-I for institutional claims.

Unless prohibited by federal law or CMS, Alterwood Health may deny payment of any claim that fails to meet Alterwood Health's submission requirements for Clean Claims or failure to timely submit a Clean Claim to Alterwood Health. A Provider whose claim is denied as described in this paragraph must not bill or accept payment from the Member for the services in question.

Coordination of Benefits (COB)

Alterwood Health shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan, applicable state and federal laws, and applicable CMS guidance. If Alterwood Health is the secondary insurer, Providers must bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to Alterwood Health. Any balance due after receipt of payment from the primary payer should be submitted to Alterwood Health for consideration and the claim must include information verifying the payment amount received from the primary payer. COB information can be submitted to Alterwood Health by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the primary insurer's explanation of benefits.

Alterwood Health may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services, to the extent permitted by applicable laws.

Balance Billing

Providers shall accept payment from Alterwood Health for Covered Services provided to Alterwood Health Members in accordance with the reimbursement terms outlined in the Agreement. Payment from Alterwood Health for Covered Services constitutes payment in full, with the exception of applicable Member Expenses. For Covered Services, Providers shall not balance bill Members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of Alterwood Health's claims policies and/or procedures does not indicate that the service provided is a Non-Covered Service, and Members are to be held harmless for Covered Services. Providers may not bill Members for:

- The difference between actual charges and the contracted reimbursement amount
- Services denied due to timely filing requirements
- Covered Services for which a claim has been returned and denied for lack of information
- Remaining or denied charges for those services where the Provider fails to notify Alterwood Health of a service that required Prior Authorization
- Covered Services for which payment was reduced as a result of claim editing as described in this Manual
- Covered Services that were not Medically Necessary, in the judgment of Alterwood Health, unless prior to rendering the service the Provider obtains the Member's informed written consent and the Member receives information that he or she will be financially responsible for the specific services
- Cost share for full-dual DSNP Members with Medicaid secondary coverage

Member Expenses and Maximum Out-of-Pocket

The Provider is responsible for collecting Member Expenses. Providers are not to bill Members for missed appointments, administrative fees or other similar type fees. If a Provider collects Member Expenses determined by Alterwood Health to exceed the correct amount of Member Expenses, the Provider must promptly reimburse the Member the excess amount. The Provider may determine an excess amount by referring to the Explanation of Payment (EOP).

For MA Benefit Plans, Member Expenses are limited by a maximum out-of-pocket amount. For more information on maximum out-of-pocket amounts, and responsibilities of a Provider to a Member, refer to Section 2 of this Manual: Provider and Member Administrative Guidelines.

Claims Payment Disputes

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Alterwood Health in writing within 90 calendar days of the date of denial set forth in the EOP.

When submitting a dispute, the Provider must provide the following information:

- Date(s) of service
- Member name
- Member ID number and/or date of birth
- Provider name
- Provider Tax ID/TIN
- Total billed charges
- The Provider's statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g., proof of timely filing, medical records)

To initiate the process, please refer to the state-specific Quick Reference Guides located on Alterwood Health's website at www.alterwoodhealth.com. Select the appropriate state from the drop-down menu and click on Overview under Medicare in the Providers drop-down menu.

Overpayment Recovery

Alterwood Advantage strives for 100% payment quality but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as retroactive Member termination, inappropriate coding, duplication of payments, nonauthorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s) and other reasons.
If the Provider independently identifies an overpayment, it can send the overpayment amount along with the written explanation to:

Alterwood Advantage, Inc.
PO Box 4175
Timonium, MD 21094

Investigative Audits

Quality healthcare is based on accurate and complete medical record documentation. Alterwood Health's Special Investigations Unit (SIU) conducts medical record audits as part of our investigation process. Medical records are requested from the Provider. Alterwood Health's coding auditors, all of whom are certified professional coders, research and pull the federal regulations/guidelines for each Provider specialty. Auditors perform a comprehensive review that includes how the claim was billed and whether the documentation meets basic billing and coding requirements, as well as documentation requirements as established by the Centers for Medicaid & Medicare Services (CMS) and the applicable state guidelines. Alterwood Health's reviews incorporate Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), CMS guidelines, federal guidelines, and regulations determined by each state.

Section 5: Credentialing

Overview

For purposes of this Section 5: Credentialing, all references to "practitioners" shall include Providers providing health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations.

Credentialing is the process by which the appropriate Alterwood Health peer review bodies evaluate the credentials and qualifications of practitioners. This review includes (as applicable to practitioner type):

- Background
- Education and Training
- Board Certification(s)
- Work history and demonstrated ability
- Malpractice History
- State and Federal Sanctions
- Patient admitting capabilities
- Licensure, to include State, DEA and CDS
- Regulatory compliance and health status which may affect a practitioner's ability to provide healthcare
- Accreditation status, as applicable to non-individuals

Practitioners are required to be credentialed prior to being listed as a Alterwood Health-participating network Provider.

The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and asks for access to the providers CAQH files. Information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification, or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation, and Alterwood Health policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals, and ancillary facilities/healthcare delivery organizations are required to be credentialed in order to be network Providers of services to Alterwood Health Members.
- Satisfactory site inspection evaluations are required to be performed in accordance with state and/or federal accreditation requirements.

After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.

Credentialing may be done directly by Alterwood Health or by an entity approved by Alterwood Health for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall be required to meet Alterwood Health's criteria that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and Alterwood Health requirements.

All Providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures, credentialing forms and files.

Practitioner Rights
Practitioner Rights are listed below and are included in the application/re-application cover letter.

Practitioner's Right to Be Informed of Credentialing/Re-Credentialing Application Status
Written requests for information may be emailed to credentialing@alterwoodhealth.com. Upon receipt of a written request, Alterwood Health will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared with the information provided by the practitioner.

Practitioner's Right to Review Information Submitted in Support of Credentialing/ ReCredentialing Application
The practitioner may review documentation submitted by him or her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies, and certification boards, subject to any Alterwood Health restrictions. Alterwood Health, or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for Provider network participation or re-credentialing.

The Provider may not review peer review information obtained by Alterwood Health.

Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame
In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by Alterwood Health, the practitioner has the right to review the information that was submitted in support of his or her application, and has the right to correct the erroneous information. Alterwood Health will provide written notification to the practitioner of the discrepant information.

Alterwood Health's written notification to the practitioner will include:

- The nature of the discrepant information
- The process for correcting the erroneous information submitted by another source
- The format for submitting corrections

- The time frame for submitting the corrections
- The addressee in the Credentialing Department to whom corrections must be sent
- Alterwood Health's documentation process for receiving the correction information from the Provider
- Alterwood Health's review process

Baseline Criteria
Baseline criteria for practitioners to qualify for Provider network participation:

License to Practice – Practitioners must have a current, valid, unrestricted license to practice.

Drug Enforcement Administration Certificate – Practitioners must have a current valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for M.D., D.O., D.P.M., D.D.S., D.M.D.).

Work History – Practitioners must provide a minimum of five years' relevant work history as a health professional.

Board Certification – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a Provider for Alterwood Health or must have verifiable educational/training from an accredited training program in the specialty requested.

Hospital-Admitting Privileges – Specialist practitioners shall have hospital-admitting privileges at a Alterwood Health-participating hospital (as applicable to specialty). PCPs may have hospital admitting privileges or may enter into a formal agreement with another Alterwood Health-participating Provider who has admitting privileges at a Alterwood Health-participating hospital, for the admission of Members.

Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any Alterwood Health plan. Existing Providers who are sanctioned, and thereby restricted from participation in any government program, are subject to immediate termination in accordance with Alterwood Health policy and procedure and the Agreement.

Providers who Opt Out of Medicare – A Provider who opts out of Medicare is not eligible to become a participating Provider. An existing Provider who opts out of Medicare is not eligible to remain as a participating Provider for Alterwood Health. At the time of initial credentialing, Alterwood Health reviews the state-specific opt-out listing maintained on the designated state carrier's website to determine whether a Provider has opted out of Medicare. The opt-out website is monitored on an ongoing/quarterly basis by Alterwood Health.

Liability Insurance
Alterwood Health Providers (all disciplines) are required to carry and continue to maintain professional liability insurance, unless otherwise agreed by Alterwood Health in writing.

Providers must furnish copies of current professional liability insurance certificate to Alterwood Health, concurrent with expiration.

Site Inspection Evaluation
Site Inspection Evaluations (SIEs) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety, and accessibility, performance standards and thresholds were established for:

- Office site criteria
- Physical accessibility
- Physical appearance
- Adequacy of waiting room and examination room space
- Medical/treatment record-keeping criteria

SIEs are conducted for:

- Unaccredited facilities
- State-specific initial credentialing requirements
- State-specific re-credentialing requirements
- When complaint is received relative to office site criteria

In those states where initial SIEs are not a requirement for credentialing, there is ongoing monitoring of Member complaints. SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

Covering Physicians
Primary care physicians in solo practice must have a covering physician who also participates with, or is credentialed with, Alterwood Health.

Allied Health Professionals
Allied Health Professionals (AHPs), both dependent and independent, are credentialed by Alterwood Health.

Dependent AHPs include the following, and are required to provide collaborative practice information to Alterwood Health:

- ARNPs
- Certified nurse midwives (CNMs)
- PAs
- Osteopathic Assistants (OAs)

Independent AHPs include, but are not limited to the following:

- Licensed clinical social workers
- Audiologists
- Speech/language therapists/pathologists

Ancillary Healthcare Delivery Organizations
Ancillary and organizational applicants, as defined by NCQA criteria, must complete an application and, as applicable, undergo an SIE if unaccredited. Alterwood Health is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage, prior to accepting the applicant as a Alterwood Health participating Provider.

Re-Credentialing
In accordance with regulatory, accreditation, and Alterwood Health policy and procedure, re-credentialing is required at least once every three years.

Updated Documentation
In accordance with the Agreement, Providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to Provider type) to Alterwood Health, prior to or concurrent with its expiration.

Office of Inspector General Medicare/Medicaid Sanctions Report
On a monthly basis, Alterwood Health or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against Alterwood Health's network of Providers. If participating Providers are identified as being currently sanctioned, such Providers are subject to immediate termination, in accordance with Alterwood Health policies and procedures and the Agreement.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials
On a monthly basis, Alterwood Health, or its designee, contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of Alterwood Health Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with Alterwood Health policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Alterwood Health policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the Provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the Provider should continue participation or whether termination should be initiated.

Participating Provider Appeal through the Dispute Resolution Peer Review Process
Alterwood Health may immediately suspend, pending investigation, the participation status of a Provider who, in the sole opinion of Alterwood Health's Medical Director, is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare or safety of Members.

Alterwood Health has a participating Provider dispute resolution peer review panel process in the event Alterwood Health chooses to alter the conditions of participation of a Provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider dispute resolution peer review process has two levels. All disputes in connection with the actions listed below are referred to a first-level peer review panel consisting of at least three qualified

individuals of whom at least one is a participating Provider and a clinical peer of the practitioner that filed the dispute.

The practitioner also has the right to consideration by a second-level peer review panel consisting of at least three qualified individuals of which at least one is a participating Provider and a clinical peer of the practitioner that filed the dispute. The second-level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by Alterwood Health entitle the practitioner affected to the Provider dispute resolution peer review panel process:

- Suspension of participating Provider status for reasons associated with clinical care, conduct or service
- Revocation of participating Provider status for reasons associated with clinical care, conduct or service
- Non-renewal of participating Provider status at time of re-credentialing for reasons associated with clinical care, conduct, service or excessive claims and/or sanction history

Notification of the adverse recommendation, together with reasons for the action, the practitioner's rights, and the process for obtaining the first- and or second-level dispute resolution peer review panel, are provided to the practitioner.

The practitioner has 30 days from the date of Alterwood Health's notice to submit a written request to Alterwood Health. This request must be sent by a nationally recognized overnight carrier or U.S. certified mail, with return receipt, to invoke the dispute resolution peer review panel process.

Upon Alterwood Health's timely receipt of the request, Alterwood Health's Medical Director or his or her designee shall notify the practitioner of the date, time, and telephone access number for the panel hearing. Alterwood Health then notifies the practitioner of the schedule for the review panel hearing.

The practitioner and Alterwood Health are entitled to legal representation at the review panel hearing. The practitioner has the burden of proof by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn therefrom, are arbitrary, unreasonable or capricious.

The dispute resolution peer review panel shall consider and decide the case objectively and in good faith. Alterwood Health's Medical Director, within five business days after final adjournment of the dispute resolution peer review panel hearing, shall notify the practitioner of the results of the first-level panel hearing. In the event the findings are positive for the practitioner, the process concludes and the action against the practitioner's network participation status does not go forward.

In the event the findings of the first-level panel hearing are adverse to the practitioner, the practitioner may access the second-level peer review panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first-level peer review panel.
Within 10 calendar days of the request for a second-level peer review panel hearing, the Medical Director or her or his designee shall notify the practitioner of the date, time, and access number for the second-level peer review panel hearing.

The second-level dispute resolution peer review panel shall consider and decide the case objectively and in good faith. The Medical Director, within five business days after final adjournment of the second-level dispute resolution peer review panel hearing, shall notify the practitioner of the results of the second-level panel hearing via certified or overnight recorded delivery mail. The findings of the second-level peer review panel shall be final. The findings of the second-level peer review panel shall be final, except that the Provider may pursue applicable dispute resolution rights, if any, in the Provider's Agreement.

A practitioner who fails to request the Provider dispute resolution peer review process within the time and in the manner specified waives all rights to such review to which he or she might otherwise have been entitled. Alterwood Health may terminate the practitioner and make the appropriate report to the National Practitioner Data Bank and state licensing agency as appropriate and if applicable.

Delegated Entities

All participating Providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to Section 8: Delegated Entities of this Manual for further details.

Section 6: Appeals and Grievances

Participating Provider Post-Service Appeals (Reconsiderations)

A Participating Provider may appeal a claim payment dispute or utilization review denial on his or her own behalf by mailing or faxing a letter of appeal or an appeal form to Alterwood Health Appeals & Grievances Department with supporting documentation such as medical records or a primary explanation of payment. Request for Reconsideration forms are located on Alterwood Health's website at www.alterwoodadvantage.com.

Filing Timeframes:

- These post-service appeals must be filed in writing and received by Alterwood Health within 90 calendar days of the notice of action (date of decision).
- Post-service appeals received after the 90 calendar days 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. Examples of acceptable proof include, but are not limited to, registered postal receipt signed by a representative of Alterwood Health, or a similar receipt from other commercial delivery services or fax submission confirmation.

Decisions and Timeframes:

- Upon receipt of all required documentation, Alterwood Health has up to 60 calendar days to review the appeal for medical necessity and/or conformity to Alterwood Health guidelines to render a decision to overturn or uphold the original denial.
- If the review determines the Provider has complied with Alterwood Health protocols and that the appealed services were Medically Necessary, the initial denial will be overturned. 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 filed. After the decision to overturn a denial, any claims previously denied as a result of the now-overturned denial will be adjusted for payment.
- If it is determined during the review that the Provider did not comply with Alterwood Health protocols and/or Medical Necessity was not established, or a claim's paid amount was correct, 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.

Required Documentation:

- Member's name, identification number, date of services, and reason why the Provider believes the decision should be overturned.
- 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 Alterwood Health due to lack of information. If the Provider believes that he/she has adequate documentation to support the request for appeal, it is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the lack of medical information denial.
- Records and documents received after that time will not be reviewed and the appeal will remain closed.

Member Appeal (Reconsideration) Process

Participating Provider
Per CMS guidance, participating providers do not have standard appeal rights.

Provider Acting on Behalf of a Member
All appeal rights described in this Section that apply to Members also apply to the Member's authorized representative or a Provider acting on behalf of a Member with the Member's consent.

Overview
A Member appeal is a formal request from a Member for a review of an action/decision taken by Alterwood Health. With the Member's written consent, an appeal may also be filed on the Member's behalf by an authorized representative, or by a Provider who has or is currently treating the Member.

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
- The failure to provide services in a timely manner, as defined by CMS

Appointment of Representative
If the Member wishes to use a representative, he or she must complete a Member Authorization for Disclosure of Protected Health Information and Personal Representative(s) Request (AOR) form. Both the Member and the person who will be representing the Member must sign the AOR form. The form is located on Alterwood Health's website at www.alterwoodadvantage.com. Prior to the service(s) being rendered, physicians may appeal on behalf of the Member.

Alterwood Health 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.

Types of Appeals (Reconsiderations)
Members may request three (3) types of appeals (reconsiderations):

1 Standard Pre-service Appeal:
These appeals must be filed before the Member has received the service. Standard pre-service appeals are requests for coverage of services that Alterwood Health has determined are not Covered Services, are not Medically Necessary, or are otherwise outside of the Member's Benefit Plan.

- These appeals must be filed in writing and received by Alterwood Health within 60 calendar days of the Notice of Action (date of decision).
- Alterwood Health will review the appeal and issue a decision to the Member or the Member's representative within 30 calendar days (7 calendar days for Pharmacy Appeals)

2 Expedited Pre-service Appeal:
These appeals must be filed before the Member has received the service. A request to expedite a Pre-Service Appeal will be considered in situations where applying the standard appeal process could seriously jeopardize the Member's life, health or ability to regain maximum function, including cases in which Alterwood Health makes a partially favorable decision to the Member.

- These appeals can be filed orally or in writing and received by Alterwood Health within 60 calendar days of the notice of action (date of decision).
- Alterwood Health will issue a decision to the Member or the Member's representative within 72 hours.
- To file an appeal orally, a Member may call Alterwood Health Member Services and request to file an expedited pre-service appeal on the phone.

3 Standard Post-Service or Retrospective Appeal:
These appeals are typically requests for payment for care or services that the Member has already received. Accordingly, a post-service appeal would never result in the need for an expedited review. Also, these are the only appeals that may be filed by the Provider on his or her own behalf.

- These appeals must be filed in writing and received by Alterwood Health within 60 calendar days of the notice of action (date of decision).
- Alterwood Health will issue a decision to the Member or the Member's representative within 60 calendar days (7 calendar days for Pharmacy Appeals)

Filing a Standard Pre-Service or Standard Post-Service Appeal After 60 calendar days

If the Member's request for a standard appeal is submitted to Alterwood Health after 60 calendar days from the notice of action (date of decision), then Good Cause must be shown for Alterwood Health 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 (original denial decision), or he or she 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.
- The Member had incorrect or incomplete information concerning the appeal process.

If the Request to Expedite a Pre-Service Appeal is Denied, the Appeal will be processed as a Standard Pre-Service Appeal

If Alterwood Health denies the request to expedite a pre-service appeal, Alterwood Health will provide the Member with verbal notification within 24 hours. Within three calendar days of the verbal notification, Alterwood Health will mail a letter to the Member explaining:

- Alterwood Health will automatically process the request using the Standard Decision timeframe of 30 calendar days for standard appeals;
- The Member's right to file an expedited grievance if he or she disagrees with Alterwood Health's decision not to expedite the pre-service appeal.
- Alterwood Health's instructions about the expedited grievance process and its timeframes; and
- The Member's right to re-submit a request to expedite the pre-service appeal, and if the Member asks his or her Provider for support by providing a written statement indicating that by applying the standard appeal decision timeframe, the Member's life, health or ability to regain maximum function could be seriously jeopardized. When the Provider's statement is received, the re-submitted request will be expedited automatically.

Medicare Beneficiaries have Five Appeal Levels Available

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

1. Reconsideration of adverse organization determination by Alterwood Health
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 have been met
4. Medicare appeals council (MAC) review
5. Judicial review, if the appropriate threshold requirements have been met

Standard Pre-Service and Post-Service Appeal (Reconsideration) Decisions

If Alterwood Health overturns its original denial decision, Alterwood Health will either issue an authorization for the preservice request or send payment if the service has already been rendered.

But if Alterwood Health upholds its original decision and/or denial of medical appeals (does not apply to pharmacy appeals), in whole or in part, Alterwood Health will submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. For standard appeals, the IRE has 30 days from receipt of the appeal case to issue a final determination.

Once the IRE makes a final determination, the IRE will notify the Member or representative and Alterwood Health. In the event the IRE agrees with Alterwood Health, the IRE will provide the Member with further appeal rights.

If the IRE overturns the original denial, the IRE will notify the Member or representative in writing of the decision. Alterwood Health 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 Alterwood Health overturns its original action and/or denial, Alterwood Health will notify the Member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision. If Alterwood Health upholds its original action and/or denial of medical appeals (does not apply to pharmacy appeals) (in whole or in part), Alterwood Health will:

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

Once the IRE makes a final determination, the IRE will notify the Member and Alterwood Health. In the event the IRE agrees with Alterwood Health, the IRE will provide the Member further appeal rights. If the IRE overturns the original denial, the IRE notifies the Member or Member's representative in writing of the decision.

Member Grievances

Participating Provider
Per CMS guidance, participating providers do not have standard grievance rights.

Appointment of Representative
If the Member wishes to use a representative, he or she must complete a Member Authorization for Disclosure of Protected Health Information and Personal Representative(s) Request (AOR) form. Both the Member and the person who will be representing the Member must sign the AOR form. The form is located on Alterwood Health's website at www.alterwoodadvantage.com.

Member Grievance Overview
Members may file a grievance, or with the Member's written consent, a grievance may also be filed on the Member's behalf by an authorized representative (which may include a Provider). All grievance rights described in this Section that apply to Members will also apply to the Member's authorized representative (including a Provider acting on behalf of the Member with the Member's consent).

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)
    - Office conditions
- Services provided by Alterwood Health including, but not limited to:
    - Hold time on telephone
    - Rudeness of staff
    - Involuntary disenrollment from Alterwood Health
    - Unfulfilled requests

- Access availability including, but not limited to:
    - Difficulty getting an appointment
    - Wait time in excess of one hour
    - Handicap accessibility

A Member or a Member's representative may file a standard grievance request either orally on the phone or in writing within 60 calendar days of the date of the incident or when the Member was made aware of the incident. Contact information for the Appeals and Grievance Department is on Alterwood Health's website at www.alterwoodadvantage.com.

Grievance Resolution

Standard Grievance

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 Alterwood Health receives the verbal or written grievance, consistent with applicable federal law. Unless an extension is elected, Alterwood Health will respond to the grievance either in writing or verbally upon review of the Member's grievance.

An extension of up to 14 calendar days may be requested by the Member or the Member's representative. Alterwood Health 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. Alterwood Health will provide the Member or the Member's representative prompt written notification regarding Alterwood Health's intention to extend the grievance decision timeframe.

Alterwood Health's Appeals & 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, Alterwood Health will cooperate with the QIO in resolving the complaint.

Alterwood Health provides all Members with written information about the grievance procedures/process available to them, as well as the complaint processes. Alterwood Health also provides written information to Members and/or their appointed representative(s) about the grievance procedure:

- At initial enrollment,
- Upon involuntary disenrollment initiated by Alterwood Health,
- 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.

Alterwood Health will provide written information to Members and/or their appointed representatives about the QIO process at initial enrollment and annually thereafter.

Expedited Grievance

A Member may request an expedited grievance if Alterwood Health makes a decision:

- Not to expedite a plan determination,
- Not to expedite an appeal or
- Not to invoke an extension to a review.

Alterwood Health 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.

Alterwood Health 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 7: Compliance

Compliance Program

Alterwood Health's Compliance Program, as may be amended from time to time, includes information regarding Alterwood Health's policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by Alterwood Health, Alterwood Health employees, Board Members, contractors (including delegated entities) and business partners in an ethical and legal manner. Alterwood Health suggests all Providers, including Provider's employees and Provider's subcontractors and their employees, be familiar with the following compliance-related matters:

HIPAA Privacy and Security Training
Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA and subsequent amendments to HIPAA.

> Proper uses and disclosures of PHI
> Member Rights
> Physical and technical safeguards
> Fraud, waste, and abuse (FWA) training which must include, but is not limited to:
  - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback Statute, HIPAA, etc.)
  - Obligations of the Provider, including Provider's employees and subcontractors and their employees, to have appropriate policies and procedures to address FWA
  - Process for reporting FWA
  - Protections for employees and subcontractors who report suspected FWA
  - Types of FWA that can occur

Providers, including Provider's employees and subcontractors, must report to Alterwood Health any suspected FWA, misconduct or criminal acts by Alterwood Health or any Provider, including Provider's employees and subcontractors, or by Alterwood Health Members. Reports may be made anonymously by emailing Compliance@alterwoodhealth.com or calling Alterwood Health's hotline at 240-201-9079. Details of the Compliance Program may be found on Alterwood Health's website at www.AlterwoodAdvantage.com.

Marketing Medicare Advantage Plans
Medicare Advantage plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V (replacing regulations formerly at 42 CFR 422.80), and the CMS Managed Care Manual, Chapter 3, Medicare Communications and Marketing Guidelines (MCMGs), including, without limitation, materials governing "Provider-Initiated Activities" in Section 60.1.

Providers must adhere to all applicable laws, regulations and CMS guidelines regarding MA plan marketing, including, without limitation, 42 CFR Part 422, Subpart V and the MCMGs.

CMS holds plan sponsors such as Alterwood Health responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting Providers. Providers are not authorized to

engage in any marketing activity on behalf of Alterwood Health without the prior express written consent of an authorized Alterwood Health representative, and then only in strict accordance with such consent.

International Classification of Diseases (ICD)
ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). Alterwood Health utilizes ICD for all diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor. All Providers must submit HIPAA compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at www.cms.gov, and the ICD-10 Lookup Tool at www.cms.gov/medicare-coverage-database/staticpages/icd-10-codelookup.aspx for specific codes. Information on the ICD-10 transition and codes can also be found at www.AlterwoodAdvantage.com. Select the appropriate state from the drop-down menu and click on ICD-10 Compliance under News and Education in the Providers drop-down menu.

Code of Conduct and Business Ethics

Overview
Alterwood Health has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. Alterwood Health's Code of Conduct and Business Ethics policy can be found at www.AlterwoodAdvantage.com.

Alterwood Health's Corporate Ethics and Compliance Program
The Code of Conduct and Business Ethics is the foundation of Alterwood Health's Compliance Program. It describes Alterwood Health's firm commitment to operate in accordance with the laws and regulations governing its business and accepted standards of business integrity. All associates, participating Providers and other contractors should familiarize themselves with Alterwood Health's Code of Conduct and Business Ethics. Alterwood Health employees, Members, participating Providers and other contractors of Alterwood Health are encouraged to report compliance concerns and any suspected or actual misconduct by Alterwood Health by emailing Compliance@alterwoodhealth.com calling Alterwood Health's hotline at 240-201-9079. Details of the Compliance Program and how to contact Alterwood Health's Fraud Hotline, may be found on Alterwood Health's website at www.AlterwoodAdvantage.com.

Reporting Fraud, Waste and Abuse
Alterwood Health is committed to the prevention, detection and reporting of healthcare FWA according to applicable federal and state statutory, regulatory and contractual requirements. Alterwood Health has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of healthcare service use, including overutilization, unbundling, up-coding, misuse of modifiers and other common schemes. A copy of Alterwood Health's Anti-Fraud Plan may be found on Alterwood Health's website at www.AlterwoodAdvantage.com.

Federal and state regulatory agencies, law enforcement, and Alterwood Health vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement

may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, Providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including, but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating Providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504), Providers and their employees must complete an annual FWA training program.

To report suspicions of FWA, email Compliance@alterwoodhealth.com or by calling Alterwood Health's hotline at 240-201-9079.

Confidentiality of Member Information and Release of Records

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. All consultations or discussions involving the Member or her or his case must be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended. All Provider practice personnel must be trained on HIPAA Privacy and Security regulations. The practice must ensure there is a procedure or process in place for maintaining confidentiality of Members' medical records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures must include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider practice is required to provide Members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Provider employees who have access to Member records and other confidential information are required to sign a confidentiality statement.

Examples of confidential information include, but are not limited to, the following:

- Medical records
- Communication between a Member and a physician regarding the Member's medical care and treatment
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws
- Any communication with other clinical persons involved in the Member's health, medical and behavioral care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.)
- Member transfer to a facility for treatment of drug abuse, alcoholism, behavioral or psychiatric problem

- Any communicable disease, such as AIDS or HIV testing, that is protected under federal or state law

The NPP informs the patient or Member of their rights under HIPAA and how the Provider and/or Alterwood Health may use or disclose the Member's PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or Member.

Disclosure of Information
Periodically, Members may inquire as to the operational and financial nature of their health plan. Alterwood Health will provide that information to the Member upon request. Members can request the above information verbally or in writing.

For more information on how to request this information, Members may contact Member Services using the toll-free telephone number found on the Member's ID card. Providers may contact Provider Services by referring to Alterwood Health's website at www.AlterwoodAdvantage.com.

Discrimination Against Members
Providers will not deny, limit, or condition the coverage or furnishing of benefits to members based on any factor that is related to health status, including, but not limited to medical condition, including mental health as well as physical illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability . Provider shall comply with Section 1557 of the Affordable Care Act (42 USC 18116) and all applicable implementing regulations, including but not limited to providing required notices and meeting applicable accessibility standards.

In addition, Provider will not:
- Make distinctions in the provision of services based on age, sex, disability, race, color, religion or national origin
- Deny a member any service, benefit or availability of a provider based on age, sex, disability, race, color, religion or national origin
- Provide a service or benefit that is different, or provide in a different manner or on a different schedule, from any other member for any reason other than medical necessity and/or capacity .
- Segregate or separate treatment based on age, sex, disability, race, color, religion or national origin
- Treat a member differently from others in receiving any covered service or benefit that is offered to other members .
- Treat a member differently from others in order to provide a service or benefit
- Assign times or places to obtain services based on age, sex, disability, race, color, religion or national origin

OIG and GSA Exclusion Screening

As a Provider of Alterwood Health, Provider is prohibited from employing or contracting with persons or entities that have been excluded from doing business with the Federal Government (42 CFR 1001 .1901). Upon hiring or contracting and monthly thereafter, Provider is required to verify that its employees (including temporary and volunteer), independent contractors, and downstream and related entities (subcontractors) are not excluded by comparing them against the Department of Health and Human

Services (“DHHS”) Office of the Inspector General (“OIG”) List of Excluded Individuals and Entities (“LEIE”) and the General Services Administration (“GSA”) System Award Management (“SAM”) Database . Upon discovery of an excluded individual, Provider must provide immediate disclosure to Alterwood Health. No payment will be made by Alterwood Health for any item or service furnished by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion. To assist Provider with implementation of the OIG/GSA Exclusion process, links to the OIG and GSA exclusion websites and descriptions of the lists are set forth below.

SAM – www.sam.gov

The Excluded Parties List System (“EPLS”) is maintained by the GSA, now a part of the System for Awards Management (“SAM”) .The EPLS is an electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States.

LEIE – http://exclusions.oig.hhs.gov

This list is maintained by HHS OIG and provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all federal health care programs . Individuals and entities who have been reinstated are removed from the LEIE.

Section 8: Delegated Entities

Delegated Entities Overview

Alterwood Health may, by written contract, delegate certain functions under Alterwood Health's contracts with CMS and/or applicable state governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales and marketing, utilization management, quality management, care management, disease management, credentialing, and network management. Alterwood Health may delegate all or a portion of these activities to another entity (a Delegated Entity and/or First-Tier, Downstream and Related Entities).

Alterwood Health oversees the provision of services provided by the Delegated Entity and/or sub-delegate and is accountable to the federal and state agencies for the performance of all delegated functions. It is the sole responsibility of Alterwood Health to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, performance standards, accreditation standards and Alterwood Health policies and procedures.

Delegation Oversight Process
Alterwood Health's FDR Oversight Committee (FDROC) was formed to provide oversight for all subcontracted vendors where specific services are delegated to an entity. Alterwood Health defines a "FDR or Delegated Entity" as a subcontractor which performs a core function under one of Alterwood Health's government contracts. The FDROC is chaired by the Vice President of Business and Regulatory Affairs. The committee members include representatives from the following areas: Compliance, Appeals and Grievances, Operations, Claims, Member Services, and Utilization Management. The Chief Compliance Officer has ultimate authority as to the composition of the FDROC membership. The FDROC holds quarterly meetings, or more frequently as circumstances dictate.

*Refer to Section 7: **Compliance** of this Manual for additional information regarding compliance requirements.*

Alterwood Health ensures compliance through the delegation oversight process and the FDROC by:

- Validating the eligibility of proposed and existing FDR/Delegated Entities for participation in the Medicare program
- If applicable, conducting pre-delegation audits and reviewing the results to evaluate the prospective entity's ability to perform the delegated function
- Providing guidance on written agreement standards with delegated entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity
- Conducting ongoing monitoring activities to evaluate an entity's performance and compliance with regulatory and accreditation requirements
- Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards
- The development and implementation of Corrective Action Plans (CAPs) if the FDR/Delegated Entity's performance is substandard or terms of the agreement are violated
- Reviewing and initiating recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the Plan.

Section 9: Dual-Eligible Members

Overview of Members with Dual Eligibility

Individuals who have Medicare and Medicaid coverage are called “dual eligibles”. For dual eligibles, Medicaid may cover Medicare premiums, Medicare Parts A and B cost share and certain benefits not covered by Medicare. Dual Eligible Special Needs Plans (DSNP) are a type of Medicare Advantage Prescription Drug Plan specifically designed for dual-eligible Members. DSNP plans provide a coordinated Medicare-Medicaid benefit package that may offer more coordinated or integrated care than a regular Medicare Advantage plan.

Types of Dual-Eligible Members in Alterwood Advantage Dual Secure
For the purposes of the agreement with the Maryland Department of Health, Alterwood Health will be offering its DSNP Plan to the following subset of dual eligibles:

- Full Benefit Dual Eligible (FBDE); and
- Qualified Medicare Beneficiaries (QMB)

Payments and Billing
For FBDE and QMB members, Medicaid will typically pay for any Medicare Parts A and B cost-share, premium or deductible amounts. Any supplemental benefit cost share amounts (e.g., hearing, vision and extra dental) are usually the responsibility of the Member.

Providers may not “balance bill” cost-share protected Members. This means Providers may not bill these Members for either the balance of the Medicare rate or the Provider’s 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.

In addition, federal law prohibits Medicare Providers from billing individuals who have QMB status. All Medicare Providers and suppliers, not only those that accept Medicaid, must not charge individuals enrolled in the QMB program for Medicare cost-sharing. QMB members keep cost-share protection even when crossing state lines to receive care. Further, QMB members cannot elect to pay Medicare cost share. Providers who bill QMB Members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

The Provider will receive an Explanation of Payment (EOP) that lists instructions on how to bill for any Medicare Parts A and B cost share amounts due. Generally, Medicare cost share amounts that are due as a result of the provision of services to a dual-eligible Member are billed to the state Medicaid agency, or billed to Alterwood Health or Alterwood Health’s delegated vendor.

Some D-SNP Plans will have a Part B deductible amount applied prior to payment, similar to how Medicare operates today. This deductible is considered a cost-sharing amount and covered by the state Medicaid agency or its designee if the state has managed Medicaid, or by Alterwood Health via an agreement with the state. Providers should bill Alterwood Health as they do today and submit the EOP provided by Alterwood Health to the state for payment. If Alterwood Health is responsible for this amount via an agreement with the state, Alterwood Health will pay this amount on behalf of the state.

Members who enroll after January of each year might have had their deductible amount paid for previously by the state or another health plan. In this instance, Providers should follow the billing process identified above and then send Best Available Evidence (BAE) illustrating that the Member has met their deductible. An example of BAE could be a remittance from the state/health plan illustrating that they have met the Member's deductible previously. If the BAE is submitted and approved, Alterwood Health will re-adjudicate the claim and send appropriate payment to the Provider.

Services that apply to the D-SNP Part B deductible include:

- Cardiac rehabilitation services
- Intensive cardiac rehabilitation services
- Pulmonary rehabilitation services
- Partial hospitalization
- Chiropractic services
- Occupational therapy services
- Physician specialist services
- Mental health specialty services
- Podiatry services
- Other healthcare professional
- Psychiatric services
- Physical therapy and speech-language pathology services
- Medicare covered outpatient diagnostic procedures/tests & lab services
- Diagnostic radiological services
- Therapeutic radiological services
- Outpatient X-rays
- Outpatient hospital services
- Outpatient Observation Services
- Ambulatory surgical center (ASC) services
- Outpatient substance abuse
- Observation services
- Outpatient blood services
- Ground ambulance services
- Air ambulance services
- Durable medical equipment (DME)
- Prosthetics/medical supplies
- End-stage renal disease
- Kidney disease education services

Referral of Dual-Eligible Members

When a Provider refers a dual-eligible Member to another Provider for services, the referring Provider must refer the dual-eligible Member to a Provider who participates with both Alterwood Health and the state Medicaid agency. A directory of Providers who participate with the state Medicaid plan can be located at the applicable state's Medicaid website. The Alterwood Health Medicare Provider Directory displays an indicator when the Provider participates in Medicaid.

Dual-Eligible Members Who Lose Medicaid Eligibility/Status
CMS requires D-SNP plans to provide a Member a period of at least 30 days and up to six months to allow those dual-eligible Members who have lost Medicaid eligibility or had a change in status an opportunity to regain their eligibility. This period is called the "Deeming Period." A change in status occurs when a dual-eligible Member either loses Medicaid eligibility or when a change in Medicaid eligibility occurs that impacts the Member responsibility. Alterwood Health implements a two-month Deeming Period for its D-SNP plan.

If a Member has deemed into a cost-share protected status during the Deeming Period, Alterwood Health applies the appropriate payment methodology to process claims and pays 100% of the Medicare allowable for all plans. Providers must accept Alterwood Health's payment as payment in full and may not balance bill the Member. If a Member is cost-share protected, the Evidence of Payment that is sent to the Provider will note the Member's cost-share protected status

DSNP Care Management Program

The Medicare Improvements for Patients and Providers Act 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.

Alterwood Health'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 Alterwood Health – Alterwood Health's Care 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 care manager. The stratification/acuity of the HRA is an indicator of the needs of the Member and is verified with the comprehensive medical assessment. Alterwood Health uses four levels of stratification/acuity starting with level 1 (low risk) and going to level 4 (high risk). The dual eligible Member is then contacted so the Care Management process can begin. Alterwood Health will conduct initial assessment within 90 days of enrollment and will conduct annual reassessment within one year of the initial assessment.

Comprehensive Medical Assessment: Conducted by Alterwood Health – The care manager telephonically 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 using these guidelines.

Individualized Care Plans: Generated by Alterwood Health – Once the care 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 care 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 time frames. The ICP is shared with all Members of the Interdisciplinary Care Team (ICT) for input and updates.

Interdisciplinary Care Team: Alterwood Health and Providers – The care manager shares the ICP with all the Members of the ICT in an effort to provide feedback and promote collaboration regarding the

Member's goals and current health status. At a minimum, the ICT includes the Member, the Member's caregiver (if appropriate), the Member's PCP and the Alterwood Health care manager. Other Members of the ICT can include specialists, social service support, behavioral health specialists, and/or caregiver and others depending on the Member's specific needs. The care manager communicates and coordinates with the Members of the ICT to educate the Member, provide advocacy and assist them as they navigate the healthcare system.

Care Transitions: Alterwood Health and Providers – The care 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 care manager will discuss any changes to the Member's health status and any resulting changes to the care plan. The care manager will notify the Member's usual Provider of the transition and will communicate any needs to assist with a smoother transition process.

Provider Required Participation

To meet the intent of the MIPPA legislation, Providers must participate in the MOC for all D-SNP plan Members. The requirements for participation are as follows:

- Complete the required MOC training. Alterwood Health offers an online training module and a printable self-study packet. If Providers opt to use the self-study packet, Alterwood Health requests they return the attestation via fax for reporting purposes. Both the online module and self-study packet can be accessed at www.AlterwoodAdvantage.com. Select the appropriate state from the drop-down menu and click on Overview under Medicare in the Providers drop-down menu. If Providers would like to request a copy mailed at no cost, they can contact Provider Services or their Provider Relations representative.
- Become familiar with Alterwood Health's 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 Care Management Department.
- Participate in the ICT for all D-SNP Members in a Provider's patient panel and give feedback as appropriate. The care manager will communicate with the members of the ICT 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 D-SNP Care 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 care manager and is the basis for the ICP.
- The ICP is generated by the care manager in collaboration with the Member and the care team.
- The ICP is shared with the ICT for review and comments as needed.
- The care manager continues to monitor, educate, coordinate care and advocate on behalf of the Member.

Section 10: Behavioral Health

Overview

Alterwood Health presently uses a delegated entity to administer those behavioral health and substance abuse benefits otherwise required by the federal and/or state government agency contracts. For information about the delegated entity and/or how to arrange behavioral health and substance abuse benefits for Members, please contact Alterwood Health's Member Services at 410-801-5866 for assistance.

Section 11: Definitions and Abbreviations

Definitions

The following terms as used in this Manual shall be construed and/or interpreted as follows, unless otherwise defined in the Agreement.

Agreement means the contract under which Provider participates in Alterwood Health's network for Medicare Advantage Benefit Plans.

Appeal means a request for review of some action taken by or on behalf of Alterwood Health.

Benefit Plan means a health benefit policy or other health benefit contract or coverage document (a) issued by Alterwood Health or (b) administered by Alterwood Health, pursuant to a government contract. Benefit Plans and their designs are subject to change periodically. This Manual applies only to Benefit Plans issued under the Medicare Advantage program.

Centers for Medicare & Medicaid Services (CMS) means the United States federal agency which administers Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

Clean Claim means a claim for Covered Services provided to a Member that (a) is received timely by Alterwood Health, (b) has no defect, impropriety, or lack of substantiating documentation from the Member's medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows current HIPAA Administrative Simplification ASC X12 837 standards and additional Alterwood Health-specific requirements in the Alterwood Health Companion Guide, including all current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for Alterwood Health to (1) meet requirements of laws and program requirements for reporting of Covered Services provided to Members, and (2) determine payor liability, and ensure timely processing and payment by Alterwood Health. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim that is under review for Medical Necessity.

Covered Services means Medically-Necessary healthcare items and services covered under a Benefit Plan.

Emergency Medical Condition means 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 or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Encounter Data means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

FBDE means full benefit dual-eligible Members who are eligible to have full Medicaid and full Medicare benefits.

Grievance means any complaint or dispute, other than one that involves a Alterwood Health determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of Alterwood Health, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item and may only be brought on behalf of a Member.

Ineligible Person means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the list of excluded individuals/entities maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG), or (ii) federal procurement or non-procurement programs, as may be identified in the excluded parties list system maintained by the U.S. General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in state medical assistance programs, including Medicaid or CHIP, or state procurement or non-procurement programs as determined by a state governmental authority.

Medically Necessary or Medical Necessity means those healthcare items or services that are (i) necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain, (ii) individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the Member's needs, (iii) consistent with generally accepted professional medical standards and not experimental or investigational, (iv) reflective of the level of service that can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide, (v) provided in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the healthcare Provider, and (vi) not custodial care as defined by CMS. For healthcare items and services provided in a hospital on an inpatient basis, "Medically Necessary" also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a healthcare Provider has prescribed, recommended or approved health care items or services does not, in itself, make such items or services Medically Necessary.

Member means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

Member Expenses means copayments, coinsurance, deductibles or other cost-share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

Organization Determination means any determination made by a Medicare health plan with respect to the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a Provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;

- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for healthcare services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Primary Care Provider (PCP) means a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioners who, within the scope of practice and in accordance with state certification licensure requirements, standards, and practices, is responsible for providing all required primary care services to Members. A PCP shall include general/family practitioners, pediatricians, internists, physician's assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with licensure requirements.

Provider means an individual or entity that has contracted, directly or indirectly, with Alterwood Health to provide or arrange for the provision of Covered Services to Members under a Benefit Plan as a participant in Alterwood Health's network.

Zero Cost Share Dual-Eligible Member means a dual-eligible Member that is not responsible for paying any Part A or Part B cost share amounts.

Abbreviations

ACS – American College of Surgeons
AEP – Annual enrollment period
Agreement – Provider Participation Agreement
AHP – Allied health professional
AIDS – Acquired Immune Deficiency Syndrome
ALJ – Administrative law judge
AMA – American Medical Association
ARNP – Advanced Registered Nurse Practitioner
CAD – Coronary artery disease
CAHPS® – Consumer Assessment of Healthcare Providers and Systems
CDSC – Controlled Dangerous Substance
CHF – Congestive heart failure
CIA – Corporate Integrity Agreement
CLAS – Culturally and linguistically appropriate services
CMS – Centers for Medicare & Medicaid Services
CNM – Certified Nurse Midwife
COB – Coordination of benefits
COPD – Chronic obstructive pulmonary disease
CORF – Comprehensive outpatient rehabilitation facility
CPT-4 – Physician's Current Procedural Terminology, 4th Edition
CSR – Controlled Substance Registration
DDE – Direct data entry
DEA – Drug Enforcement Agency

DM – Disease Management
DME – Durable medical equipment
D-SNP – Dual-Eligible Special Needs Plans
EDI – Electronic data interchange
EOB – Explanation of Benefits
EOP – Explanation of Payment
ESRD – End-stage renal disease
FBDE – Full Benefit Dual-Eligible Members
FDA – Food and Drug Administration
FDROC – First-Tier, Downstream, and Related Entity Oversight Committee
FFS – Fee-for-service
FWA – Fraud, waste and abuse
HEDIS® – Healthcare Effectiveness Data and Information Set
HHA – Home health agency
HHS – U.S. Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act of 1996
HIV – Human Immunodeficiency Virus
HMO – Health maintenance organization
HMO-POS – Health maintenance organization with point-of-service option
HOS – Medicare Health Outcomes Survey
HRA – Health Risk Assessment
HTN – Hypertension
ICD-10-CM – International Classification of Diseases, 10th Revision, Clinical Modification
ICP – Individualized Care Plans
ICT – Interdisciplinary Care Team
INR – Inpatient nursing rehabilitation facility
IPA – Independent physician association
IRE – Independent Review Entity
IVR – Interactive voice response
LCSW – Licensed Clinical Social Worker
LTAC – Long-term acute care facility
MA – Medicare Advantage
MAC – Medicare Appeals Council
MIPPA – Medicare Improvements for Patients and Providers Act of 2008
MOC – Model of Care
MOOP – Maximum out-of-pocket
MSP – Medicare Savings Programs
NCCI – National Correct Coding Initiative
NCQA – National Committee for Quality Assurance
NDC – National Drug Codes
NIH – National Institutes of Health
NPI – National Provider Identifier
NPP – Notice of Privacy Practice
OIG – Office of Inspector General
OT – Occupational therapy
OTC – Over-the-counter
P&T – Pharmacy and Therapeutics Committee
PA – Physician Assistant

PCP – Primary Care Provider
PHI – Protected health information
POS – Point-of-service
PPC – Provider-preventable condition
Provider ID – Provider identification number
PT– Physical therapy
QI Program – Quality Improvement Program
QIO – Quality Improvement Organization
QMB – Qualified Medicare Beneficiary
SFTP – Secure file transfer protocol
SIE – Site inspection evaluation
SLMB – Specified Low-Income Medicare Beneficiary
SNF – Skilled nursing facility
SNIP – Strategic National Implementation Process
SSN – Social Security Number
ST – Speech therapy
Tax ID/TIN – tax identification number
TNA – Transition Needs Assessment
TOC – Transition of care
UM – Utilization management