PROVIDER MANUAL 2024

Astrana Care Partners of Arizona

Arizona (Maricopa County)

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SECTION 1 INTRODUCTION

PURPOSE OF THIS MANUAL

This Provider Manual is intended to provide providers and their staff with information necessary for serving and coordinating the care of AstranaCare Partners of Arizona, LLC ("AstranaCare") members and patients.

AstranaCare may update or amend this Provider Manual and the policies herein as may be necessary . All amendments will be distributed through the AstranaCare newsletter to AstranaCare providers and are effective thirty (30) days after such distribution.

AstranaCare

The primary purpose of AstranaCare is to provide arrange for the provision of quality medical care and culturally sensitive services to meet the needs of our community. AstranaCare operates as a contracting entity, contracting with health plans, which may include Medicare Advantage and Medicaid plans, and arranging to provide care to members attributed to AstranaCare.

ASTRANACARE MISSION STATEMENT

The mission of AstranaCare is to provide quality healthcare services in a timely and culturally sensitive manner and to work in cooperation with community organizations and government agencies to create vibrant, healthy, physical, and social environments in the communities that we serve.
In support of its mission, For AstranaCare is committed to:

1. Leveraging the services of Astrana Health to support AstranaCare's contracted IPAs, community health care institutions, hospitals, managed care health plans, ambulatory care services, ancillary providers, physicians and other professionals, and an array of community health programs.
2. Providing a value-based delivery model, promoting, and strengthening the provider network of AstranaCare, providing managed care contracting opportunities for participating AstranaCare providers, and maintaining an open panel of needed community providers screened by an appropriate credentialing process.

SECTION 2 CONTACTING ASTRANACARE

Office: 1668 S. Garfield Ave., Alhambra, CA 91801
Phone: (877) 282-8272
Email: AZ.providerrelations@AstranaHealth.com
Fax: (626) 943-6375

Please contact AstranaCare Provider Relations for matters relating to:

- Notification of changes to your provider information, including changes in office locations, tax ID number, billing address, or telephone numbers
- Questions about AstranaCare policies, guidelines, or information in this Handbook
- Requesting login information for the AstranaCare's Provider Portal
- Inquiries about electronic health records (EHR) implementation
-

AstranaCare Partners of Arizona, LLC

Operations Management		EMAIL
Claims	David Kwei, Sr. Director	David.Kwei@AstranaHealth.com
Claims	Octavio Campos, Sr. Director	Octavio.Campos@AstranaHealth.com
Compliance	Khurrum Shah, VP	Khurrum.Shah@AstranaHealth.com
Contracting	Paul Van Duine, Senior VP	Paul.VanDuine@AstranaHealth.com
Credentialing	Walter Gamulo, Manager	Walter.Gamulo@AstranaHealth.com
Customer Service	Jamie Situ, Manager	Jamie.Situ@AstranaHealth.com
EDI	Yash Doshi, Director	Yash.Doshi@AstranaHealth.com
Eligibility	Carol Guillermo, Director	Carol.Guillermo@AstranaHealth.com
Provider Data	Francisco Hernandez, Manager	Francisco.Hernandez@AstranaHealth.com
Provider Relations	Traci Zieper, Director	AZ.ProviderRelations@AstranaHealth.com
QCI - Medicare	Traci Zieper, Director	Traci.Zieper@AstranaHealth.com
QCI – Commercial & Medi-Cal	Diana Lam, Director	Traci.Zieper@AstranaHealth.com
Risk Adjustment	Mauriel Chaidez-Puentes, Manager	Mauriel.Chaidez-Puentes@AstranaHealth.com
Health Services		**EMAIL**
UM – Medical Director	Dr. William Wang	William.Wang@AstranaHealth.com
Population Health – Medical Director	Dr. George Christides	George.Christides@astranahealth.com
Health Services	Mitch Agorrilla, Sr. Director	Mitch.Agorrilla@AstranaHealth.com
Ambulatory CM	Linda Violas, Director	Linda.Violas@astranahealth.com
Inpatient CM	Dourly Galvez, Manager	dourly.galvez@astranahealth.com
Utilization Management	Brenda Kernell, Supervisor	Brenda.Kernell@astranahealth.com
UM Delegation Oversight	Margie Sanchez, Supervisor	Margie.Sanchez@astranahealth.com

ASTRANACARE QUICK REFERENCE SHEET

<table>
<tr><th>AREA</th><th>CONTACT DETAILS</th></tr>
<tr><td>Main Customer Service Line</td><td>• Phone: (480) 470-0243 or (626) 282-0288
• Hours: Mon-Fri., 8:30 AM – 5:00 PM
• Scope: Eligibility, Referrals, Claims, Provider, and Member Inquiries</td></tr>
<tr><td>Claims Submission</td><td>• Via Office Ally
• Mail: Astrana Health
Attention: Claims Department
1600 Corporate Center Dr.
Monterey Park, CA 91754
<table><tr><td></td><td></td></tr><tr><td>Office Ally</td><td>NMM12</td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>**Paper claims will not be accepted for contracted providers**</td></tr>
<tr><td>Case Management</td><td>To report an admission,
• Please fax: (480) 542-2889
Ambulatory Care Management

• (626)876-2191
• Ambulatorycare.dept@astranahealth.com</td></tr>
<tr><td>Eligibility</td><td>To have a new patient added, you can:
• Submit through the Astrana Health Portal: https://provider-portal.astranahealth.com/login
• For urgent requests, please call (877) 282-8272</td></tr>
<tr><td>Utilization Management</td><td>• Submissions: Please use the Astrana Health Portal at: https://provider-portal.astranahealth.com/login
• Faxes will be accepted on a limited basis at:
Routine: (480) 542-2885
Urgent: (480) 542-2886
Notes/Modifications: (480) 542-2887</td></tr>
<tr><td>Web Portal Assistance</td><td>• Technical Assistance/New Users: Portal.Help@AstranaHealth.com
• Phone: (626) 943-6146
• Fax: (626) 943-6350</td></tr>
</table>

Provider Services	You can also email the Astrana Health Provider Relations Team at az.providerrelations@astranahealth.com

CONTRACTED HEALTH PLANS

NOTIFICATION OF PROVIDER STATUS & PRACTICE CHANGES

Please notify AstranaCare in writing regarding changes of address, phone numbers, and related information with as much advance notice as possible. Providers must provide AstranaCare with adequate advance written notice for any changes in status and practice changes. Please fax or mail written notices to AstranaCare at the fax number or address listed under the "Contacting AstranaCare" section.

NOTIFICATION OF CONTRACT TERMINATION OR RESIGNATION FROM AstranaCare

Providers who want to terminate their AstranaCare Provider Agreement must provide AstranaCare with adequate advance written notice as required in the provider services agreement or other contract agreement between AstranaCare the provider (each, a "Participation Agreement") before the effective date of the termination. This includes physicians who are retiring or closing their practices. The adequate advance notice allows AstranaCare to notify contracted health plans of a Provider's termination from AstranaCare's network and will allow health plans to notify their Members and assist them in transitioning care to another in-network physician. It will also ensure that those who may be eligible to continue receiving care from the terminating provider for a designated period are notified per state law. Notice of resignation or termination of your Provider Agreement must be faxed or mailed to AstranaCare at the fax number or address listed under the "Contacting AstranaCare" section. Provider's obligations following termination will remain as set forth in the Participation Agreement or as otherwise set forth herein.

CONTACTING ASTRANACARE CONTRACTED HEALTH PLANS FOR PATIENT ELIGIBILITY

Member eligibility should always be verified by all Providers before providing medical services. A patient's insurance ID card is not necessarily proof of eligibility, and benefits/copayments may vary. All health plans also offer online eligibility verification on their websites. The following is a list of AstranaCare contracted health plans. For information on new health plans added from time to time, you may contact Astrana Health's Customer Service Department at (480) 470-0243.

Providers must contact the health plans directly for information on accessing online eligibility and benefits.

HEALTH PLAN PROVIDER MANUAL

In addition to the requirements set forth herein, all Providers must comply with any requirements of each AstranaCare contracted health plan provider manual. Copies of such manuals may be available from the health plan website, or upon request from AstranaCare.

SECTION 3 ASTRANACARE PROVIDER RESPONSIBILITIES

RESPONSIBILITIES OF ASTRANACARE PRIMARY CARE PHYSICIANS (PCP)

Members of AstranaCare contracted health plans are required to select a primary care physician from AstranaCare's network of primary physicians. Primary insurance members may select different PCPs from dependents on the same policy.

The AstranaCare PCP is responsible for:

- Providing covered services to patients as medically necessary
- Assuring reasonable access and availability to primary care services
- Making referrals to in-network or out-of-network providers when medically necessary
- Providing 24-hour coverage for medical advice and/or access to care for patients
- Communicating authorization decisions (approvals and denials) to patients

Members may require services that go beyond the scope of their PCP. When this occurs, the PCP refers the patient to an appropriate AstranaCare provider. If AstranaCare does not have providers under the needed specialty, the PCP must request prior authorization from AstranaCare's Utilization Management Department for an out-of-network specialist using an AstranaCare Treatment Authorization Request (TAR) form. In the case of an emergency, authorization requests should be obtained on the next working day following the emergency.

RESPONSIBILITIES OF AstranaCare SPECIALIST PHYSICIANS (SPECIALIST)

Patients may be referred to an AstranaCare Specialist provider (Specialist) by an AstranaCare PCP or another AstranaCare Specialist. When a member has been referred to a Specialist, the Specialist is responsible for diagnosing the patient's condition and managing treatment of the condition as necessary.

AstranaCare Specialist providers are responsible for:

- Providing covered services to patients as medically necessary
- Informing the patient's PCP of the patient's condition with a consultation report
- Obtaining concurrence from the patient's PCP and/or prior authorization from AstranaCare's Utilization Management Department for medically necessary services as needed
- Notify the patient's PCP when the member requires services from other specialists or ancillary providers for further diagnosis or specialized treatment, or if the patient requires admission into a hospital
- Providing 24-hour coverage for medical advice and/or access to care for patients

When an AstranaCare PCP or provider identifies the need to refer a patient to another in-network provider, giving clinical notes to the referring provider is recommended. If AstranaCare does not have an appropriate provider under the needed specialty, a prior authorization must be requested from AstranaCare's Utilization Management Department for out-of-network services using an AstranaCare Treatment Authorization Request form. In the case of an emergency, authorization requests should be obtained on the next working day following the emergency.
**Important Note: OB/GYN specialists may provide routine care and preventative services to female patients without a referral from a PCP; consistent with Arizona law. **

RESPONSIBILITIES OF ALL ASTRANACARE PROVIDERS

Verifying Member Eligibility

Verification of member eligibility and benefits must be completed before rendering medical services. As member eligibility and medical benefits (i.e. copayments, coinsurance, etc.) are subject to change, both must be verified before providing medical services to the Member. Providers should contact the patient's respective health plan/insurance company directly for the most accurate information. All health plans offer online eligibility verification on their website. Providers must contact the health plans for information on accessing online eligibility and benefits or may contact the respective health plan's customer service line.

Please ask Members to present their insurance ID card each time, before their appointment. ID cards will contain information to assist you in verifying the Member's eligibility. An insurance ID card is NOT proof of eligibility.

Failure to check Member eligibility and benefits may result in non-payment by AstranaCare.

Collecting Copayments

Co-payments should be collected from the patient based on the patient's health insurance benefits. It is important to verify member eligibility and benefits before providing medical services. When a claim is paid by AstranaCare, the co-payment is deducted from the payable amount. An AstranaCare Explanation of Benefits (EOB) or Remittance Advice (RA) will accompany each payment and will indicate the applicable copay deduction. Members are obligated to pay any applicable copayment according to their insurance benefits. Any overpayments made by a patient more than the allowed amount must be refunded to the patient.

Depending on a patient's health benefits, copayments may be waived for preventive services. Providers must check member eligibility and benefits to determine the appropriate copayment when performing preventive services. Providers are expected to review a patient's medical record to determine if and when the patient needs to receive preventive services. Preventive service guidelines are recommended by the United States Preventive Services Task Force (USPSTF). For the most up-to-date information, please go to: http://www.uspreventiveservicestaskforce.org

Notification of Authorization Approvals

Decisions to approve a request for service authorization that was requested before, or concurrent with the provision of health care services shall be communicated by the Utilization Management Department to the requesting provider within 24 hours of the decision. It is the responsibility of the requesting provider to communicate to the member the specific health care service(s) that was approved and document when the Member was notified of the approved service. Patients may be notified by telephone, written notice, email, or in person.

Providing & Documenting Language Assistance

AstranaCare providers must document in the patient's medical records the language preference of patients who may be Limited English Proficient (LEP). It is the physician's responsibility to notify and document an LEP member's right to language assistance. The following requirements are to be followed at all times:

- A qualified interpreter should always be offered to Limited English Proficient (LEP) patients as a preferred option.

- If patients decline the use of a qualified interpreter and prefer to use a friend or family member for interpretation, they have the right to do so. When patients decline the services of a qualified interpreter, this must be documented in the patient's medical records.
- Minors should only be used as interpreters in an emergency.

Please contact the patient's respective health plans for language interpreter services offered.

Providing Members with Grievance & Appeals Information

If a Member is dissatisfied with a decision or action made by AstranaCare, their Health Plan, or AstranaCare providers must inform the Member of their right to file a grievance and offer to provide the Member with a copy of their Health Plan Member Grievance and Appeal forms. Grievance forms are available on the Health Plan's website.

Training Requirements for Providers & Staff

AstranaCare requires that all providers and their respective staff complete the following training and attest to having completed the training on an annual basis.

- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud, Waste, and Abuse (FWA)
- Workplace Harassment
- Cultural Competency
- Any training as required by contracted health plans, e.g. Model of Care (MOC)

AstranaCare provides training materials and an attestation form on our website. To access the training materials, please go to: AZ.astranahealth.com

Providers and their staff only need to complete compliance training (see list of required training above) once a year. If the provider has already completed the required training through a different organization (i.e. health plan, medical group, etc.), an attestation indicating the completion of such training must be submitted to AstranaCare to satisfy this requirement. All attestations must be submitted to AstranaCare using one of the following methods:

By Fax: (626) 943-6375
By Email: az.providerrelations@astranahealth.com

Participation in all AstranaCare Contracted Health Plans

AstranaCare requires that all contracted providers participate in all AstranaCare contracted Health Plans (refer to Section 1 Introduction of this Handbook). Should a physician wish to close their panel from accepting new Members for one AstranaCare contracted Health Plan, the physician's panel will be considered closed for all AstranaCare contracted Health Plans.

SECTION 4 CREDENTIALING AND RE-CREDENTIALING

AstranaCare is committed to providing quality care to its members. On behalf of AstranaCare, Astrana Health, AstranaCare's Management Services Organization, uses a rigorous process to evaluate providers. This process thoroughly evaluates a provider's experience, licensing, sanction activity, and quality of care.

Procedure

1. The Credentialing Committee is responsible for making decisions regarding provider credentialing. The Credentialing Department reviews each initial application with all supporting verifications and documentation before submission to the Credentialing Committee.
2. Initial Application: Astrana Health uses an online credentialing portal, aka "Provider Hub", for the submission of credentialing applications. These applications will require the provider to provide information on:
    a. Reasons for inability to perform the essential functions as a provider, with or without accommodation
    b. Lack of present illegal drug use
    c. History of loss of license and felony convictions
    d. History of loss or limitations of privileges or disciplinary activities
    e. Attestation by the applicant of the correctness and completeness of the application. Attestations will cover seven (7) years for initial providers and three (3) years for re-credentialed providers
3. Completed application for Primary Care Physicians and Specialists: Each applicant will be required to complete an application. In addition, the applicant will provide:
    a. Curriculum Vitae (CV)
    b. A copy of current State Medical or Dental License(s) (pocket license)
    c. A copy of a valid DEA certificate (if applicable)
    d. Face Sheet of Professional Liability Policy or Certification for past and present coverage, in the minimum amounts of $1 million per occurrence and $3 million aggregate
    e. Board Certification Certificates (if applicable)
    f. Certificates of Degree Completion (i.e., medical, or dental school)
    g. Internships and Residency certificates of completion
    h. A copy of the Educational Commission for Foreign Medical Graduates (ECFMG), if applicable
    i. Addendum A (Provider Rights)
    j. Addendum B (as applicable)
    k. HIV Designation Form
    l. Delegation of Service Agreements (mid-levels) (as applicable)
    m. Forms of identification issued by state or federal agency
    n. Social Security Card
    o. National Provider Identifier
    p. Request for Taxpayer Identification Number (W-9)
4. Incomplete application: The Credentialing Department will send three follow-up requests for missing information (e.g., any incomplete application, is not accompanied by all supporting documentation, does not include a signed Physician Provider Agreement, or is dated more than three months before receipt). If the requested information is not received after the third request, the application will be considered inactive.
5. Primary source verification: Upon receipt of a completed application, Astrana Health will obtain and verify the information. The Credentialing Department will obtain, through the most effective methods, additional information or clarification, as needed, to provide the Medical Director and Credentialing Committee adequate information to make an informed decision regarding the applicant's qualifications.
6. Providers' rights (Due Process). Providers shall have:

a. The right to review the information submitted in support of their credentialing application. Exception: Applicants are not to review references, recommendations, or other information that is peer review-protected
b. The right to respond to information obtained during the credentialing process, which varies substantially from the information provided to Astrana Health by the applicant
c. The right to correct information provided to Astrana Health which the applicant considers to be erroneous
d. The right to be informed upon request of the status of his/her credentialing/re-credentialing application

7. Re-applying: Providers denied by the Board of Directors will not be eligible to reapply for membership for at least two (2) years.
8. Length of appointment: Providers will be credentialed for an initial period of not to exceed three years (36 months).
9. Errors and Omissions: The providers will be immediately notified in writing of any occurrence. A copy of the official report (if applicable) will be sent to the provider along with a letter of explanation.
10. All documents received will be date-stamped and initialed.

Recredentialing:

The re-credentialing process is also completed within Astrana Health's online credentialing portal, aka "Provider Hub". Six months before the credentials expiration date, providers will receive an email from our automated credentialing system. Upon receiving the email, please follow the instructions to log in and complete the re-credentialing application. Be sure to attach/upload the following documents as may be required for the provider type:

- Midlevel practitioners (NPs/PA): Supervising/collaborating physician agreement.
- Physicians without hospital privileges: Identify the admitting physician or hospitalist group, and the name(s) of the hospitals where patients will be admitted.
- All Providers: Current copy of malpractice insurance certificate.

In addition to the credentialing and recredentialing process set forth above, Provider may be required to comply with the credentialing and/or re-credentialing requirements of all AstranaCare contracted health plans. AstranaCare may provide health plans with all credentialing information in collects in accordance with the above.

All questions regarding credentialing and/or re-credentialing should be directed to the Credentialing Department at (877) 282-0288.

SECTION 5 HEALTH SERVICES

UTILIZATION MANAGEMENT PROGRAM

Utilization management (UM) involves the evaluation of the medical necessity of services and the appropriateness of the selected level of care and procedures according to established criteria or guidelines. Resources must be effectively managed. Utilization metrics are used to determine how much care is being utilized by a network's members. Typically, utilization is measured per thousand members so that it can be compared and analyzed across providers and practices. Some common utilization metrics are:

- ER/K: Emergency room visits per thousand members
- UC/K: Urgent care visits per thousand members
- Admits/K: Admissions per thousand members
- Bed days/K: Inpatient days per thousand members

The key to successful utilization is proactive identification and medical management of those members who are at risk for inappropriate utilization of the costliest points of care. It is important to determine if these Members can be more appropriately treated in less acute settings and/or with targeted care management programs. In addition to the aforementioned list, utilization can also be measured through referral metrics on referral patterns to providers and through encounter submission data which tracks the frequency with which providers see the network's Members.

Astrana Health's Utilization Management Committee, and Quality Management Committees will regularly monitor and assess the performance of its participants (e.g., Medical Director, Utilization Management and Quality Management Committee Members, Case Managers) involved in determining medical necessity, managing care and evaluating the effectiveness of the process and outcomes involved. The assessment is based on the ability to consistently apply specified utilization management criteria (e.g., Federal and State guidelines, health plan guidelines, MCG [formerly Milliman Care Guidelines], and Health Care Management Guidelines). The Utilization Management (UM) Program is designed to monitor, evaluate, and manage the appropriateness of care resources, and promote the delivery of high-quality, medically necessary, and efficient care.

UM policies and procedures are available upon request. Please contact the UM Department at (480) 470-0243.

A. Specialty Referral Data

Specialty referral data on contracted providers is collected and tabulated every quarter by Astrana Health on behalf of AstranaCare. Providers whose referral patterns differ significantly from the average will be identified and reviewed by the Utilization Management Committee. Potential outliers will be reviewed for differences in case mix, appropriateness of referrals, and evidence of knowledge or skill gaps. A statistical report will be generated for each provider indicating referral performance relative to the mean and standard deviation of the group.

B. Hospital Admission/Re-admission

Outliers for hospital admissions and/or re-admissions may be due to intensive treatment for members or underutilization reflective of barriers to care, case mix differences, or lack of access to effective preventive health care. Outliers will be identified using MCR guidelines.

C. Emergency Room Visits

High outliers for emergency room visits may be reflective of poor access to primary care, management issues, or be due to case mix differences. A combination of high emergency room use, or low institutional use may raise concerns about barriers to primary care and secondary care. Providers with statistics higher than MCR guidelines or industry benchmarks will be flagged for possible access issues.

D. Feedback and Corrective Action

Providers reviewed by the Astrana Health Utilization Management and Quality Management Committees will receive specific feedback and/or ongoing education. Provider Corrective Action Plans (CAP) will be developed as appropriate at the recommendations of the Committees.

E. Referral to Non-contracted Provider

All Members must be referred to a contracted and credentialed provider through AstranaCare. If a provider cannot be located for a particular health service, the referring provider must contact Astrana Health's Utilization Management Department for further guidance. Providers who inappropriately refer a member to a non-contracted provider without prior authorization may be held responsible for the medical charges incurred.

F. Service Coordination

Astrana Health is responsible for coordinating the following services on behalf of AstranaCare:

- Acupuncture
- AIDS and AIDS-related conditions waiver program
- Arizona Department of Child Safety
- Chiropractic services
- Dental
- Direct observation therapy for the treatment of tuberculosis
- Drug and alcohol treatment
- Transplants
- Lead poisoning case management
- Local education agency assessment services
- Mental health
- Prayer or spiritual healing
- Community-Based Adult Services (CBAS)
- Regional centers
- Vision
- Developmentally Disabled-Continuous Nursing Care (DD-CNC)
- Family Planning, Access, Care and Treatment Program (Family PACT)
- Transportation services
- Women Infants and Children (WIC)
- Pediatric Palliative Care Waiver (PPC)

Decision Making

Utilization Management (UM) decision-making is based only on the appropriateness of care and service and the existence of coverage. Astrana Health does not specifically reward practitioners or other individuals for

issuing denials of coverage or care. No financial incentives are involved in UM decisions that result in underutilization. Notwithstanding the foregoing, AstranaCare is not a provider, and Providers do not have an employer-employee, principal-agent, partnership, or similar relationship with AstranaCare. Nothing herein is intended to interfere with or affect a Provider's independent medical judgment in providing health care services to his/her patients. Nothing in the Agreement is intended to create any right for AstranaCare or any other party to intervene in or influence medical decision-making regarding by any Provider.

PROCESS FOR SUBMITTING A REFERRAL REQUEST

An authorization referral request must be submitted with all pertinent information to Astrana Health for authorization before the provider performs any treatment and/or services. Incomplete medical information may cause a delay in the referral request. Providers can submit authorization referral requests 24 hours a day / 7 days a week. Providers can submit retro requests up to 90 days after the date of service. Authorization approval, modification, deferred, or denial determinations will be made based on medical necessity and will reflect the appropriate application of approved guidelines.

The request will be reviewed and completed accurately and timely within Industry Collaboration Effort (ICE), health plan, and/or regulatory agency compliance standards as follows:

- Urgent within 72 hours/three (3) calendar days (to be used if the 5-day turn-around time would seriously jeopardize the life, health, and or ability to regain maximum function)
- Routine within five (5) business days
- Standing Referral – may be subject to a treatment plan that may limit the number of visits to the specialist, limit the time for which the visits are authorized, or require the specialist to provide regular reports to the primary care physicians.

  Requests include:
  - Member demographics
  - Member diagnosis(s)
  - Required treatment(s)/testing
  - Requested frequency and period/duration of treatment
  - Relevant history and physical, medical records, laboratory, and radiology results.

For cases that need to be expedited (i.e., non-emergency services needed within 24 hours), providers should submit the request via the Astrana Health Web Portal and contact Astrana Health's Customer Service Department at (480) 470-0243.

Authorization Process

Providers wishing to submit an authorization referral request may fax the Astrana Health Authorization Request Form (ARF) or log into the Astrana Health Web Portal at https://provider-portal.astranahealth.com/login and follow the steps included in the Web Portal User Guide provided at the time of orientation.

After authorization is submitted, the following process will occur:

1. If the requested medical treatment, service, and/or procedure is covered by the health plan and meets the established criteria, the request will be approved for ninety (90) days. An approval letter is sent to the Member via the U.S. Postal Services (USPS) and a fax is sent to the requesting provider, or it is posted on the provider's portal.
2. If additional information is required, Astrana Health's Authorization Coordinator will contact the requesting provider and/or specialist by fax or telephone to obtain specific information as appropriate. If the case is pending additional medical information, it will be held for 14-45 days depending on the Member's health plan.
3. Once an approved decision is made, the provider will be notified within 24 hours of the decision via fax and or posted to the portal.

4. If the authorization is denied, the reason for the denial, an alternative treatment, and the Utilization Management criteria will be included in the letter. The Medical Director and/or designee shall be available by telephone to discuss the case.
5. The letters denying or modifying requested services are sent to the Member via USPS and fax or posted to the portal to the requesting provider and the Member's primary care provider within two (2) working days of the determination. Only a Medical Director or designee physician may make an adverse determination.

In some cases, a provider can re-submit an authorization with new supporting documentation. Providers should attach additional supporting documentation to the authorization via the Astrana Health Web Portal. If the provider is unable to upload the information, supporting documentation should be submitted via fax.

Treatment Authorization Request (TAR)

All Treatment Authorization Requests should be submitted through the web portal. However, a Treatment Authorization form is also available. Attach any medical information to support the request.

Fax routine and retro requests and supporting clinical information to the UM Dept. at (480) 542-2885.

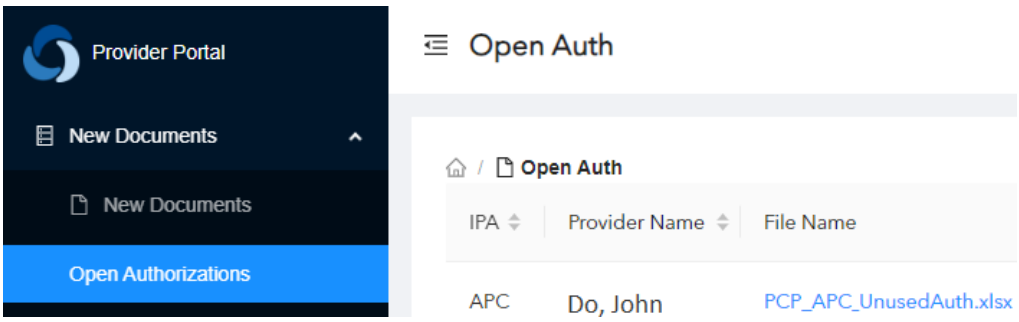
Fax urgent requests and supporting clinical information to the UM Dept. at (480) 542-2886**.**

Standardized Prescription Drug Prior Authorization Form

All providers must utilize the uniform Prescription Drug Prior Authorization Request form Pursuant to A.R.S. § 203406(A)

Specialty Referral Tracking

The PCP and Specialist may track their Member's open referrals to ensure the Member is receiving the required care and to ensure the PCP office obtains the specialist consultation notes. On your provider portal, a list of open authorizations for your Member is provided. The list consists of authorizations that are 90 days old in which there is no claim on file. The office staff is to contact your Member to determine if this authorization should be closed, if the Member has been seen, or if the services are scheduled for a later date.



Turn Around Time Decision Standards

Routine/Non-Urgent Requests	Up to 14 calendar days
Urgent Requests	Up to 5 calendar days
Retro Requests	Up to 30 calendar days

Standing Referrals

PCP's may allow standing referrals where a member requires continuing specialty care over a prolonged period (e.g., a Member has a life-threatening, degenerative, or disabling condition that requires coordination of care by a specialist instead of PCP). PCP's and referred specialists coordinate care and treatment, along with the Member, and develop a treatment plan that addresses the number of approved visits or the period during which the visits are authorized and the plan for each visit.

Specialist Physician Referrals

When a PCP refers a member to a specialist physician, in addition to consultation, the specialist may refer the Member for additional in-network testing and services that are within the guidelines of their specialty. A treatment plan must be agreed upon by the PCP, the specialist physician, and the Member. In addition, a specialist physician may substitute as a PCP for a Member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, when authorized by the medical group.

Second Opinions

Second opinions are covered even if the service is determined not to be covered. PCP's must provide referrals to another network physician when a second opinion is requested and appropriate. Patient-initiated second opinions that relate to the medical need for surgery or major nonsurgical diagnostic and therapeutic procedures are covered under Medicare. If the recommendations of the first and second physicians differ regarding the need for surgery (or other major procedures), a third opinion is also covered. Second-opinion referrals are for consultation only and do not imply referral for ongoing treatment.

Transplants

Transplant evaluation and services must be provided in a Medicare-approved transplant center; therefore, Members may only be referred to facilities that meet minimum standards established by Medicare to ensure Member safety. See https://www.cms.gov///MedicareApprovedFacilitie/index.html. Contact ambulatory care management for assistance with COE at ambulatorycare.dept@astranahealth.com

Documentation of Referrals

Referring providers are responsible for ensuring that all relevant clinical information is sent to the preferred provider. The referral, as well as denial or acceptance of the referral needs, are to be documented in the Member's medical record by both the referring provider and preferred provider. Specialists must provide the referring PCP with relevant reports on care rendered in a timely manner.

Specialist Requirements/Responsibilities

- Document all work-ups and treatments done and include them with your request for authorization
- If the Member was seen, please forward your consultation and/or progress notes to the Member's Primary Care Physician.

Primary Care Physician Requirements/Responsibilities

As a standard requirement, PCP's must document that they have received/read the specialist consultation notes and document any outreach to the Member and/or specialist provider. PCPs are responsible for coordinating care and addressing Member needs.

- If a Member missed their appointment, please follow up with the Member.
- Document all work-up and treatments done including authorization requests.

Hospice/Palliative Care

For the geriatric population and/or the terminally ill, assessment and Member wishes must be documented.

- End-of-life discussions related to advanced directives, palliative care, and/or hospice.

Referrals to Out-Of-Network Providers

All Members must be referred to a contracted and credentialed provider through AstranaCare. If a provider cannot be located for a particular health service, the referring provider must contact the Utilization Management Department for further guidance. Providers who inappropriately refer a Member to a non-contracted provider without prior authorization may be held responsible for the medical charges incurred.

Prior authorization is required to refer Members to an out-of-network provider. Authorization Request Forms (ARF) must be submitted for all services from non-contracted AstranaCare providers including non-contracted AstranaCare behavioral health providers as these require prior authorization from the Utilization Management Department.

RECOMMENDED RECORDS & CLINICAL GUIDELINES

The following section lists recommended records and clinical guidelines for specialty referrals. For each specialty (listed alphabetically) there are documents/information that Astrana Health may require to evaluate medical necessity. The following list is intended to be illustrative and not definitive, Astrana Health may request such additional records as may be required:

<u>Allergy</u>

- Clinical notes describing the Member's signs and symptoms and conservative management attempted; e.g., nasal steroids
- Consult notes (if obtained) by ENT

Bariatric Surgery

- Completion of bariatric screening tool, to include Member's height, weight, BMI, and attempts at weight reduction
- Psych and Cardiac consults

Cardiac consultation is appropriate for:

- Evaluation of Member who is high-risk and who remains symptomatic or uncontrolled after provider (PCP) initiation of and titration of therapy
- Evaluation of Members with unstable cardiac conditions, including unstable angina
- Sustained or complex non-sustained ventricular arrhythmia
- Sustained or severely symptomatic supra-ventricular arrhythmia
- Severe cardiomyopathy
- Angina despite maximal medication or markedly abnormal stress test
- Evaluation and surveillance of complex or cyanotic congenital disease
- Severe valvular disease
- Symptomatic
- Associated with LVD
- Atrial fibrillation (AF), if Member is a candidate for cardioversion or chronic AF with inability to control rate or patient is symptomatic with usual measures
- Chest pain with an unstable pattern of angina, exercise stress test abnormal at low-level, ischemia with LV dysfunction, angina post-M.I., suboptimal response to medications with limiting symptoms
- Palpitations, if Member is having disabling symptoms or has had syncope or near syncope
- Members with new or frequent palpitations, particularly when associated with other symptoms in the face of known CAD or significant LVD or other serious structural heart diseases
- Request for cardiac rehabilitation must be initiated/recommended by a cardiologist
- Information necessary with consultation request may include:
    - Clinical record documenting risk, condition, and treatment regimen
    - EKG
    - Previous (outside) report of cardiac cath, PTCA, CABG, stress test, Echo, Chest x-ray, etc.

Endocrine

- Clinical record documenting medical need for service, Member's signs and symptoms of concern, and treatment tried
- Current lab verifying deficiency/problems; e.g., thyroid panel
- Special diagnosis study reports; e.g., U.S., C.T., etc., which may have been obtained to validate/diagnose the condition

Otolaryngology (ENT)

- Clinical record indicating concern, physical exam findings, signs and symptoms, and conservative treatment tried; e.g., series of antibiotics (date and type), antihistamine, and/or steroid use (oral and/or nasal)
- Any current lab and/or x-ray finding specific to the concern
- Any specialty consult that may have been accomplished; e.g., allergy consultation or FNA report (of neck node)
- Any diagnostic study that indicates pathology; e.g., biopsy, MRI, CT, etc., requiring surgical intervention
- Any outside records/consultations which indicate the need for follow-up

Gastroenterology

- Clinical record documenting signs and symptoms; e.g., anorexia, weight loss, upper abdominal distress persistent after treatment, melena, fecal occult blood, and conservative treatment tried.

- Current lab demonstrating concern; e.g., iron deficiency, anemia.
- Current radiology report demonstrating concern; e.g., Barium Enema
- Current specialty study/exam demonstrating concern; e.g., Barium Enema or UGI series report(s)
- Past specialty study/exam/surgical report demonstrating concern; e.g., previous colorectal cancer operative report, colonoscopy, or EGD with path report (specifically, previous polyp size and type)

General Surgery

- Clinical record documenting signs and symptoms of condition and treatment tried (if appropriate)
- Current lab demonstrating concern; e.g., CBC with diff
- Current radiology report demonstrating concern; e.g., KUB, U.S.
- Current specialty exam demonstrating concern; e.g., colonoscopy/sigmoidoscopy report with path findings

Genitourinary (G.U.)

- Clinical records indicating the reason for a consult, with treatment tried
- Urinalysis and, where appropriate, C&S (which should have been treated if positive growth)
- P.S.A. report, where appropriate. If elevated, need to include previous PSA result(s) or document if this was the first PSA study
- Any special diagnostic study

Nephrology

- Clinical records indicating concern with signs and symptoms of same and treatment attempted
- Current pertinent lab reports; e.g., BUN, Creatinine
- Reports of any special diagnostic study performed

Neurology

- Clinical record documenting concern, a neurology exam appropriate to the concern, as well as signs and symptoms
- If the referral request is due to ALOC, a mini-mental status exam should be included
- Report of previous (outside) consult/report indicating the need for follow-up or further studies
- Results of any diagnostic study demonstrating concern relative to the issue to be investigated. Neurology consults should be considered before requesting EMG/NCS

Neurosurgery

- Clinical record documenting signs and symptoms of the condition, treatment tried, and neuro exam/deficit, etc.
- Current radiology/imaging reports demonstrating concern; e.g., MRI, CT.
- Consult report (if appropriate) from Neurology or Pain Specialist, suggesting further specialty care

Oncology

- Clinical record describing medical need; e.g., signs and symptoms of concern
- Current lab results
- If hospitalized, previous to consult request, copy of H&P and discharge summary
- Operative report (if the surgical procedure has been accomplished) with a pathology report
- Any staging studies (reports) accomplished

Orthopedics

- Ortho consult is appropriate for:
    - Evaluation of a condition to determine surgical remedy; e.g., osteoarthritis of hip or knee for possible replacement, possible torn ligament or meniscus, for possible orthoscopic procedure
    - Evaluation of and treatment plan advertisement of an orthopedic condition that has not been amenable to or is showing progressive disability despite usual conservative management
    - Evaluation of suspected aseptic neurosis, locked knee, unstable joint, acute or sub-acute effusions

- Provider (PCP) to submit clinical notes, including history of concern and P.E. findings, signs and symptoms expressed by Member, and treatment regimen tried
- Current x-ray reports. Member should be instructed to pick up films and take them to consult appointment, once the request has been authorized
- Current labs pertinent to concern, as appropriate
- Any specialty procedure/study report that may have been done in or outside the group/IPA specific to the concern; e.g., MRI, previous operative notes

Pain Management

- Pain Management consults are generally appropriate for:
  - Chronic long-standing back pain
  - Pain unrelieved by conservative measures
- Current clinical notes documenting Member's signs and symptoms and treatment previously tried; e.g., medication use, local injections
- Any consult (if appropriate) from neurology or neurosurgery indicating the need for further specialist consultation
- X-ray or image report defining the concern

Physical and Occupational Therapy

- Current clinical notes documenting Member's condition and treatment previously attempted (e.g., rest, medications)
- Referral should advise therapist(s) of any specific movement limitations or restrictions (i.e., do not hyper-extend joint)

Podiatry

- Clinical record documenting signs and symptoms regarding the concern and conservative management attempted
- Any comorbidities
- X-ray report of foot/feet
- Copies of any previous podiatry provider reports

Pulmonary

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Radiology report; e.g., chest X-ray
- O_2 sat results
- Previous consult relative to concern or indicating need for follow-up
- Copy of any specialty diagnostic report demonstrating concern; e.g., chest CT, MRI, pulmonary function exam
- Spirometry
- Request for pulmonary rehabilitation may require Pulmonologist endorsement

Rheumatology

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Lab reports documenting/demonstrating concern; e.g., Rheumatology studies, CBC with differential and platelets, chemistry panel 18, sedimentation rate, C reactive protein, rheumatoid factor, ANA
- X-ray reports documenting/demonstrating concern (if accomplished)
- Specialty reports demonstrating concern; e.g., bone density, MRI

Vascular Surgery

- Clinical record documenting signs and symptoms of concern and treatment attempted
- X-ray/Specialty study report documenting concern; e.g., U.S., previous Angiography
- Copy of previous consult (outside IPA) indicating the need for follow-up

DENIALS

Members and providers will receive written notification of any denial of medical treatment, service, and/or procedure.

1. All denials for service will be handled on time and will be entered into the system for tracking purposes.
2. Utilization review criteria are applied consistently, and the assessment information is documented by the Medical Director or designee. Approval, modification, deferred, or denial determinations will be based on medical necessity, benefit coverage, and approved criteria and guidelines.
3. All expedited appeals will be processed in compliance with the timeframe required by the Centers for Medicare and Medicaid Services (CMS) or applicable state law and following health plans' processes.
4. Only providers may make an adverse determination; they will use clinical reasoning and approved criteria and/or clinical guidelines to determine medical necessity.
5. The requesting provider may at any time contact the Astrana Health Medical Director or designee during normal working hours to discuss the determination of medical appropriateness.
6. Common reasons for denials:
    a. The provider is not contracted
    b. The service does not meet utilization review criteria or benefits
    c. The Member is not eligible
    d. The service is not a covered benefit (this includes "Carve-Out" plans)
    e. The Member's benefits for that service have been exhausted

TTY numbers available

Procedures and Criteria are disseminated to Members and providers upon request by calling Astrana Health's Customer Service department at (877) 282-8272 Opt.1, Monday through Friday between 9 AM and 5 PM. For Members with impaired hearing, Members can call our TTY telephone at (877) 735-2929, Monday through Friday between the hours of 8:30 AM to 5 PM. A requesting provider may call Astrana Health to discuss a denial, deferral, modification, or termination decision with the physician (or peer) reviewer at (877) 282-8272 ext.6195. This phone line is open 24 hours per day / 7 days per week. All calls will be returned within 24 hours.

APPEALS

Member Appeals

The policy of Astrana Health is to refer all Member appeals to the appropriate health plan. The health plan will contact Astrana Health for appropriate information needed to resolve the Member's issue. Astrana Health will contact the provider to obtain the requested information, which must be submitted within the timeframe guidelines mandated by each health plan. Providers shall comply with all final determinations made by health plans through their Member Grievance and Appeals procedures.

Provider Appeal

The Utilization Management Committee will review all denial and appeal determinations regularly. If the provider chooses to appeal the determination for a denial of a requested service, the appropriate medical information is gathered by the Utilization Management Coordinator for review by the Medical Director and/or the Utilization Management Committee. Requesting providers must resubmit new authorization with supporting documentation with the reason for appeal. If appropriate, the appeal will be reviewed at the next regularly scheduled Utilization Management Committee meeting. All expedited appeals are reviewed by the Medical Director or designee immediately, and all expedited appeal responses are made within seventy-two (72) hours. Determinations to modify, reverse, or uphold the original decision will be completed and processed within five (5) days of the appeal. Reversals of denials for requests for expedited appeals are processed immediately. The requesting provider shall receive written notification of the outcome.

PROCEDURES RECOMMENDED FOR OUTPATIENT SETTING

The following procedures are recommended to be performed in an outpatient ambulatory surgery setting. This is not an exclusive list of procedures. Exceptions require prior authorization.

A. Gastroenterology
- Liver Biopsy
- Colonoscopy (screening)
- ERCP (Endoscopic Retrograde Cholangiopancreatography)
- Sigmoidoscopy
- Esophagogastroduodenoscopy (EGD)
- Esophagoscopy

B. Gynecology
- Marsupialization of Bartholin Cyst
- Treatment of Condylomata Acuminata
- Cryotherapy (alone or with a biopsy and/or dilation & curettage)
- Dilation and Curettage
- Examination under Anesthesia
- Culdoscopy
- Hymenotomy
- Hysterosalpingogram
- Therapeutic Abortion (first trimester)
- Dilation and Evacuation (second trimester)
- Laparoscopy, diagnostic, or sterilization
- Removal of IUD
- Hysteroscopy
- Culdocentesis (office)
- Amniocentesis or Amniogram
- Perineorrhaphy (minor)
- Cervical Amputation
- Cervical Conization

C. General Surgery
- Breast Biopsy (if a two-stage procedure for a possible malignancy)
- Cervical Node Biopsy
- Lipoma Excision
- Muscle Biopsy
- Rectal Polypectomy
- Excision of Sebaceous Cyst
- Excision of Skin Lesion with Primary Closure
- Excision Bakers Cyst
- Excision Breast Masse(s)
- Excision Draining Sinus Tract
- Excision Neuroma
- Foreign Body Removal
- I & D abscesses
- Varicose Vein Ligation (without stripping)
- Minor hemorrhoidectomy
- Hernia Repair (infant)

- Paracentesis

D. Plastic Surgery
- Blepharoplasty (upper/lower or combined)
- Mammoplasty (augmentation, revision) after mastectomy for cancer, unless a major case requires postoperative hospital days.
- Small Skin Graft
- Dupuytren's Contracture
- Many Tendon Repairs
- Fingertip Injury Revisions
- Excision Lesions (minor)
- Excision Ganglion (wrist)
- Acute Nerve Repair (hand)
- Other Minor Hand Procedures
- Staged Reconstructive Procedures
- Scar Revision

E. Ophthalmology
- Argon Laser Prescription
- Chalazion
- Discussion
- Ectropion and Entropion
- Insertion of the glass tube into the lacrimal duct
- Lacrimal Duct probing
- Pterygium
- Strabismus

F. Otolaryngology
- Myringotomy (with or without tubes)
- Antral Puncture (with or without irrigation)
- Inferior Turbinate Fracture
- Nose, Closed Reduction
- Type I: Tympanoplasty with the removal of attic and oval window cholesteatoma sacs
- Nasal reconstruction
- Otoplasty unilateral, bilateral (Depending on age: young children may require hospitalization overnight)
- Cervical node biopsy
- Esophagoscopy
- Frenulectomy
- I & D abscess (simple)
- Otoscopy (with or without removal of foreign body)
- Removal of foreign body from nose or ear
- Removal of scars, moles, or basal cell CA
- Wiring simple joint fracture

G. Orthopedic Surgery
- Ganglion Excision
- Carpal tunnel decompression
- Excision of foreign body
- Tenotomy
- Manipulation of joints, individual consideration, depending upon the joint involved and

indication for the procedure
- Removal of bursae (Olecranon)
- Dupuytren's Contracture
- Many Tendon Repairs

H. Urology
- Circumcision (pediatric and adult)
- Dorsal slit
- Meatotomy
- Urethra dilation
- Vasectomy
- Cystoscopy
- Fulguration of venereal warts
- Excision and biopsy of the scrotal lesion
- Cystoscopy and retrograde
- Prostatic biopsy

I. Endoscopy
- Culdoscopy
- Diagnostic cystoscopy
- Gynecological laparoscopy
- Otoscopy
- Proctosigmoidoscopy
- Fiberoptic sigmoidoscopy and fiber optic colonoscopy (diagnostic only)
- Gastroscopy

J. Thoracic or Vascular
- Esophageal dilation
- Excisional surgery: chest wall lesion
- Lymph node biopsy
- Mediastinoscopy
- Thoracentesis

K. Pulmonology
- Bronchoscopy

PROCEDURES RECOMMENDED FOR SAME-DAY SURGERY

Prior authorization is required from Astrana Health

A. Gynecology
   - Mini Lap (tubal ligation)
   - Bartholin Cystectomy
   - Vaginal Tubal Ligation

B. General Surgery
   - Pilonidal Cystectomy
   - Excision of Thyroglossal Duct Cyst
   - Varicose vein ligation with stripping
   - Hernia repair (Inguinal and Femoral)
   - Umbilical Herniorrhaphy

C. Ophthalmology
   - Correction of eye muscle impairment
   - Cataract extraction
   - Iridectomy
   - Phacoemulsification
   - Prolapsed iris, etc.
   - Reconstruction of lacrimal duct

D. Urology
   - Cystoscopy with fulguration of small bladder tumors
   - Installation of chemotherapy in the ureter and bladder locally

E. Otolaryngology
   - Ethmoidectomy (intranasal)
   - Tonsillectomies
   - Adenoidectomies
   - T & A
   - Tympanoplasty
   - Sinus surgery

F. Neurosurgery
   - Morton's neuroma
   - Neuroma

G. Cardiology
   - Pacemaker generator change
   - Pacemaker programming
   - Cardiac catheterization (if findings negative)

H. Orthopedics/Podiatry
   - Morton's neuroma
   - Hammertoes with tenotomies and resection of bone (This procedure is recommended for outpatient surgery except when performed on both feet at the same time, or when the patient is elderly and cannot ambulate on crutches or walker without physical therapy training)
   - Arthroscopy
   - Bunionectomy

I. Endoscopy
   - Observation bronchoscopy (flexible, for patients under 40 years of age)
   - Triple upper endoscopy

NO AUTHORIZATION REQUIRED/AUTO-PAYABLE SERVICES

Procedure:

A. ALL services require prior authorization except the services listed below. They are exempt from prior authorization per State, Federal, or Health Plan regulations:

- Preventive Health Services including immunizations
- Preventative screenings for women, infants, children, and adolescents
- Annual well-women care
- Basic Prenatal Care, including OB/GYN in-network referrals and consults
- FDA-approved contraceptive drugs and devices without cost sharing
- Family Planning Services provided to members of childbearing age to delay or prevent pregnancy through any family planning providers.
    - Pregnancy testing and counseling
    - Vasectomies
    - Tubal ligation
    - Provision of contraceptive pills, devices, and supplies
    - Health education and counseling to make informed choices about family planning and birth control choices
    - Limited physical and history examination to support family planning and birth control choices
    - Limited physical and history examination to support family planning services
    - Laboratory and pharmacy services if medically necessary to support a choice of contraceptive methods
    - Follow-up care for any complications related to contraceptive care provided by the family planning service
    - Diagnosis, treatment, and counseling for STDs and HIV
- Communicable Disease Services
- Sexually Transmitted Disease (STD) services for both within and outside the provider network
- Sensitive Services for Minors
- Sensitive and confidential services and treatment (including, but not limited to, services relating to sexual assault, pregnancy, and pregnancy-related services, family planning, abortion/pregnancy termination, sexually transmitted diseases, drug and alcohol abuse, HIV testing and treatment, and outpatient mental health counseling and treatment)
- Pre-exposure and post-exposure HIV prophylaxis drugs (e.g. PrEP) without prior authorization or cost-sharing
- Confidential HIV testing including access to confidential HIV counseling and testing services both through the network and the out-of-network local health department and family planning providers;
- Members may access LHD clinics and family planning clinics for diagnosis and treatment of an STD episode. For community providers other than LHD and family planning providers, out of plan services are limited to one office visit per disease episode for the purposes of:
    - Diagnosis and treatment of vaginal discharge and urethral discharge
    - STDs that are amenable to immediate diagnosis and treatment those include syphilis, gonorrhea, Chlamydia, herpes simplex, chancroid, trichomoniasis, HPV, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and evaluation and treatment of pelvic inflammatory disease.

- Out of Network Renal Dialysis services
- Emergency services (medical screening & stabilization) including emergency behavioral health care crisis stabilization, including mental health screenings
- Urgent Care
- Urgent care for home and community service-based recipients
- Biomarker testing (FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer only)
- Screening for certain cancers based on USPSTF recommendations
- Diabetic screenings based on USPSTF recommendations
- Non-Emergency Medical Transportation (NEMT)
- Flu Vaccines

Upon receipt of a request for prior authorization of a preventive service, Astrana Health will send the "Prior Authorization Not Required" letter, if applicable, to the member and the requesting provider to notify that the requested service is covered at no cost and does not require prior authorization.

INPATIENT CASE MANAGEMENT

A. Availability

Astrana Health's Case Management Department provides 24/7 on-call coverage for contracted providers. Providers needing to reach Case Management after hours or on weekends should call (877) 282-8272 or 725-377-4231. The answering service will contact the appropriate on-call provider for any problem that may arise after hours, including emergency room authorizations or after-hour patient calls. If a Member feels they have a serious medical condition, they will be instructed to hang up and dial 911 or to go to the nearest emergency room.

B. Hospital Admissions

Non-business hours

All non-emergency hospital admissions must be authorized. Hospitals calling after hours to report a hospitalization will be put in contact with the designated Case Manager who will coordinate the Member's care accordingly. The answering service has access to contact the Case Manager after hours and on weekends. The provider should notify Astrana Health of any admissions by calling (877) 282-8272 or 725-377-4231 in the event they are contacted by the hospital regarding a hospitalization.

Business Hours

Providers requesting to admit a Member into the hospital should contact Astrana Health's Case Management Department. The provider may need to submit an authorization request for hospital admission.

C. Hospitalists

To coordinate hospital admissions, Astrana Health may provide hospitalists on-call. The Case Management Department will be contacted by the admitting hospital for notification purposes. The Case Manager will contact the hospitalist assigned to coordinate the Member's care. Astrana Health encourages providers to contact its Case Management Department if they receive notification of admission or if they require assistance in directing the Member to the appropriate hospital. Case Management is available 24 hours a day / 7 days a week at (877) 282-8272 or 725-377-4231. Admission face sheets and in-patient medical records can be faxed to Case Management at (480) 542-2889.

D. Discharge Planning

Case Management is available to assist providers in discharge planning and the post-acute hospital phase. During the treatment planning phase, options for post-acute services are identified early in the patient's hospitalization. If the patient discharged is from another facility, the assigned Case Manager coordinates with the hospital staff to ensure a smooth transition out of the acute care facility.

The Case Manager can assist by:

- Identifying and authorizing services that can benefit the patient after acute hospitalization.
- Working with the hospital Discharge Planner to arrange for Skilled Nursing Facility placement or home health care at home.

Inpatient CM policies and procedures are available upon request. Please contact the Inpatient CM Department at (626) 282-3749.

AMBULATORY CARE MANAGEMENT

Purpose

The Case Management (CM) Program, in collaboration with network providers, meets individual patient needs through communication and the use of available resources, intending to deliver quality cost-effective care and positive health outcomes.

Scope

Astrana Health's care management program provides individualized assistance to members experiencing complex, acute, or catastrophic illnesses. The focus is on early identification of and engagement with high-risk members, applying a systematic approach to coordinating care and developing treatment plans that increase satisfaction, control costs, and improve health and functional status, resulting in favorable outcomes.
The program scope includes Basic Case Management (BCM), Complex Case Management (CCM) as delegated, Pediatric Case Management, High-Risk Pregnancy Case Management, CM Triage for Coordination of Care (COC), Transplant Care Management, ESRD, Disease Management, Readmission Management and High ER Use and SNP dual eligible Case Management.

Ambulatory CM policies and procedures are available upon request. Please contact the Ambulatory CM Department at (626) 282-3749.

Care Management Program Goals, Objectives, and Functions

Astrana Health's program goals are to achieve, in collaboration with providers, the following:

Quality health outcomes – identifies, manages, measures, and evaluates the quality of health care delivered to high-risk populations. This is accomplished by using identification tools and performance benchmarks that continually evaluate clinical, functional, satisfaction, and cost indicators.

Cost-effectiveness – Astrana Health is committed to measuring the effectiveness of the care management program. Astrana Health seeks clinical and cost information feedback from internal encounter data and Health Plans to assist in enhancing the performance of medical management programs.

Resource efficiency – Astrana Health's care management team works with internal and external

stakeholders (Health Plans) to improve the efficiency and effectiveness of the medical group's care management activities.

The goal of Care Management is to assist members in navigating the health care system and obtaining necessary services in an optimal setting for any critical medical event or diagnosis they experience. The focus is on reducing future inpatient admissions and coaching self-care management. Collaborating with the member, the PCP, and/or Providers, the Care Manager assists in identifying educational and care options that are acceptable to the Member and family. Motivational Interviewing and coaching for behavioral changes are techniques used in the process to increase adherence to treatment plans leading to successful outcomes. CM involvement is short-term with a ninety (90) day Care Plan (CP) Goal. The processes of assessment, planning, facilitation, and advocacy for options and services are incorporated into the overall case management approach.

Access to Care Management and Complex Care Management (CCM)

Referral Criteria

Conditions, diseases, or high-risk groups most frequently managed include, but are not limited to the following:

- Over-, under-, or inappropriate utilization of services
- Multiple/frequent ER visits, acute inpatient admissions or readmissions
- Multiple Referrals and/or Providers in and out of network
- Multiple/severe disabilities
- Chronic Diseases w/co-morbidities
- Permanent or temporary alteration of functional status
- Medical/psychosocial/functional complications
- Non-adherence to treatment or medication regimens, or missed appointments
    - High-cost injury or illness
- Lack of family or social support or financial resources
- Exhaustion of benefits - for example, a member with medical necessity for a specialized hospital bed, but the member's durable medical equipment (DME) benefit is exhausted

Source of referrals

Astrana Health utilizes the following sources to identify Members for care management:

- Health Risk Assessment
- Claims or encounter data
- Hospital discharge data
- Pharmacy data, if applicable
- Data collected through the UM management referral/authorization process, if applicable
- Data supplied by purchasers, if applicable
- Data supplied by members or caregivers, if applicable
- Data supplied by practitioners
- Data received from health plans and internal sources are analyzed by the UM team and triaged for possible referral for CM services

The referral avenues for Members to be considered for CM or CCM referrals include the following sources:

- Astrana Health's Transition of Care Team
- Medical management program referral, including disease management program, UM program, or referral that comes from other organizations' programs or vendors
- Discharge planner referral
- Member or caregiver referral
- Primary Care Physician referral via Provider Portal or AmbulatoryCare.Dept@AstranaHealth.com

HEALTH SERVICES CONTACT INFORMATION

Phone Numbers

UM Customer Service: (626) 282-3749

Acute & SNF Admissions:

Office Hours – (415) 216-0088

After-Hours/Weekend – 725-377-4231 or (626) 282-0288 x0

Ambulatory Care Management (626)876-2191

Fax Numbers

Routine and Retro Services: (480) 542-2885

Urgent Services: (480) 542-2886

Acute & SNF Face sheet & Clinical Notes: (480) 542-2889

E-Mail

Ambulatory Care: AmbulatoryCare.Dept@AstranaHealth.com

Delegation Oversight: Delegation.Oversight@AstranaHealth.com

Inpatient Services: CaseManagement.Dept@AstranaHealth.com

Quality Management: QualityManagementDept@AstranaHealth.com

Outpatient Services: UtilizationManagementDept@AstranaHealth.com

SECTION 6 CLAIMS PROCEDURES

TIMELY FILING GUIDELINES

Claims must be submitted to AstranaCare within the timeframes specified in the Provider Agreement as referenced below:

- Medicare Advantage Plans:
  - 365 Days from the date of service for non-contracted providers
  - Contracted Providers – As specified in the Provider Agreement
- Commercial and Medi-Cal Plans:
  - 90-Days from the Date of Service for contracted providers
  - Contracted Providers – As specified in the Provider Agreement

FILING ELECTRONIC CLAIMS

AstranaCare highly recommends billers submit claims electronically. If providers are submitting claims electronically, they may do so through the following methods:

- Web Portal – https://provider-portal.astranahealth.com/login
  (Preferred submission method)
- Office Ally (clearing house)
  - NMM12: Astrana Care Partners of Arizona

FILING PAPER CLAIMS

All paper claims for AstranaCare must be submitted on a CMS 1500 Form or UB04 as appropriate to:

AstranaCare Partners of Arizona, LLC
Attention: Claims Department
1600 Corporate Center Dr.
Monterey Park, CA 91754

CHECKING CLAIMS STATUS

Claims status can be checked online by using AstranaCare's online provider portal. For more information on using our provider portal, please contact our Portal Team at (626) 943-6146 or by email at Portal.Help@AstranaHealth.com.

CLAIM PAYMENT TIMELINES

The first date stamp on a claim begins the counting of days. The counting of days ends when the check is in the mail.

- Clean claims are to be paid or denied within thirty (30) calendar days of receipt.
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- .

CLAIM SUBMISSIONS

All claims should be submitted on a CMS 1500 Form or UB04 as appropriate. Important elements that are necessary for billing include:

1. Patient's name, and address.
2. Patient ID number (including suffix #, i.e. 01, 02, 03, etc.)
3. Date of birth
4. Date of service
5. Provider's name, address, NPI, tax ID number, and provider signature.
6. Usual charges
7. ICD-10 diagnosis codes
8. Modifiers (if applicable)
9. J Codes (if applicable)
10. Authorization number if the procedure(s) need(s) an Authorization
11. Rendering Provider ID #/NPI
12. Federal Tax ID Number
13. CPT procedure codes
14. Place of service codes
15. Completion of item 11. If there is insurance primary to Medicare, the insured's policy or group number should be entered. If there is no insurance primary to Medicare, then "none" should be entered.

Reference to the following link for the elements that should be used for claim processing:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26pdf.pdf

The ensuing pages list "place of service" codes and some CPT codes. If you use computer-generated forms, such forms must carry the same information. The provider's signature should be on all paper claim forms.

CLAIMS FOR REFERRED SERVICES

For electronic claims, the AstranaCare specialist physician must indicate the name of the referring AstranaCare physician on the electronic claim.

For paper claims, the AstranaCare specialist physician must indicate the name of the referring AstranaCare physician on the claim.

CLAIMS FOR AUTHORIZED SERVICES

Be sure that a claim for authorized services includes the following:

a) The procedure code(s) that was authorized on the Authorization Request Form (ARF) matches the code on the claim form
b) The reference number for the authorization
c) And, when submitting a paper claim, attach a copy of the approved ARF

CLAIMS RESUBMISSION POLICY

To avoid duplicate claims, please first check the status of your claims on our provider portal to confirm receipt.

Paper Claims Processing Fee

It is strongly encouraged that all providers submit claims electronically through EDI (Electronic Data Interchange).

If a provider has already signed up for the Electronic Remittance Advice (ERA) service, it will reflect such a charge on it.

The paper claim processing fee will be waived for the following situations:

- Paper claim submission with supporting documents including medical note, timely proof, cost invoice, and primary EOB
- Payment for an overturned PDR

ZELIS E-PAYMENT CENTER

Astrana Health currently utilizes the Zelis Provider Network platform with our contracted providers to improve efficiency to streamline payment and data facilitation processes. Astrana Health may change vendors at any time following the provision of notice to the Providers.

How to Enroll

To ensure timely, efficient, payments using Astrana Health's ePayment Center (Powered by Zelis). Please follow the enrollment instructions below.

What do I need to register for the ePayment Center?

- Federal tax identification number (TIN) or employer identification number (EIN)
- Your practice's corporate name and principal information
- Bank account routing transit number (RTN) or ABA routing number

How do I register for ePayment Center?

1. Visit nmm.epayment.center/register
2. Follow the instructions to obtain a registration code (a link will be sent to you)
3. Follow the link to complete your registration and set up your account
4. Log in to the portal and enter your bank account information
5. Review and accept the ACH Agreement and click "Submit"
6. Your bank account will be validated before electronic fund transfer (can take up to 6 business

days)

Need Help?

Call (855) 774-4392 or email help@epayment.center with questions.

ELECTRONIC REMITTANCE ADVICE (ERA)

It is the policy of Astrana Health to provide eligible providers the means of receiving electronic remittance advice (ERA/835) in lieu of paper. Astrana Health has a standard procedure that is followed to ensure provider registrations for ERA's are processed in a timely manner. To begin receiving ERAs for any payers going through Zelis Payments, you must first register and enroll with Zelis Payments.

Procedure:

1. Go to nmm.epayment.center/register and click on "Get Started"
2. To create an account you will select one of two registration options:
    - *I Don't Have A Registration Code* (you've never received a payment/ERA from Zelis Payments before)
        - Complete and submit the *New Provider Registration Form.* You will receive your registration code within 28 business hours
    - *I Have A Registration Code* (you've received a payment/ERA from Zelis Payments and have a registration code)
3. Read and click "I Accept" to approve the Zelis Payments Site User Agreement and Terms
4. You will need the following information to complete your enrollment
    - *Organization Legal Name and Business Type*
    - *Contact Information for your designated EPS contacts*
    - *Banking information for payment and fees*
5. After you have logged into your account, you will need to complete the account setup (next 3 steps)
6. Payment Enrollment: Select your desired method for receiving ePayments by selecting one of these options
    - *Receive MasterCard Payments to your account*
    - *Receive Direct ACH to your bank account*
7. ERA Enrollment: Select "Clearinghouse" from the drop-down menu
    - After selecting this option, you will be automatically directed to the delivery options page where you can select "Office Ally" from the drop-down menu
    - Next, you will need to enter the provider contact information (name and telephone) then select the checkbox to confirm you are an authorized representative of your practice
    - Click "Submit"
8. Notifications: Select which notifications you would like to receive and how you would like to receive them
    - Available Notification Reports:
        - Provider Payment Alert
        - Provider Remittance Alert
        - Provider Daily EOP
        - Provider Summary

9. Click “Review Information” to examine the enrollment information you entered – Business Contact, Banking, Data Delivery, and the Select+ Service Agreement – on the page. Click “Modify” to make changes to any of the sections
10. Submit Enrollment: In the “Agreement” section at the bottom of the Enrollment Review page, check the checkbox and click “Submit” to complete your enrollment

For more information on ERA Enrollment, contact the Provider Relations Department

Direct Line: (480) 470-0463
E-mail: az.providerrelations@astranahealth.com

REFUNDS

When submitting a refund, please include a copy of the corresponding remittance advice, an explanation of why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer’s remittance advice (if applicable).

PLACE OF SERVICE CODES

CODES DEFINITION

02	Telehealth
11	Office
12	Patient Home
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus- Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility
32	Nursing Home/Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air or Water)
51	Inpatient Psychiatric Facility
52	Psych Facility-Partial Hospitalization
53	Community Mental Health Center
54	Intermediate care Facility/Individuals with Intellectual Disabilities
55	Residential Treatment Center/Substance Abuse
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehab Facility
62	Comprehensive Outpatient Rehab Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic

72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

For a full list of Place of Service codes, please refer to the link below:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

CLAIM SUBMISSION INSTRUCTIONS

A. Sending Claims to AstranaCare. Claims for services provided to Members assigned to AstranaCare must be sent to the following:

Via Mail: AstranaCare Partners of Arizona, LLC
Attention: Claims Department
1600 Corporate Center Dr.
Monterey Park, CA 91754

B. Claims status can be checked online by using AstranaCare's online provider portal. For more information on using our provider portal, please contact our Portal Team at (626) 943-6146 or by email at Portal.Help@AstranaHealth.com.

C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information, and claims documentation required by AstranaCare:

Claims are to be submitted on a CMS-1500/UB-4 form or their respective successor forms and shall include patient name, date of service, gender, date of birth, Member ID number, authorization number, type of service provided, valid CPT codes, pricing and reports as necessary or requested, within ninety (90) days from the date of service or the date specified in the Provider Agreement.

D. Claim Receipt Verification. For verification of claim receipt by AstranaCare, please do the following:

- Call the Claims department at (626) 282-0288

PROVIDER DISPUTES

I. Dispute Resolution Process for Contracted Providers Commercial and Medicaid

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to AstranaCare and/or the Member's applicable health Plan challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name, provider's identification number, provider's contact information, and

   a. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from AstranaCare to a contracted provider the following must be provided: a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect. Overpayment notice shall be issued (i) within three hundred sixty-five (365) calendar days of the date of payment, or at any time, in the event of fraud and/or misrepresentation.

   b. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue, and

   c. If the contracted provider dispute involves a member or group of Members, the name and identification number(s) of the Member or Members, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and a member's written authorization for the provider to represent said Members.

B. Sending a Contracted Provider Dispute to AstranaCare. Contracted provider disputes submitted to AstranaCare must include the information listed in Section I. A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of the Provider Dispute Resolution Unit at the following:

   Via Mail: AstranaCare Partners of Arizona, LLC
   Attention: Provider Dispute Resolution Unit
   1600 Corporate Center Dr.
   Monterey Park, CA 91754
   Fax: (626) 656-6323

C. Period for Submission of Provider Disputes.

   a. Contracted provider disputes must be received by AstranaCare within three hundred sixty-five (365) calendar days from AstranaCare's action that led to the dispute (or the most recent action if there are multiple actions), or

b. In the case of inaction, contracted provider disputes must be received by AstranaCare within three hundred sixty-five (365) calendar days after the time for contesting or denying a claim (or most recent action if there are multiple claims) has expired.

c. Contracted provider disputes that do not include all required information as set forth above in Section I. A. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to AstranaCare within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. AstranaCare will acknowledge receipt of all contracted provider disputes as follows:

a. Electronic contracted provider disputes will be acknowledged by AstranaCare within two (2) Working Days of the Date of Receipt by AstranaCare.

b. Paper contracted provider disputes will be acknowledged by AstranaCare within fifteen (15) Working Days of the Date of Receipt by AstranaCare.

E. Contact AstranaCare Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to AstranaCare at (877) 282-8272.

F. Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing, or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

a. Sort provider disputes by a similar issue

b. Provide a cover sheet for each batch

c. Number each cover sheet

d. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets

i. Period for Resolution and Written Determination of Contracted Provider Dispute. AstranaCare will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

ii. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, AstranaCare will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

II. Dispute Resolution Process for Non-Contracted Providers Commercial and Medicaid

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to AstranaCare challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

   a. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from AstranaCare to the provider the following must be provided: a clear identification of the disputed item, the Date of Service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

   b. If the non-contracted provider dispute involves a member or group of Members, the name and identification number(s) of the Member or Members, a clear explanation of the disputed item, including the Date of Service, the provider's position on the dispute, and a member's written authorization for the provider to represent said Members.

B. Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as outlined in sections I.B., I.C., I.D., I.E., and I.F. above.

C. Medicare Provider Dispute Resolution Process:

   a. Effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) expanded its current provider payment dispute resolution process for disputes between non-contracted and deemed providers and Private Fee for Service Plans to include disputes between non-contracted providers and all Medicare Advantage Organizations:

   b. Applies to only Non-Contracted Providers

   c. Includes decisions where a non-contracted provider contends that the amount paid by the payer for a covered service is less than the amount that would have been paid under Original Medicare.

   d. Effective September 18, 2020 - A CMS PDR DOES NOT INCLUDE:

      i. Payment denials by payers that result in zero payments being made to a non-contracted provider.

      ii. Payment disputes for contracted providers.

      iii. Local and National Coverage Determinations.

      iv. Medical necessity determinations.

      v. Payment disputes for which no initial determination has been made.

   e. Effective September 18, 2020, all dispute reasons, except for fee schedule disputes received

from a non-contracted provider, are now classified as an appeal.

i. Example of common appeals are:

1. Diagnosis code / Down-coding / Bundling issues
2. DRG Payment denials
3. Level of care or rate of payment denials
4. Local and National Coverage Determinations
5. Medical necessity determinations, including DRG medical necessity review
6. Payment denials by payers that result in zero payments being made to a non-contracted provider
7. Payment disputes for contracted providers
8. Payment disputes for which no initial determination has been made
9. Payment disputes for which no Medicare rate exists

f. Submission of a first-level Provider Dispute must be filed within a minimum of one hundred twenty (120) calendar days after the notice of initial determination (i.e., EOBs/RAs/Letters).

g. Payers may allow an additional five (5) calendar days for mail delivery.

h. The payer may extend the time limit for filing a provider dispute if good cause is shown.

i. If documentation has not been submitted for review of the Provider Dispute, the payer may request that required documentation be submitted.

j. Requests can be made via phone or in writing.

k. If the additional documentation that was requested is not received within fourteen (14) calendar days from the date of request, the payer conducts the review based on the information in the file.

l. In the event the documentation is received after the fourteen (14) calendar day deadline, the payer must consider the evidence before making and issuing the final determination.

D. The payer's decision on the Payment Dispute must be within thirty (30) calendar days from the date the Payment Dispute is first received by the payer.

a. Must be in writing.

b. Include facts and rationale about the resolution

c. Inform the provider about their right to the MAO-Health Plan or designee, Provider Dispute Resolution (Second Level) review process.

d. Thirty (30) Calendar Day TAT based on:

i. A decision in the provider's favor = Mail Date of Payment/Letter

ii. The decision upheld = Letter Mail Date

e. The non-contracted provider may submit a second-level written request to the applicable MAO-Health Plan or designee for a second-level review, by email, fax, or mail within one hundred eighty (180) calendar days of written notice from the payer.

f. The Second Level request may be filed if:

i. Thirty (30) calendar days have elapsed from the date the payer received the payment dispute, and the payer has not responded.

g. The MAO-Health Plan or designee may request documentation from the payer who processed the first-level provider dispute.

CLAIM OVERPAYMENTS

A. AstranaCare processes overpayment recovery following CMS regulations or contractual agreements. By law, Providers are required to report and return the overpayment to AstranaCare within sixty (60) calendar days after the date the overpayment was first identified. Overpayments occur when too much has been paid to the Provider and a refund to AstranaCare is necessary.For Medicare Advantage health plans, overpayments include but are not limited to the following:

i. Duplicate submission of the same service claim

ii. Billing for excessive services or noncovered services

iii. Payment for excluded or medically unnecessary services

iv. Payment to the incorrect payee

v. Claims-system configuration issues

vi. Pricing errors

vii. Incorrect adjustments

viii. Primary payment when AstranaCare is secondary

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

C. Providers must mail refund checks, along with a copy of the notification or other supporting documentation to:

Via Mail: AstranaCare Partners of Arizona, LLC
Attention: Recoveries Department
1600 Corporate Center Dr.
Monterey Park, CA 91754

D. Notice of Overpayment of a Claim. If AstranaCare determines that it has overpaid a claim, AstranaCare will notify the provider in writing through a separate notice identifying the claim, the name of the patient, the Date of Service(s), and a clear explanation of the basis upon which AstranaCare believes the amount paid on the claim was more than the amount due, including interest and penalties on the claim.

E. Contested Notice. If the provider contests AstranaCare's notice of overpayment of a claim, the provider, within thirty (30) Working Days of the receipt of the notice of overpayment of a claim, must send a written notice to AstranaCare stating the basis upon which the provider believes that the claim was not overpaid. AstranaCare will process the contested notice following AstranaCare's contracted provider dispute resolution process described in Section II above.

F. No Contest. If the provider does not contest AstranaCare's notice of overpayment of a claim, the provider must reimburse AstranaCare within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.

G. Offsets to payments. Per section D of this Exhibit, the Provider specifically authorizes AstranaCare to offset an uncontested notice of overpayment of a claim against the provider's current claim submission when; (i) the Provider fails to reimburse AstranaCare within the timeframe outlined in Section C, above. If an overpayment of a claim or claims is offset against the provider's current claim or claims according to this section, AstranaCare will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

SECTION 7 QUALITY MANAGEMENT

PROCEDURES

Quality Management (QM) promotes the highest quality of medical care and service to Members by performing ongoing evaluations and modifications.

QM Identifies and resolves issues that directly or indirectly affect Member care.

Quality Management Committee Meetings:

- Special studies & trending
- Preventative Health Services
- Development/Implement Clinical
- Practice Guidelines
- Policy and Procedures
- Grievance Resolution
- Access Monitoring
- Culturally and Linguistically Appropriate Services (CLAS)

All Primary Care Physician offices will be audited on a routine basis by Astrana Health and periodically by the Health Plans.

It is imperative that the PCP office be kept tidy and that all logs are kept current and available for these audits.

For assistance preparing for audits, please contact our Quality Management Department at (626) 282-0288. Astrana Health will assist you in any way that we can to make sure that you are audit-ready at all times.

GRIEVANCES & APPEALS PROCESS

The policy of Astrana Health is to refer all Member grievances and appeals to the appropriate health plan, to ensure Members are provided appropriate medical care of the highest possible quality.

The health plan will contact Astrana Health for appropriate information needed to resolve the Member's issue. Astrana Health will contact the provider to obtain the information requested, which must be submitted within the time guidelines mandated by each health plan. Providers shall comply with all final determinations made by health plans through their Member Grievance and Appeals procedures.

ACCESS TO CARE STANDARDS

Quality and Health care access standards established by Astrana Health ensure all members have access to healthcare services. Astrana Health makes these standards known to all providers, continuously monitors its provider networks' compliance with these standards, and takes corrective action, as necessary. These standards ensure that the hours of operation of Astrana Health networks are convenient to and do not discriminate against Members, and are no less available than hours offered, and that services are available 24/7 when Medically Necessary. Astrana Health access standards are following Arizona, health plans, and NCQA standards.

Access Criterion	AstranaCare Standard
Primary Care Provider (PCP) Accessibility Standards:	
Routine Primary Care Appointment (Non-Urgent)	Within 10 business days of a request
Urgent Care Appointment	Within 48 hours of request
Emergency Care	Immediate, 24 hours a day, 7 days per week
Preventive Care	Within 10 business days of a request- 30 calendar days for Medicare
First Prenatal Visit	Within 10 business days of a request
Post Stabilization Services	59695969 (CMS = 1 hour)
Specialty Care Provider (SPC) Accessibility Standards:	
Routine Specialty Care Appointment (Non-Urgent)	Within 15 business days of a request
Urgent Care Appointment	Within 96 hours of request
Ancillary Care Accessibility Standards:	
Routine Ancillary Care Appointment (Non-Urgent)	Within 15 business days of a request
Behavioral Care Accessibility Standards:	
Routine Behavioral Care Appointment (Non-Urgent)	Within 15 business days of the request (Physicians)
	Within 10 business days of the request (non-Physicians)
Urgent Care Appointment	Within 48 hours of request
Life Threatening Emergency	Immediately
Non-Life Threatening Emergency	Within 6 hours of request
Emergency Care	Immediate, 24 hours a day, 7 days per week
After-Hours Care Standards:	
After-Hours Care	• Automated systems must provide emergency 911 instructions
	• An automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP or covering physician
	• Offer a call-back from the PCP, covering physician, or triage/screening clinician within 30 minutes
Physician Telephone Responsiveness:	
In-Office Waiting Room Time	Within 30 minutes
Speed of Telephone Answer	Within 30 seconds
Missed Appointments	Within 48 hours to reschedule

ASTRANA HEALTH DEFINES THE ACCESS CRITERION AS FOLLOWS:

1. Preventive care: Care or services provided to prevent disease/illness and/or its consequences. For example, an annual physical exam, immunizations, or a disease screening program.
2. Specialty care: Medical care provided by a specialist, such as a cardiologist or a neurologist.
3. Routine primary care: Services that include the diagnosis and treatment of conditions to prevent further complications and/or severity. These are non-acute, non-life, or limb-threatening.
4. Urgent care: Care given for a condition(s) that could be expected to deteriorate into an emergency or cause prolonged impairment, such as acute abdominal pain, fever, dyspnea, serious orthopedic injuries, vomiting, and persistent diarrhea.
5. Post-stabilization services: Contracted providers must provide 24/7 access to providers for prior authorization of Medically Necessary post-stabilization care and to coordinate the transfer of stabilized Members in an emergency department. Requests from the facility for prior authorization of post-stabilization care must be responded to by Astrana Health within a reasonable amount of time (CMS = 1 hour) or the service is deemed approved. Upon stabilization, additional medical-necessity assessment will be performed to assess the appropriateness of care and assure that care is rendered in the appropriate venue.
6. After-hours non-urgent phone call: Examples include an Rx refill, questions regarding the current treatment plan, or problems identified.
7. After-hours emergency/urgent phone call: A call made for a life-threatening illness or accident requiring immediate medical attention for which delay could threaten life or limb.
8. Waiting time: The period from the scheduled appointment time until seen by the provider in the exam room (assuming that the Member arrives on time). The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.
9. Ancillary services: Include, but are not limited to, the provisions of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, home-health service providers, and providers of mental health or substance abuse services.
10. Triage or screening: The assessment of a Member's health concerns and symptoms to determine the urgency of the Member's need for care.

Providers are encouraged to accept walk-in members in case of unforeseen circumstances and should let members know of their office policy for same-day appointments.

HEALTH EDUCATION PROGRAMS

Providers are encouraged to inform Members about Health Education programs offered by Astrana Health and contracted Health Plan organizations which are available in the threshold languages and different formats. The following is a list of health education programs that are available:

- Asthma
- Childhood Obesity
- Diabetes
- Drug and Alcohol Problems
- Exercise
- Family Planning/Birth Control
- How to Quit Smoking
- Nutrition
- Parenting
- Prenatal Health (for pregnant women)
- Safety Tips
- STDs and HIV
- Tobacco Cessation
- Weight Problems

ASTRANA HEALTH
HEALTH EDUCATION REFERRAL PROCESS

1. Complete Treatment Authorization Request (TAR).
2. Retain a copy of TAR in Medical Records and document the Health Education referral in progress notes.
3. Fax to the Utilization Review Department at the number specified on the TAR corresponding to Medical Group.
4. Utilization Review Coordinators will enter the request into the system and give an authorization number.

HEALTH EDUCATION MATERIAL REQUEST FORM

If your office needs Health Education (HE) Materials, please fill out this assessment form and fax it to (626) 943-

6383.

Provider Name: _____

Provider Address: _____

Provider Telephone: _____

Provider Fax Number: _____

Provider Health Plan Contracts: _____

1. Would you like more information about health education classes?
   _____Yes _____No

2. Do you have health education materials in your office?
   _____Yes _____No

3. What sources have you used to obtain health materials?
   _____

4. Please Circle Health Education Materials needed in your office and specify the languages.

Advance Directive	Hypertension	Medi-Cal Materials
Asthma	Men's Health	Healthy Family
Breastfeeding	Nutrition	Staying Healthy
Cholesterol	Pregnancy	WIC Services
Congestive Heart Failure	STD's	Parenting
Depression	Stress Management	Other: _____
Diabetes Mellitus	Smoking Cessation	_____
Family Planning	Weight Management	
GYN Disorders	Women's Health	

Language: English Spanish Chinese Other: _____
(circle one)

Completed by: _____ Date: _____

ASTRANA HEALTH USE ONLY

Date (HE) Materials sent to Provider: _____ By: _____

MEDICAL RECORD STANDARD

It is up to AstranaCare to ensure that medical records are maintained in a manner that is consistent with the legal requirements, current, protected, relevant, standardized, detailed, organized, available to practitioners

at each patient encounter, facilitate coordination and continuity of care, and permits effective, timely, confidential, quality review, care, and service. It is the policy of AstranaCare through Astrana Health to distribute this policy to all practitioners and to ensure its practitioners comply with these standards.

1. The medical records serve as the basis for planning and maintaining the quality of patient care. Medical records that are devoid of pertinent medical information may impact other treating providers' or health professionals' ability to provide appropriate care
2. Reimbursement for services may be limited or denied unless documentation supports the charges that the physician is charging for the level of care.
3. Incomplete medical records documentation may interfere with a physician peer's ability to perform peer review to maintain quality health care delivery and may subject the physician to disciplinary action or severe sanction by outside review agencies.
4. Medical records are often a physician's best evidence in a professional liability lawsuit. Inadequate medical records may undermine a physician's ability to defend him or herself.
5. It is recommended that each physician office site employ a process for ensuring that pertinent medical information about medical and non-medical services rendered to Members is available at each patient visit and that periodic purging and archiving of medical records information be conducted following all applicable state and federal laws. Astrana Health has adopted a seven (7) year minimum period from the last medical visit in which to purge and archive medical records. Ten (10) years for Medicare Members. Records of minors must be maintained for the later of when the minor has reached the age of twenty-one (21) but in no event less than six (6) years. Member medical information and records must be stored anonymously, and if disposed of must be destroyed in a way such that information is not identifiable. This may mean reformatting, shredding, or another form of destruction, depending on the media involved. It is Astrana Health's policy that medical records be retained for seven (7) years to retain a record of the patient care and to establish facts regarding the patient's condition and course of treatment, should those facts ever come into question. Ten *(10) years for Medicare Members), six (6) years for Medicaid) from the end of the current fiscal year in which the date of service occurred; the record or data was created or applied; and when the financial record was created or the Contract is terminated)*
6. Occasionally an entry may be made in a medical record that is incorrect due to a mistake or clerical error. If such an entry is discovered, it should be corrected. The erroneous entry itself should not be obliterated or erased. Rather, a line should be marked through it to indicate the error, with the current date and initials of the person correcting the entry. Obliteration of the entry with correction fluid so that it may not be read, may raise a question later as to what the entry contained or why it was erroneous and may jeopardize the defense of a medical malpractice case should one be filed.

The clinical record should be maintained and organized in the following manner:

1. An individual medical record is maintained for each patient. Each patient's medical record will be individualized, format standardized, organized, and secure and permit effective confidential Member care, and quality review.
2. Each patient medical record will be filed and stored in a central place (restricted from public access), utilizing a standardized and centralized medical group network tracking system assuring ease and accuracy of filing, retrieval, availability, and accessibility as well as confidentiality. *Personnel must be periodically trained and have evidence of confidentiality on HIPPA guidelines.*

3. Member identification is on each page, including first and last name, and/or unique patient number established for use on clinical sites. Electronically maintained records and printed records from electronic systems contain patient identification.
4. Biographical/personal data will include name, date of birth, address, employer name/phone, sex, home phone, work phone, principally spoken/written language, marital status, and insurance information which will be kept in the Member's medical record.
5. Member's emergency contact information must be documented in the medical record. This shall include the name and phone number of a relative or friend or a home, work, cellular, or message phone number. If the patient is a minor, the emergency contact must be a parent or guardian. If the patient refused to provide information, "refused" is noted in the medical record.
6. Entries must contain author authentication including title and date.
7. Entries must be legible to someone other than the writer.
8. Medical records are consistently organized, content and formats of printed and or/electronic records within the practice site are uniformly organized.
9. Medical records content is securely fastened.
10. There must be evidence that the Advanced Health Directive information has been offered and discussed with adult patients 18 years of age and over.
11. Documentation is to occur within 24 hours of the patient visit.
12. Identifiable chronic problems/significant conditions (inclusive of behavioral health) are listed and must be maintained and dated in the medical record such as on a problem list. A chronic problem is defined as one which is of long duration, shows little change, or is a slow progression. *The absence of chronic problems will be noted on the problem list.*
13. An identifiable current continuous medication is listed with name, strength, route, dosage, duration, dates of initial or refill prescriptions, and quantity of all prescribed medications must be noted and maintained in the medical record. Discontinued medication must be noted in the progress notes and the stop date will be noted in the medication list.
14. All services provided directly by the PCP, reasons for and results of ancillary services, diagnostic and therapeutic services. *This includes all diagnostic and therapeutic services for which a Member was referred by a practitioner such as home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports.*
15. Allergies and adverse reactions shall be prominently displayed on the front of the medical record or inside cover, including in the problem list and on each visit progress note. If the Member has no allergies or adverse reaction, "No Known Allergies" (NKA), or "No known Drug Allergies" (NKDA), this also needs to be noted in the medical record.
16. The history of the present illness must be documented. Physical exam must be documented related to presenting complaint including subjective and objective information.
17. Diagnosis or medical impression, clinical findings, and evaluation must be documented regarding each visit.
18. The plan of treatment must be documented and consistent with findings and care that is medically appropriate.
19. Follow-up plan and date of a return visit, if indicated is noted specifically in weeks, months, or as needed.
20. Unresolved and/or continuing problems are addressed in subsequent visit(s).
21. Evidence of continuity of care between PCP and providers if applicable via progress note notation indicating review of consultant's reports and actions taken by PCP if necessary or that patient was contacted. Evidence of appropriate use of consultants, if applicable. All requested referral information is to be placed in the Member's medical records. *The medical record shall include identification for all practitioners participating in the Member's care and information on services they render.*

22. Evidence of appropriate utilization of labs and other diagnostic studies with reasons for and results of studies. All labs and diagnostic reports should reflect PCP review via initials and date. This includes pertinent inpatient records that must be maintained in the office medical record. These records may include but are not limited to the following: history and physical, surgical procedure reports, ER reports, and/or discharge summaries.
23. Missed/failed appointments, cancellations, and follow-up contacts/outreach efforts are noted in the medical record to ensure appropriate medical care and Member non-compliance monitoring. "No-show", "Rescheduled" or "Canceled" is noted in the medical records as applicable. In addition, the Practitioner must document intervention in the medical records.
24. Evidence of compliance with established practice guidelines and related policies and procedures. (e.g., Confidentiality, Missed Appointments, Notification of Test Results, After Hours Calls, Treatment Consent)
25. Documentation shall substantiate medical care rendered.
26. Initial Health Assessment (IHA) must be completed on all Members within 120 days of the effective date of enrollment into the plan or documented within 12 months of prior Member's enrollment. This assessment must include a comprehensive history and physical, assessment to determine health practices, values, behaviors, beliefs, literacy levels, and health educational needs.
27. Individual Health Education Behavioral Assessment (IBEHA) for new Members must be conducted within 120 days of effective enrollment date as part of the initial health assessment. For existing Members, age-appropriate IBEHA is conducted at the Member's next non-acute care visit, but no later than the next scheduled health screening exam. The tool is re-administered at appropriate age intervals.
28. The Member's primary language must be noted in the medical record.
29. Linguistics needs for non or limited English proficient Members will be prominently noted in the medical record. Request for language and/or interpretation services will be documented. The Member's refusal of these services will also be documented. Evidence of documentation on request for and refusal of Language interpretive services.
30. Tracking of record location when out of the filing system will be accomplished by way of a tickler system indicating medical record whereabouts.
31. Medical record data obtained between visits will be forwarded to the PCP's office for review and incorporated into the patient's medical record.
32. Adult patients (18 years and older) who inspect their medical records are allowed to provide a written addendum to their records if the patients believe that the records are incomplete or inaccurate. This addendum is included when disclosed to other parties.
33. Medical records shall be transferred among practitioners when a Member changes to a new PCP (before the Member's first visit with the new PCP). The privacy of the medical record must be safeguarded in transit. The requested information must be delivered on time (before the Member's first visit with the new PCP) to ensure continuity of care. A practitioner furnishing a referral service must report appropriate information to the referring practitioner/provider on time. Also, the record contains referral notes from medical practitioners to behavioral health practitioners (as applicable) and documented evidence of clinical feedback (i.e. consultations report inclusive of diagnosis, treatment plan, and psychopharmacological medication, as applicable) Practitioners shall request information from other treating practitioners as necessary to provide care on time. *For Senior Members there is no charge for medical records and information transfer. Release of medical records to the Member must include reasons but not be limited to the Member's request and quality improvement activities.*

Disclosure of Medical Information/HIPPA- The expanded definition of "individually identifiable" (includes name, address, phone number, Social Security number, email address, etc.)

- Prohibition of requiring a patient as a condition to receiving Healthcare services to sign an authorization, release, consent, or waiver permitting disclosure of medical information subject to confidentiality protection under the law.
- Medical information is released after Member authorization and following applicable Federal or State law.
- A Member has the right to authorize/deny the release of PHI beyond uses for treatment, payment, or health care operations
- Disclosures and security measures for PHI meet the requirements under HIPPA
- In the event of improper use or disclosure of PHI, steps must be taken to notify the health plan by self-reporting.

Health Maintenance documentation must include the following:

A. Appropriate adult past medical history documentation to include:
   1. Smoking habits
   2. Alcohol use
   3. Substance abuse history
   4. Family planning, reproductive health history
   5. Surgical procedures
   6. Illnesses & serious accidents
   7. Discharge summaries from hospitalized Members
   8. Inpatient hospital admissions
   9. For Members seen multiple times are easily identified and include serious accidents, operations, and illnesses.

B. Appropriate Children/Adolescents' past medical history documentation must include:
   1. Smoking history
   2. Alcohol usage/history of substance abuse for patients over 12 years of age
   3. Surgical procedures
   4. Childhood illnesses
   5. Personal/psychosocial/family history
   6. Completed and current record
   7. Documentation of education and age-appropriate preventive/risk screening services and risk factors following Astrana Health practice guidelines (including behavioral health practice guidelines, if applicable)
   8. For Members seen </= 18 years, past medical history relates to prenatal care, birth, operations, and childhood illnesses.

Pediatric Preventive Services Documentation should include the following:

A. Referral to Health Assessment Procedure to notify beneficiary to receive a health assessment:
   1. For Members under the age of 18 months, the PCP is responsible for performing an initial health assessment (IHA) within 60 days of enrollment or within periodic timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.
   2. For Members 18 months of age and older upon enrollment, including all adults, the PCP is responsible for ensuring an initial health assessment (IHA) is performed within 120 days of enrollment.

B. Periodic Assessments should include:
    1. Persons Eligible for periodic assessments shall receive one assessment during each designated age period. Providers must follow the schedule recommended by the American Academy of Pediatrics.

C. Appropriate Health Education Documentation must include:
    1. Date of health education intervention Type and topic of health education Intervention (i.e. one-on-one class, sub-group).
    2. Patient feedback or comments regarding health Intervention.
    3. Referrals to other classes if applicable.
    4. Follow-up from previous health interventions with explicit notations in the medical record particularly for consultation, abnormal lab, and imaging study results

D. Community Resource- Documentation in the patient's medical records if receiving services from/through
    1. Arizona Department of Child Safety Services
    2. Regional Center
    3. Women, Infants, and Children (WIC)

ADVANCE DIRECTIVE

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Astrana Health providers shall provide each adult (18 years and older) subscriber (incapacitated included) with an Advance Directive Brochure on the first visit or when reasonably feasible. Also, the Provider will assist Members in their understanding of advance directives. This information may be given to the Member's family or surrogate. The provider (staff) is instructed to follow up to ensure that the information is given directly to the individual at the appropriate time.

Patients are not obligated to complete an Advance Directive if they do not wish to. If they choose to complete an Advance Directive, it is important that patients, and their physicians, receive a copy to place in their medical records.

Additionally, you may refer to the Astrana Health Web Portal under the section "Provider Recourses" for a copy of an Advanced Directive form.

SECTION 8 CULTURAL AND LINGUISTIC SERVICES

OVERVIEW

Culturally and linguistically appropriate services (C&L) areas include:

A. Identification of Limited English Proficient (LEP) and hearing-impaired Members and recording language preferences/American Sign Language in medical records.

B. Posting signs at all Member key points of contact to inform LEP and hearing-impaired Members of the availability of free interpreter services.

C. Ability to access interpreter services through Astrana Health and/or health plans for medical and non-medical points of contact.

D. Ensuring access to free interpreter services to LEP and hearing-impaired Members on a 24-hour basis which includes an after-hours protocol on how to access interpreter services. This also includes face-to-face and over-the-telephone interpreter services.

E. Offering interpreter services and recording requests/refusal of interpreter services in LEP or hearing-impaired Member's medical records. Minors are prohibited from being used as interpreters except in emergency/life-threatening situations.

F. Attend and/or promote cultural competency training/resources for providers and staff. Ensure the qualifications of bilingual staff are kept on file.

G. Making available Member information and health education materials to LEP Members in the threshold languages and alternative formats such as Braille, large print, etc.

H. Having the right of the Members/providers to file a grievance when a C&L is not met and having the availability of the form in the threshold languages and how to obtain it. If Providers need Health Education materials, they must contact the Quality Management department at (626) 282-0288 and fill out the Material Needs Form (page 89).

Practices should contact Astrana Health's Customer Service Department at (480) 470-0243 or the Member's health plan Customer Service to obtain more information on how to access cultural and linguistic services for Members of Astrana Health which is located on the back of the member's insurance card.

C&L SERVICES – PROVIDER RESPONSIBILITY

Astrana Health and its affiliates expect providers/practitioners to adhere to the following:

24-Hour Access to Interpreters

When the Provider/Practitioner does not speak the Members' language, he/she must ensure 24-hour access to interpreters for Members whose primary language is not English. To access interpreters for Astrana Health Members at no cost to you or the patient call Language Line Services at 1-800-367-9559, the access code for Astrana Health is 2554 or ID 295164 or utilize free interpretation services provided by the contracted health plan. It is never permissible to ask a family member to interpret.

State and Federal laws state that it is never permissible to turn away or limit the services provided to them because of language barriers. It is also never permitted to subject a Member to unreasonable delays due to language barriers or provide services that are lower in quality than those offered in English. Linguistic services must be provided at no cost to the Member.

Documentation

If a patient insists on using a family member as an interpreter or refuses the use of interpreter services after being notified of his or her right to have a qualified interpreter at no cost, document this in the Member's medical record.

All counseling and treatment done via an interpreter should be noted in the medical record that such counseling and treatment were done via interpreter services. The provider should document who provided the interpreter service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreters' name, operator code number, and vendor.

Should the Member refuse to utilize the Interpretative Services, the Request/Refusal for Interpretive Services Form must be completed and placed in the Member's medical record.

Facility Signage

All Provider offices should post important signs in the threshold languages such as the "free interpretation services" poster. Check the health plan's website for downloadable signs in a variety of languages. If you need particular signage and cannot locate it, contact the Quality Management Department for assistance at (626) 282-0288 ext.6207.

ASTRANA HEALTH LANGUAGE LINE SERVICES INFORMATION

Language Line Automated Access offers a fast and efficient way to connect to a professional Interpreter, anytime, anywhere. Language Line Automated is an over-the-phone interpretation service that has more than 140 languages, 24 hours a day. The following is a *Quick Reference Guide* on how to use this free service provided for your office by Astrana Health. Please ensure that all users in your office know how to use the conference feature on their phones for this service to be used efficiently.

Login Information	*Help Information*
Toll Free Line: 1-800-367-9559	Customer Service Line: 1-800-752-6096 - Option 1
Client ID# 295164	E-mail: www.LanguageLine.com
Access Code: 2554	

1. Place the non-English speaker on Conference Hold.
   A. If you are placing an outbound call, access the Interpreter first and then place the call to the non-English speaker.
2. Dial Language Line Services at 1-800-367-9559
3. Follow Prompts
   A. Press 1 for Spanish.
      - Say "help" if you encounter a problem. Your call will be transferred to a representative.

   B. Press 2 for all other languages.
      - Speak the name of the desired language clearly; (e.g., "Chinese", "Japanese"). *Say only the language name* – do not add any other words. The system will repeat your request and ask that you:
        - Press 1 to confirm the language.
      - Say "help" if you encounter a problem. Your call will be transferred to a representative.
4. Enter your 6-digit Client ID# (provided above) on the telephone keypad.
5. Enter your numeric Access Code (provided above) followed by the pound sign (#) on the telephone keypad.
6. Your Interpreter is connected to the call. Brief the Interpreter about the nature of the conversation and provide specific information to be relayed to the non-English speaker.
7. Add a non-English speaker to the line after you have briefed the Interpreter.

INTERPRETIVE SERVICES REQUEST/REFUSAL FORM

Patient Name: _____

Primary Language: _____

- ❑ Yes, I am requesting interpretive services.
  Language: _____
- ❑ I prefer to use my family or friends as an interpreter. (Interpreters must be over 18 years of age)
- ❑ No, I do not require interpretive services.
- ❑ N/A

  Please explain: _____

  _____

  _____

_____ _____

Patient Signature Date

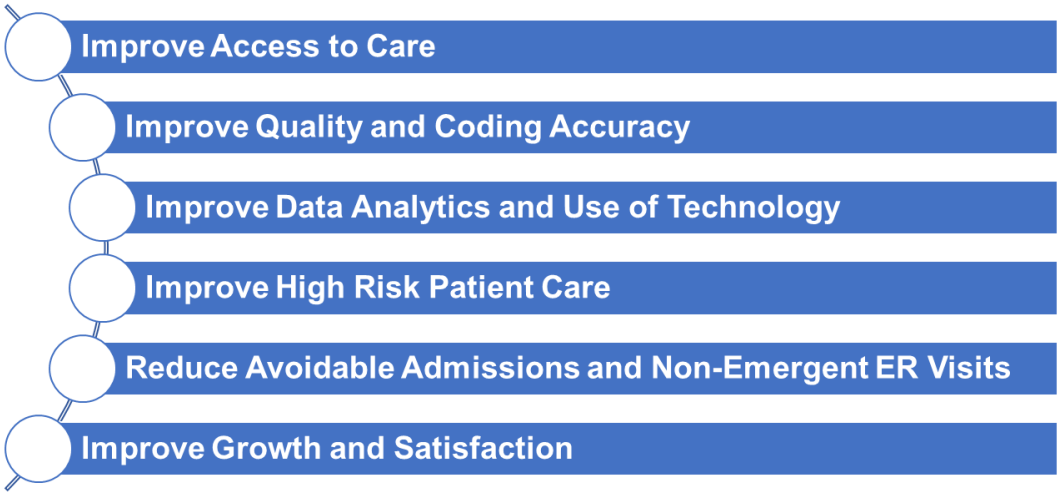
Other languages are available upon request. (Spanish, Chinese, Vietnamese, Armenian, Russian, Khmer)

*Please place in the patient's medical record.

SECTION 9 POPULATION HEALTH/QUALITY

POPULATION HEALTH INTRODUCTION

As the healthcare landscape continues to shift from a fee-for-service, volume-based model, to a quality-driven, value-based care model, population health plays a critical part in providing the framework and tools to help providers drive success. Population health management is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. The goals of Astrana Health's population health program are to provide the highest quality of care most cost-effectively and to ensure high patient and provider satisfaction. With these goals in mind, our population health program will be grounded and focused on the 6 Pillars of Population Health Performance. The 6 Pillars of Population Health Performance are:



Concerning "Improve Quality and Coding Accuracy," the subsequent sections will provide more detailed information on how quality outcomes are reflected through Health Effective Data and Information Set (HEDIS) measures and how the Member's risk adjustment factor (RAF) reflects the complexity of the Member's health condition through Hierarchical Condition Categories (HCCs). Whether it's capturing HCCs or addressing/closing HEDIS measures, the work that the provider and his/her office staff do is critical to the performance of our population health program.

The subsequent sections provide more details regarding quality HEDIS measures and risk adjustment components.

HEALTH EFFECTIVE DATA & INFORMATION SET (HEDIS) OVERVIEW

Health Effective Data & Information Set (HEDIS) is a tool used by more than 1,000 health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of more than 90 measures across 6 domains of care. With data collection and technical specifications, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to identify areas for improvement.

Each health plan implementing HEDIS is required to collect data and report HEDIS results based on the technical specifications of the HEDIS measurement sets. Health plans report their HEDIS rates separately for each product line and provide this reporting on their internal websites and marketing materials. To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by The National Committee of Quality Assurance (NCQA).

Consumers also benefit from HEDIS data through the State of Health Care Quality report, a comprehensive look at the performance of the nation's healthcare system. HEDIS data also are the centerpiece of most health plan "report cards".

To ensure that HEDIS stays current, NCQA has established a process to evolve the measurement set each year. NCQA’s Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans, and others, debates and decides collectively on the content of HEDIS. This group determines what HEDIS measures are included, and field tests determine how it gets measured.

MEASURES & CATEGORIES

HEDIS data is collected from the providers through encounters and medical record audits. The following are the key measures that will be measured through HEDIS criteria:

Category		MEASURE	MEDICARE	COMMERCIAL	MEDICAID
Adult Health	1	Annual Wellness Visit (AWV)	✓		
	2	Care for Older Adults (COA)	✓		
	3	Colorectal Cancer Screening (COL)	✓	✓	
	4	Eye Exam for Patients with Diabetes (EED)	✓	✓	✓
	5	HbA1C Control for Patients with Diabetes (HBD)	✓	✓	✓
	6	Kidney Health Evaluation for Patients with Diabetes (KED)	✓	✓	✓
	7	Blood Pressure Control for Patients with Diabetes (BPD)			✓
	8	Controlling High Blood Pressure (CBP)	✓	✓	✓
	9	Transition of Care (TRC)	✓		
Women's Health	10	Breast Cancer Screening (BCS)	✓	✓	✓
	11	Cervical Cancer Screening (CCS)		✓	✓
	12	Osteoporosis Management in Women Who Had a Fracture (OMW)	✓		
	13	Chlamydia Screening in Women (CHL)		✓	✓
	14	Postpartum Care (PPC)		✓	✓
	15	Prenatal Care (PPC)		✓	✓
Pediatric Health	16	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)		✓	✓
	17	Immunization for Adolescents (IMA)		✓	✓
	18	Well Child Visits in the First 30 Months of Life (W30)		✓	✓
	19	Childhood Immunization Status (CIS)		✓	✓
	20	Child and Adolescent Well-Care Visits (WCV)		✓	✓
General Health	21	Annual Physical Exam		✓	✓
	22	Initial Health Assessment (IHA)	✓	✓	✓
Medication-Related	23	Statin Therapy	✓	✓	✓
	24	Medication Adherence	✓		

For a complete summary of the most current HEDIS measures, please visit the NCQA website, http://www.ncqa.org/tabid/59/Default.aspx, or reach out to:

Quality Care Improvement Team:
Tel: (626) 282-0288 Ext. 5548
E-mail: QualityImprovement.Dept@AstranaHealth.com

HEDIS ENGAGEMENT

All contracted PCPs are required to participate with the IPA network in the HEDIS (including STAR measures) program. The IPA network will provide the PCP with gaps in care (GIC) reports, monthly eligibility, and other ad hoc reports provided by the health plans. GIC reports and other ad hoc reports will be provided electronically to the PCP ab

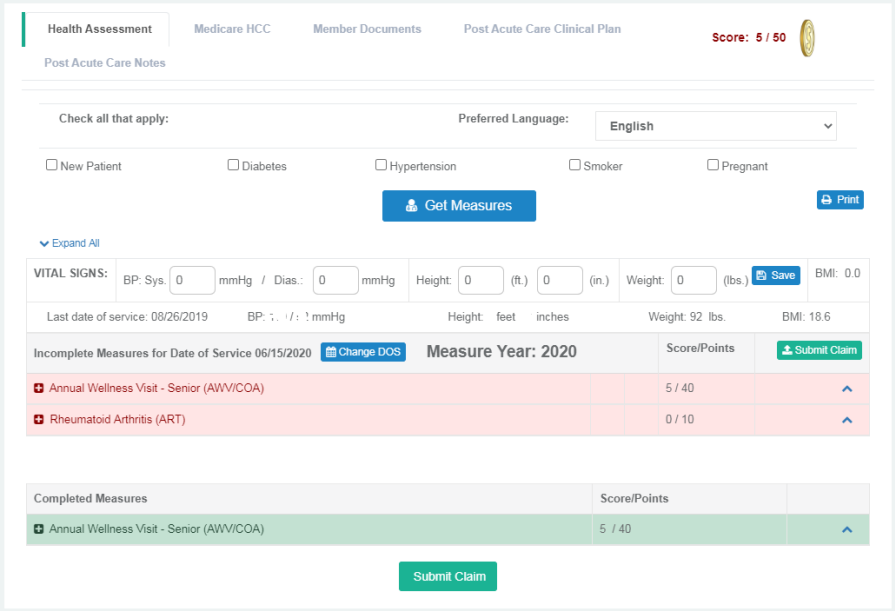
The PCP and IPA network will review the GIC reports to address the following:

1. Patients with true “gap in care”
2. Patients who have had the screening/test but may be new to the IPA and/or PCP. The IPA and PCP will work on collecting supplemental data to report findings to the applicable health plan
3. Patients who are non-compliant with disease or preventative care management

The IPA network will work with the health plans to maximize administrative and encounter data transactions. The IPA network will provide the PCP with references and resources to ensure appropriate CPT, CPT II, and ICD-10 codes are utilized by the PCP when billing. The IPA will monitor the PCP claims encounter data submissions to ensure appropriate service codes are utilized for compliance with HEDIS/STAR measures criteria.

PCP providers can use the Astrana Health Web Portal system to monitor patients with gaps in care. The Astrana Health Web Portal provides indicators (see image example below) for patients who have completed or require specific measures. It integrates data collected from Encounter data, Laboratory data, Radiology data, and Health Plan data. We encourage the PCP office to use the resources provided by the IPA to monitor patients with gaps in care to ensure the IPA is compliant with the health plan and state standards for preventative or disease management measures.

The Astrana Health Web Portal can be accessed at: https://provider-portal.astranahealth.com/login

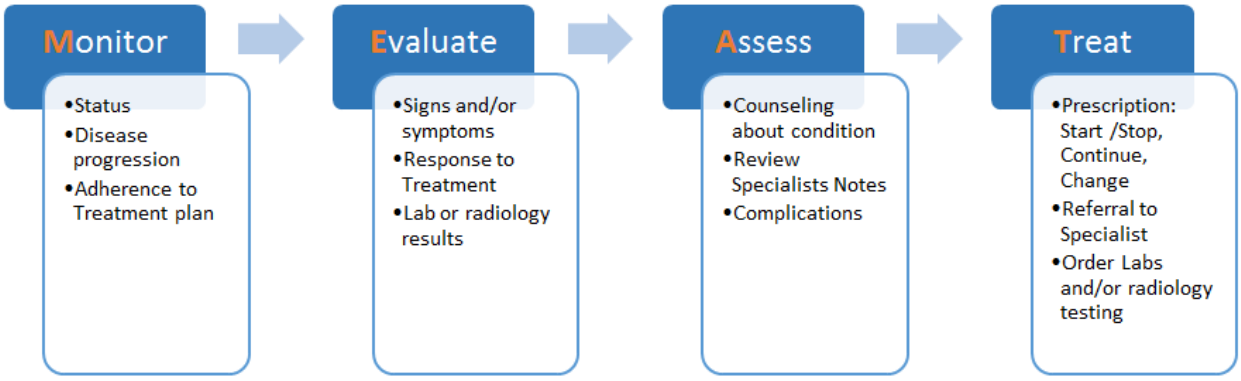


RISK ADJUSTMENT

Documentation Requirements

To ensure the accuracy and integrity of the risk adjustment data submitted to CMS:

- All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit
- Diagnosis must be accurately coded according to ICD-10 CM guidelines
- Assessing all conditions at least once annually
- The reported diagnosis must be supported by M.E.A.T.



Risk Adjustment Factor (RAF)

- Risk adjustment is calculated using an actuarial tool developed to predict the cost of healthcare for covered beneficiaries/Members
- A risk adjustment score is determined by using a combination of demographic information (Age, Sex, Status) along with disease information to predict future healthcare costs for Members
- The score is highest for the sickest patients as determined by a combination of factors
- A Risk Score of 1.000 reflects the Medicare incurred expenditures of an average beneficiary/Members

Disease Interactions

- Disease Interactions allow for additive factors based on conditions and disabled status to increase funding
- Additional risk scores are added automatically when certain diseases are coded together
  - ✓ Congestive Heart Failure and Diabetes
  - ✓ Congestive Heart Failure and Chronic Obstructive Pulmonary Disease
  - ✓ Congestive Heart Failure and Arrhythmia
  - ✓ Congestive Heart Failure and Renal
  - ✓ Cardiorespiratory Failure and Chronic Obstructive Pulmonary Disease
  - ✓ Disorders of Immunity and Cancer
  - ✓ Substance Use Disorder and Psychiatric

Hierarchical Condition Categories (HCC)

- Developed by CMS for Risk adjustment of the Medicare Advantage Program (Medicare Part C)
- Predictive Model using current year data to predict next year's risk
- HCC categories are additive
- Data Derived from:

- ✓ Inpatient Diagnosis
- ✓ Outpatient Diagnosis
- ✓ Provider Office Diagnosis
- ✓ Clinically trained non-physician provider

Comparison of RAF Score – Documentation and Coding Complexity

All Conditions Coded Complex		Some Conditions Coded Moderate		No Conditions Coded Healthy	
69-year-old female (non-dual)	0.323	69-year-old female (non-dual)	0.323	69-year-old female (non-dual)	0.323
DM w/chronic complications	0.302	DM w/chronic complications	0.302		0.000
CHF	0.331	CHF	0.331		0.000
COPD	0.335		0.000		0.000
Disease Interaction DM/CHF	0.121	Disease Interaction DM/CHF	0.121		0.000
Disease Interaction CHF/COPD	0.155		0.000		0.000
TOTAL RAF	1.567	TOTAL RAF	1.077	TOTAL RAF	0.323

*Estimated Score for illustration purposes.

Documentation Guidelines Available on Web Portal:

- ✓ Atherosclerosis of the Aorta (AAA)
- ✓ Cancer
- ✓ Chronic Obstructive Pulmonary Disease (COPD)
- ✓ Chronic Kidney Disease (CKD)
- ✓ Eligible Progress Note with Chart Mechanics
- ✓ Dementia
- ✓ Rheumatoid Arthritis
- ✓ Senile Purpura

Medical Record Review

Consistent and complete documentation in the member's medical record is an essential component of quality patient care. Primary care physicians are required to maintain a medical record for each member that must include patient records of care provided within the IPA/medical group, as well as care referred outside the IPA/medical group.

Astrana Health requires medical record reviews to assess both physician office records and institutional

medical records, which are reviewed for quality, content, organization, confidentiality, and completeness of documentation.

Medical records are reviewed annually against Astrana Health medical record standards. Records are sampled from those submitted for HEDIS review. Astrana Health requires that the physician's office medical records include the following:

- Identifying information on the member (patient ID on each page)
- Problem list noting significant illnesses and medical conditions
- Allergies and adverse reactions prominently noted
- Preventive Health Services
- Proof that baseline clinical exams were conducted, documented, and pertinent to the patient's presenting complaints
- Current summary sheets of medical history including past surgeries, accidents, illnesses/past diagnoses and medications, and immunization history
- Consultation reports, hospital summaries, emergency room reports, and test reports that are easily accessible and in a uniform location
- Treatment plan consistent with the diagnosis
- Evidence of medically appropriate treatment
- Continuity and coordination of care between primary and specialty physicians
- Prescribed medications, including dosages and dates of initial prescription or refills
- Evidence that the patient has not been placed at risk by a diagnostic or therapeutic procedure
- For Medicare Advantage members, evidence on the presence or absence of Advance Directives, for adults over age 18 is prominently located in the medical record

Providers must also comply with all applicable confidentiality requirements for medical records as imposed by federal and state law. This includes the development of specific policies and procedures, when required by Astrana Health, to demonstrate compliance.

To assist Astrana Health in maintaining continuity of care for its members, physicians are required to share medical records of services and supplemental data for care rendered to Astrana Health members. Members may also be entitled to obtain copies of their medical records, including copies of Emergency Department records, X-rays, CT scans, and MRIs. Upon the reassignment or transfer of a member, the physician must provide one copy of these materials, at no charge, to the member’s new physician or IPA/medical group.

Health Risk Assessment

A Health Risk Assessment Survey is mailed to all new health plan members. This survey is designed to identify members who may be among the frail elderly, who require reminders for preventive health services, who may require assistance with activities of daily living, and those with certain chronic diseases. Those whose results show five or more identified risks are forwarded to AstranaCare Medical Directors quarterly for dissemination to these members' primary care physicians . For Dual Special Needs Plan members, the Health Risk Assessment results are sent to the AstranaCare and primary care providers with each completed Health Risk Assessment.

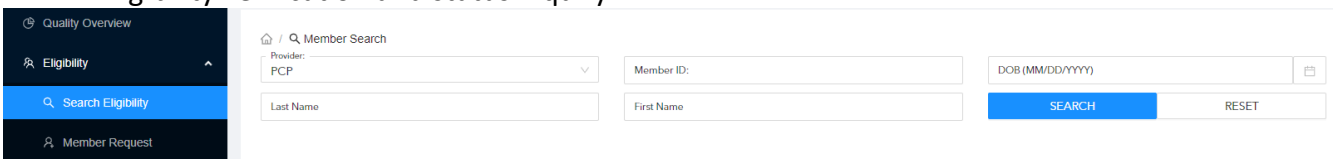
SECTION 10 WEB PORTAL

Astrana Health's Provider Web Portal is a web-based application that enables practices to verify member eligibility, submit/view authorization requests, and submit/view claims data from any location with internet access. Providers can also take advantage of the portal to download a copy of the provider rosters (PCP and/or specialist) and can search individually for a provider (PCP and/or specialist) and/or ancillary service provider.

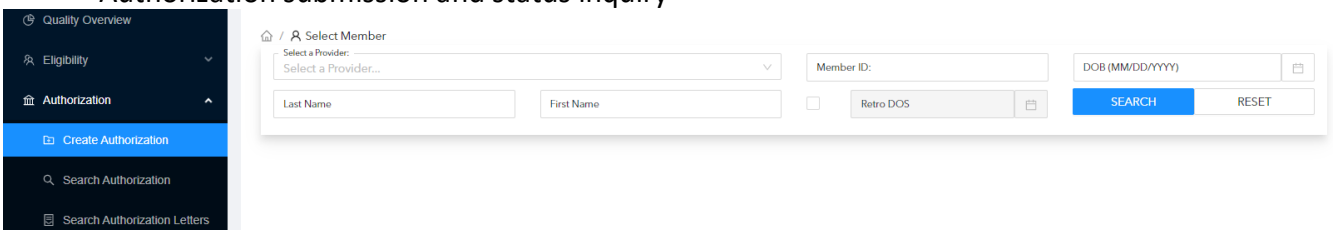
In order to set up a portal account, a practice must fill out the Web Portal New Account Registration Form available at https://provider-portal.astranahealth.com/login. The provider may also contact Astrana Health's Web Portal team by calling (626) 943-6146 or via email at Portal.Help@AstranaHealth.com.

Portal features include:

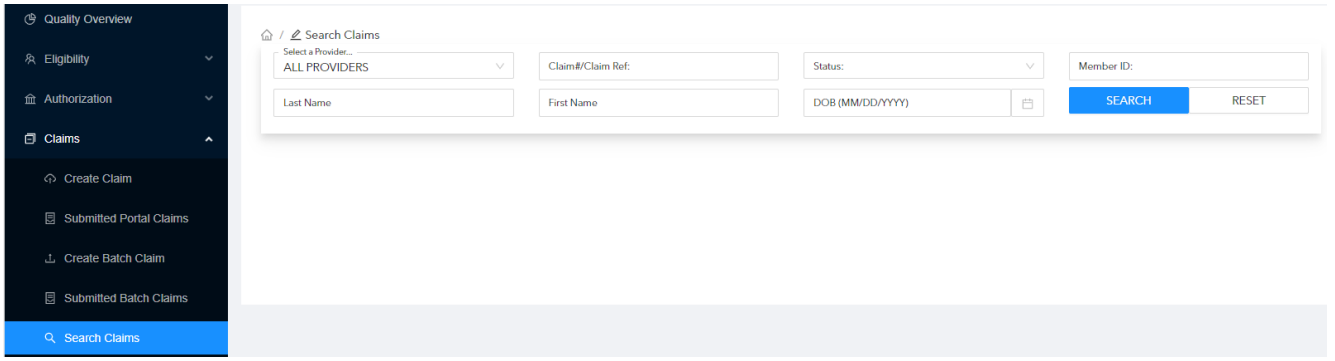
- Eligibility verification and status inquiry



- Authorization submission and status inquiry



- Claims submission and status



- New Documents (provider progress notes, hospital admit/discharge report, open authorization report, and more...)
- Member List (PCP)
- HEDIS Gap Report
- HCC RAF and Gap Reports
- Provider Resources and Member Educational Material

SECTION 11 INITIAL HEALTH APPOINTMENT

An initial health appointment must be completed for all Members and periodically re-administered.

An IHA:

- Must be performed by a Provider within the primary care medical setting.
- Is not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months.
- Must be provided in a way that is culturally and linguistically appropriate for the Member.
- Must be documented in the Member's medical record.

An IHA must include all of the following:

- A history of the Member's physical and mental health;
- Identification of risks;
- An assessment of the need for preventive screens or services;
- Health education; and
- The diagnosis and plan for treatment of any diseases

SECTION 12 COMPLIANCE

INTRODUCTION & PURPOSE

AstranaCare (AstranaCare) developed this Compliance Program manual to meet the requirements set forth by the Centers for Medicare and Medicaid Services ("CMS") to ensure all Workforce Members, directors, contractors (including providers, delegates, and other vendors), and first tier, downstream, and related entities ("FDR") understand their duties to act in a compliant and ethical manner within a managed care setting. In addition, the Compliance Program is intended to apply to AstranaCare's business arrangements with any of its FDRs, including physicians, hospitals, and entities that may be impacted by federal or state laws relating to fraud, waste, and abuse to demonstrate our commitment to compliance.

AstranaCare (AstranaCare) is committed to adhering to all applicable federal and state standards, including, but not limited to:

- Federal and state false claims acts
- Anti-kickback statute
- Prohibition on inducements to beneficiaries
- Federal Health Insurance Portability and Accountability Act ("HIPAA")
- Code of Federal Regulations
- Sub-regulatory guidance produced by the Centers for Medicare and Medicaid Services ("CMS"), which includes manuals, training materials, and guides, including CMS compliance program guidelines in Chapter 21 of the Medicare Managed Care Manual ("MMCM") and Chapter 9 of the Prescription Drug Benefit Manual ("PDB")
- Applicable civil monetary penalties and exclusions
- Applicable state laws
- Terms and conditions of government contracts

AstranaCare (AstranaCare) Workforce Members, directors, and all first tier, downstream, and related entities are expected to adhere to the CMS program requirements, the Compliance Program and Code of Conduct, and all applicable Policies and Procedures ("P&Ps"). We ensure adherence and implement compliance-related programs through our internal controls, engagement of senior staff, monitoring and auditing, risk assessment, training and education, and proactive identification of possible issues.

To ensure all Workforce Members, directors, contractors, and first-tier, downstream, and related entities learn about and have access to the compliance program, this Compliance Program description will be distributed in the following manners:

- To all new Workforce Members within ninety (90) days of hire
- To all new contractors upon executing the final contractual agreements
- To all directors at their first official Board of Directors meeting
- When requested by the Compliance Department by appropriate persons

Additionally, Program materials are on AstranaCare's (AstranaCare) Intranet, available to all Workforce Members at any time. To ensure Workforce Members, directors, contractors, and first-tier, downstream, and related entities have received the Compliance Program materials, acknowledgment forms will be signed, gathered, and kept on file.

AstranaCare (AstranaCare) ensures the mandates and responsibilities of the Compliance Program are met by:

- Providing annual compliance training to each Workforce Member, contractor, director, and first tier, downstream, and related entity ("FDRs") and at each new hire orientation.
- Providing a compliance hotline at (844) 975-2651 for named or anonymous reporting of suspected or actual non-compliance.
- Developing an email account (Compliance@AstranaHealth.com) for the sole purpose of ensuring Workforce Members, FDRs, contractors, and directors both receive compliance information and have an additional mechanism to communicate with the Compliance Officer.
- Establishing well-publicized disciplinary standards.
- Establishing a fraud, waste, and abuse policy and training program, which may be a part of general compliance training.
- Incorporating AstranaCare (AstranaCare)'s Compliance Program and Code of Conduct (APPENDIX A).
- Incorporating AstranaCare (AstranaCare)'s Handbook (APPENDIX B).

DEFINITIONS

Abuse: Providing products or services that are either inconsistent with accepted practices or are unreasonable or unnecessary.

CMS: Center for Medicare and Medicaid Services.

Downstream Entities: Any party to a written agreement below that of a first-tier entity, such as subcontractors.

First Tier Entity: Any party to a written administrative or health care services agreement with a Medicare Advantage plan. Examples include an organization under contract to provide services to plan Members, AstranaCare (AstranaCare), and marketing organizations.

FDR: First tier, downstream, and related entities.

Fraud: Intentional submission of false or misleading information to receive payments

FWA: Fraud, waste, and abuse.

HIPAA: The federal Health Insurance Portability and Accountability Act.

Related Entities: Any entity related to AstranaCare (AstranaCare) by common ownership or control.

Waste: Extravagant, careless, or needless spending resulting from weak practices and poor decisions.

COMPLIANCE PROGRAM ELEMENTS

Written Policies, Procedures, and Code of Conduct

AstranaCare (AstranaCare) is proud to offer Medicare Advantage services to our contracted health plan Members. We do so while ensuring high standards of conduct that meet our principles and values. Each Workforce Member, director, consultant, and FDR must adhere to these standards, articulated in AstranaCare (AstranaCare)'s Compliance Program and Code of Conduct (APPENDIX A) and in separate written P&Ps including, but not limited to, AstranaCare (AstranaCare)'s Fraud, Waste and Abuse P&P. The Compliance Program and Code of Conduct are our standards of conduct and articulate AstranaCare (AstranaCare)'s commitment to complying with all federal and state laws as well as CMS policies and regulations. AstranaCare (AstranaCare) has P&Ps that describe the operation of the Compliance Program and detail such issues as fraud, waste and abuse, training, and monitoring of FDRs. These policies and this Compliance Program will be distributed to Workforce Members, directors, contractors, and FDRs annually, within ninety (90) days of hire or engagement, and when updated. Distribution will occur by email, fax, hand, or any other effective method.

Compliance Officer and Compliance Committee, Program Oversight

AstranaCare (AstranaCare) has designated a Compliance Officer ("CO") who reports to the Chief Executive Officer and the Board of Directors. The CO is responsible for overseeing the day-to-day operations of the Compliance Program. The CO will not be a Workforce Member of AstranaCare (AstranaCare)'s downstream or related entities or contractors. The Compliance Committee (CC) and the Board of Directors meet at least annually to, among other duties, approve all compliance-related P&Ps and documents; review any audits, issues, and investigations; oversee any corrective actions; review compliance, HIPAA, FWA, Code of Conduct and other compliance-related training; and ensure the Compliance Program is operating effectively. The minutes of each CC meeting are maintained by the Compliance Department.

Governing Body

AstranaCare (AstranaCare)'s Board of Directors ("BOD") is responsible for maintaining knowledge of the content and operation of the Compliance Program and is tasked with overseeing the implementation and oversight of the Compliance Program. To ensure effective communication and awareness, the CO regularly meets with senior management to make certain the Board keeps abreast of the operation and implementation of the Compliance Program. At Board meetings, the CO will accept and incorporate any advice and counsel received regarding the operation of the Compliance Program. While the Board has delegated oversight of the Compliance Program to the CO and the CC, it may not and does not delegate overall responsibility for reviewing the status of the Compliance Program.

AstranaCare (AstranaCare)'s Board of Directors has approved this Compliance Program Description. The Board will remain informed of any Compliance Program modifications, compliance issues and resolutions, and audit results, among other items. Any documentation regarding material corrective actions will be presented to the Board and discussed. The Audit Program will be discussed, as will the timing and results of all internal and external audits. The minutes of each Board meeting are maintained by the Compliance Department. With these and similar steps, the Board exercises the required oversight concerning the implementation and effectiveness of the Compliance Program.

Senior Management

All senior management, defined as those reporting directly or indirectly to the Chief Executive Officer, is engaged in the operation of the Compliance Program. Senior staff meets regularly to discuss AstranaCare (AstranaCare) operations, including the Compliance Program. At each meeting, the CO has an opportunity to

speak and report the status of the Compliance Program, any risk areas and mitigation as well as any communication from Health Plans.

TRAINING & EDUCATION

General Compliance and Ethics Training

AstranaCare (AstranaCare) has established a general compliance and ethics training program that occurs annually and within ninety (90) days of hire. All Workforce Members, FDRs, directors, contractors, and senior management, including the Chief Executive Officer, shall complete or attest to the equivalent completion of training. Compliance training topics include a description of the Compliance Program and related P&Ps, relevant laws, and regulations, including:

- How Workforce Members can communicate with the Compliance Department and report compliance concerns, anonymously if desired,
- How to identify and react to potential compliance, legal, and/or ethical violations, and
- An overview of the auditing and monitoring process.

Training is either held in person and/or online through a learning management solutions platform. Evidence of completion is documented for each training course confirming an understanding of the content, requirements, and duties presented.

Fraud, Waste, and Abuse Training

Workforce Members, directors, contractors, senior management, and FDRs will also receive training on the topic of FWA. This training will occur annually and within ninety (90) days of hire. FWA training will also occur if a Workforce Member is found to be noncompliant or if a corrective action plan ("CAP") is necessary. Workforce members who continue to not comply shall face disciplinary action, up to and including termination. FDRs who have met the FWA certification requirements through enrollment in the Medicare and Medi-Cal program or accreditation as a Durable Medical Equipment ("DME"), Prosthetics, Orthotics, and Supplies ("DMEPOS") are deemed to have met the requirements but must provide AstranaCare with proof of compliance.

FWA training will address topics such as laws and regulations related to Medi-Cal plans, Medicare Advantage ("MA") plans, and Part D FWA, such as the False Claims Act, Anti-Kickback statute, etc., obligations of FDRs to have in place appropriate FWA P&Ps, processes for AstranaCare and FDR Workforce Members to report suspected FWA, protections for AstranaCare's and FDR's Workforce Members reporting suspected FWA, and types of FWA that can occur in the settings where AstranaCare and FDR Workforce Members' work.

Privacy and Information Security Training

Workforce Members, directors, contractors, senior management, and FDRs will also receive training on the topics of privacy and information security, i.e., requirements related to HIPAA and other applicable State laws. This training will occur annually and within ninety (90) days of hire and before access to any Protected Health Information ("PHI"). Privacy and information security training will also occur if a Workforce Member is found to be noncompliant or if a corrective action plan ("CAP") is necessary. FDRs who have met the privacy and certification training requirements through training provided by their organization are exempt from completing AstranaCare's training; however, they must provide AstranaCare with proof of compliance.

COMMUNICATION & REPORTING ISSUES

AstranaCare has established methods by which Workforce Members, directors, contractors, and FDRs may

communicate directly with the Compliance Officer. The most common methods are by email, phone, or in person, but AstranaCare has also developed confidential and anonymous methods:

i. Between Workforce Members, contractors, and the Compliance Department

Each AstranaCare Workforce Member, contractor, and director may contact the Compliance Officer, at AstranaCare's compliance hot line (844) 975-2651 or email Compliance@AstranaHealth.com. Confidential means of communication are also available and described below. All Workforce Members, contractors, and directors are directed to contact the Compliance Officer with questions about the Compliance Program or with any concerns or reports about potential FWA, compliance or ethics, privacy, or other violations.

ii. Between FDRs and the Compliance Department

Each FDR Workforce Member may contact the Compliance Officer at AstranaCare 's compliance hotline at (844) 975-2651 or email Compliance@AstranaHealth.com. The Compliance Department may contact FDRs at any time to discuss compliance-related issues. FDR Workforce Members should make themselves reasonably available for communicating with AstranaCare's Compliance Department.

When reporting any compliance issues, FDR Workforce Members may also use confidential means of communication described below. Any FDR Workforce Member is directed to contact the Compliance Officer with questions about the compliance program or with any concerns or reports about potential FWA, compliance, or ethics violations.

iii. Enrollee/Member Education

AstranaCare will educate our Members about reporting potential FWA and compliance issues through AstranaCare 's website content and/or informational materials. Members may also avail themselves of the reporting mechanisms described above in addition to contacting AstranaCare 's member services.

iv. Reporting Issues

All AstranaCare Workforce Members, Directors, contractors, and FDRs are obligated to report and assist in the investigation of any identified or suspected noncompliant or unethical behavior, potential FWA or compliance issues as well as any possible violations of laws, regulations, or AstranaCare policies or procedures. To ensure effective reporting, AstranaCare has created four communication options:

Communication Method	Available To	Contact Information
1. Speak with an immediate supervisor, reporting authority, or an AstranaCare contact, who then communicates to the Compliance Officer	Everyone	Whomever the Workforce Member reports to, the person overseeing the contractor, or the FDR AstranaCare contact.

2. Confidential compliance hotline	Everyone	(844) 975-2651 (available 24/7)
3. Email	Everyone	The form may be emailed to Compliance@AstranaHealth.com. The Employee may remain anonymous.
4. Directly contacting the Compliance Officer	Everyone	(844) 975-2651

v. No retaliation for reporting issues; assisting in investigations

Workforce Members, contractors, directors, and FDR Workforce Members must report any potential or suspected legal, ethical, or compliance violations and any incidents of possible or potential FWA. AstranaCare maintains an environment where people feel comfortable in reporting any good faith issues or violations by ensuring that no AstranaCare Workforce Member, director, contractor or FDR retaliates, attempts to retaliate, or intimidates anyone who, in good faith, participated in the Compliance Program by reporting, investigating, or speaking to a supervisor or an investigator concerning a suspected compliance issue or a legal, regulatory or procedural violation. This includes any investigation issues, remedial actions, self-evaluations, and audits. Additionally, laws and regulations protect those who lawfully report possible violations to their employers.

AstranaCare as an organization has a strict non-retaliation policy to make certain each person feels comfortable in raising any good faith violation concerns. As part of this policy, every Workforce Member with supervisory responsibilities must encourage a work environment where ethical concerns are raised and openly discussed without fear of retribution or reprisal. Anyone who is found to have engaged in any such retaliation or intimidation is subject to immediate disciplinary actions, up to and including termination and referral to the appropriate authorities.

Workforce Members, contractors, directors, and FDR Workforce Members are required to assist in any investigation of a suspected legal, ethical, or compliance breach. This assistance may include speaking directly to the Compliance Officer, a Compliance Department member, or supervisor, completing a report or other written document, making themselves available to meet or speak with any investigator, and generally supporting an ongoing investigation.

DISCIPLINARY STANDARDS

As mentioned above, AstranaCare expects to receive any reports of compliance issues, including non-compliant, illegal, or unethical behavior. All Workforce Members, contractors, directors, and FDR Workforce Members will receive training outlining how to report any potential violations and AstranaCare 's policy of non-retaliation. Examples of non-compliant, illegal, or unethical behavior subject to discipline include:

- Failing to perform an obligation detailed in the Compliance Program or related P&Ps, including any conduct resulting in a legal violation.
- Failing to report a suspected or actual compliance or legal violation.
- Failing to reasonably assist or obstruct a compliance investigation.
- Behavior leading to the filing of a false or improper claim in violation of federal or State laws.

Anyone found to be engaged in non-compliant, illegal, or unethical behavior is subject to discipline, which, depending on the severity of the violation, may include an oral or written warning, a personal development plan, suspension, or termination. Disciplinary standards will be well publicized through annual training, P&Ps, communications with FDRs, AstranaCare's website, newsletters and other documents, and emails. Any enforcement of these standards will be documented and maintained in the Compliance and Human Resources Departments.

ROUTINE MONITORING, AUDITING, & IDENTIFICATION OF COMPLIANCE RISKS

AstranaCare has in place a mechanism for routinely monitoring and identifying internal and external compliance risks to test and confirm our adherence to CMS regulations, agreements, policies, and applicable federal and State laws. Internal monitoring includes reviewing the performance of our operational systems while auditing is a formal review of our compliance against a set of standards. External monitoring includes reviewing the performance and operations of FDR services and systems while external auditing includes a formal review of FDR compliance and contractual obligations against a baseline set of standards as dictated in AstranaCare 's Audit Program.

AstranaCare begins our monitoring and auditing process with an audit program overseen by the Compliance Officer and the CC, which identifies and addresses any potential Medicare Part C and Part D risks, and any other risks AstranaCare faces based on all applicable authority. Audits and monitoring will follow based on the results of the audit program, the results of which will be communicated to the CC and the Board. The CC and the Board will discuss the results and record meeting minutes. The following are the procedures by which we will perform internal and external monitoring and auditing:

Identifying risks

AstranaCare will conduct a baseline assessment to gauge potential risk areas. Areas of assessment will include, but may not be limited to:

- UM Operations
- Appeal and Grievance Procedures
- Exclusions
- Claims Processing
- Health Plan Requirements
- FWA
- FDR and Other Contractor Oversight
- Software Security
- HR Requirements
- Regulatory Requirements
- Solvency
- Member Rights
- CAPs Issued by a Governing Body

Audit Program

The audit program may include certain methodologies and vary in audit types (desk or onsite). The audit program will include a process for monitoring and follow-up review of any non-compliant areas. Any corrective action will be led by the Compliance Officer, in conjunction with senior management related to the affected department(s). Results will be communicated to the CC as necessary.

Office of the Inspector General/General Services Agency Exclusion

Government payments from both Medicaid and Medicare may be issued for any item or service furnished or prescribed by a person excluded by the Office of the Inspector General ("OIG") or the General Services Agency ("GSA"). Monthly, AstranaCare staff will check the OIG and GSA and all other excluded party lists to ensure compliance with exclusions.

Prompt Response to Compliance Issues

Any potential issue regarding FWA or noncompliance for either AstranaCare 's Part C or Part D or any other applicable duties and responsibilities will result in a reasonable and timely inquiry with the implementation of any necessary corrective actions. This process is also used if AstranaCare discovers evidence of misconduct related to the payment or delivery of items or services under its contract with Health Plans. If misconduct related to payment or contractually obligated services delivery is found, the corrective action plan will include communication with Health Plans, rectifying the error (e.g., repaying any overpayments), providing additional training, modifying processes as necessary, and/or disciplinary action as needed.

If a Workforce Member, contractor, director, or FDR Workforce Member suspects Medicare-related FWA or misconduct, he or she may voluntarily contact the Health Plan directly to report the suspicion. If Medicare-related FWA or misconduct impacting one or more beneficiaries is discovered, the Compliance Officer or designee will contact the Health Plan to voluntarily self-report the issue and cooperate with any investigations undertaken by the Health Plan or CMS.

FRAUD, WASTE, & ABUSE

FWA is unacceptable. Workforce Members, directors, contractors, and FDRs must, at all times, act with efficiency and care. Resources are to be used appropriately and judiciously and services must be rendered in a manner consistent with the contract with the Health Plan, other applicable authorities, and P&Ps. AstranaCare uses the monitoring and auditing measures outlined here as tools and measures to detect and prevent FWA, as well as the following procedures:

- Anyone who suspects FWA must report the situation immediately, with any supporting documents, to his or her supervisor, Plan contact, or Compliance Officer (see contact methods above). The suspected individual should not be contacted by the person suspecting the noncompliance.
- If communication is made to a supervisor or a Plan contact is informed, that person must contact the Compliance Officer immediately by email or phone number.
- The Compliance Department will document the report, begin investigating the claim, make a report to the CC and the Board as necessary, and conduct follow-up reviews as necessary.
- Corrective actions may include identifying the root cause of the issue, contacting the Health Plan, conducting additional training, repayment, or similar error correction, adding additional procedures, or modifying existing procedures, and follow-up reviews.

Examples of FWA one may encounter in a workplace include, but are not limited to:

- Over and underutilization activities
- Mishandling a member's appeal
- Forwarding or processing a fraudulent claim
- Misrepresenting or falsifying information
- Duplicating co-pays or imposing excessive co-pays

- Manipulating data regarding members

RELEVANT LAWS

The False Claim Act, Anti-Kickback Statute, Physician Self-Referral (Stark Law), HIPAA, and criminal codes are also used to address any FWA.

i. The False Claims Act

The False Claims Act protects the government from being overcharged or selling substandard goods or services. Civil liability is imposed on anyone who knowingly submits, or causes the submission, a false or fraudulent claim to the federal government.

ii. The Anti-Kickback Statute

The Anti-Kickback statute makes it a criminal offense, with some exceptions, to knowingly and willfully offer, pay, solicit, or receive any payment to induce or reward referrals of items or services that can be reimbursed by Medicare or Medicaid.

iii. Physician Self-Referral (Stark Law)

The Stark Law prohibits a physician from referring certain health services to an entity where that physician or immediate family member has an ownership or investment interest, or which he or she has a compensation arrangement with applicable exceptions.

iv. Health Insurance Portability and Accountability Act of 1996

Health Insurance Portability and Accountability Act of 1996 ("HIPAA") mandated industry-wide standards for the privacy of healthcare information and strengthened efforts to combat FWA by establishing the Health Care Fraud and Abuse Control Program.

v. Criminal Codes

The Federal criminal statute prohibits anyone from knowingly or willfully executing, or attempting, a scheme to defraud any federal health care benefit program or obtain by pretenses or promises any money or property owned by or under the control of any federal health care benefit program. Penalties for violating the criminal statute may include fines, imprisonment, or both.

SECTION 13 NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT PATIENTS MAY BE USED AND DISCLOSED AND HOW PATIENTS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

The primary purpose of AstranaCare is to provide quality Healthcare services in a timely and culturally sensitive manner and to work with the cooperation of the community and government agencies to create a vibrant healthy, physical, and social environment.

At AstranaCare ,we respect the confidentiality of your health information and will protect your information responsibly and professionally. We are required by law to maintain the privacy of your health information and to provide you with this notice. We must follow the terms of this notice while it is in effect.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights concerning your health information and how you can exercise those rights.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) is information created or received by AstranaCare that identifies an individual applying for or enrolled in a health benefits program in which AstranaCare is a provider, the person's participation in the program, the person's past, present, or future physical or mental health condition, the provision of health care to that person, or payment for the provision of health care to that person. PHI does not include publicly available information or information that is available or reported in a summarized or aggregate fashion that does not identify any person.

HOW AstranaCare MAY USE OR SHARE INFORMATION

The following are ways we may use or share PHI:

- AstranaCare may use the information to help pay patients' medical bills that have been submitted to us by doctors and hospitals for payment.
- We may share patients' information with doctors or hospitals to help them provide medical care. For example, if a patient is in the hospital, we may give them access to any medical records sent to us by the patient's doctor.
- We may use or share patient information with others to help manage the patient's health care. For example, we might talk to the patient's doctor to suggest a disease management or wellness program that could help improve the patient's health.
- We may share patient information with others who help us conduct our business operations. For example, we may contract with a disease management company to offer services to improve the patient's health status. We will not share your information with these outside companies unless they have proper securities in place and agree to keep the provided information protected.
- We may use or share patient information for certain types of public health or disaster relief efforts.
- We may use or share patient information to send reminders if the individual has an appointment with your doctor.
- We may use or share patient information to give information about alternative medical treatments and programs or about health-related products and services that the patient may be interested in. For example, we might send the patient information about smoking cessation or weight loss programs.
- We may use or share patient information with an employee benefit plan through which the patient receives health benefits. We will not share detailed health information with the patient's benefit plan unless they have proper securities in place and agree to keep it protected.

There are also state and federal laws that may require us to release patient health information to others. We may be required to provide information for the following reasons:

- We may report information to state and federal agencies that regulate us such as the US Department of Health and Human Services.
- We may share information for public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking prescription drug and medical device problems.
- We may report information to public health agencies if we believe there is a serious health or safety threat.

- We may share information with a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions).
- We may provide information to a court or administrative agency (for example, under a court order, search warrant, or subpoena).
- We may report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness, or missing person.
- We may report information to a government authority regarding child abuse, neglect, or domestic violence.
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with a funeral director as necessary to carry out their duties.
- We may use or share information for the procurement, banking, or transplantation of organs, eyes, or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- We may report information on job-related injuries because of requirements of your state worker compensation laws.

If one of the above reasons does not apply, *we must get a patient's written permission to use or disclose their health information*. If the patient provides written permission and changes their mind, the patient may revoke their written permission at any time.

What Are the Patient's Rights

The following are patients' rights concerning their health information. If a patient would like to exercise the following rights, please contact the *AstranaCare Compliance Officer, c/o AstranaCare, 1668 S. Garfield Ave., Alhambra, CA 91801, Phone: (844) 975-2651.*

- *Patients have the right to ask us to restrict* how we use or disclose information for treatment, payment, or healthcare operations. Patients also have the right to ask us to restrict the information that we have been asked to give to family members or to others who are involved in their health care or for payment for your health care. Please note that while we will try to honor the patient's request, we are not required to agree to these restrictions.

- *Patients have the right to ask to receive confidential communications* of information. For example, if a patient believes that they would be harmed if we send information to their current mailing address (for example, in situations involving domestic disputes or violence), patients can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate reasonable requests.

- *Patients have the right to review or obtain copies of their protected health information records, with some limited exceptions*. Usually, the records include enrollment, billing, claims payment, and case or medical management records. Requests to review and/or obtain a copy of protected health information records must be made in writing. A fee for the costs of producing, copying, and mailing a patient's requested information may be applicable, and patients should be notified of the cost in advance.

- *However*, patients do not have the right to access certain types of information and we may decide not to provide patients with copies of the following information:
    - Contained in psychotherapy notes;
    - Compiled in reasonable anticipation of, or for use in a civil criminal or administrative action or proceeding; and
    - Information is subject to certain federal laws governing biological products and clinical laboratories.

  In certain situations, we may deny the request to inspect or obtain a copy of the information. If we deny a patient's request, we will notify the patient in writing and may provide the patient with a right to have the denial reviewed.

  AstranaCare will deny requests to inspect or obtain a copy of the information if there is reasonable doubt or question to the following:
    - Identity of the person presenting the authorization
    - Status of the individual as the duly appointed representative of a minor, a deceased, or an incompetent patient
    - Legal age or status as an emancipated minor
    - Patient's capacity to understand the meaning of the authorization to disclose PHI
    - The authenticity of the patient's signature
    - Current validity of the authorization

- *Patients have the right to ask us to make changes* to the information we maintain in their records. These changes are known as amendments. We may require that the patient's request be in writing and that the patient provides a reason for the request. We will respond to the request no later than 60 calendar days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify the patient of the delay and the date by which we will complete action on the patient's request.
  If we make the amendment, we will notify the patient that it was made. In addition, we will provide the amendment to any person that we know who has received the patient's health information. We will also provide the amendment to other persons identified and authorized by the patient.

  If we deny a patient's request to amend, we will notify the patient in writing of the reason for the denial. The denial will explain the patient's right to file a written statement of disagreement. We have a right to respond to the patient's statement. However, the patient has the right to request that their written request, our written denial, and statement of disagreement be included with the patient's information for any future disclosures.

- *Patients have the right to request and receive an accounting of certain disclosures* of PHI made by us during the six years before the request. Please note that we are not required to provide patients with an accounting of the following information:
    - Any information collected before April 14, 2003.
    - Information disclosed or used for treatment, payment, and health care operations purposes.
    - Information disclosed to the patient or according to their authorization.
    - Information that is incident to a use or disclosure otherwise permitted.
    - Information disclosed for a facility's directory or to persons involved in the patient's care or other notification purposes.
    - Information that was disclosed for national security or intelligence purposes.

- Information that was disclosed to correctional institutions, law enforcement officials, or health oversight agencies.
- Information that was disclosed or used as part of a limited data set for research, public health, or healthcare operations purposes.

We may require that the patient's request be in writing. We will act on the patient's request for an accounting within 60 days. We may need additional time to act on the patient's request. If so, we may take up to an additional 30 days. The patient's first accounting will be free. We will continue to provide the patient with one free accounting upon request every 12 months. If the patient requests additional accounting within 12 months of receiving the free accounting, we may charge a fee. We will inform the patient in advance of the fee and provide the patient with an opportunity to withdraw or modify the request.

Capacity to Authorize: Who Can Submit Requests for Health Information

AstranaCare requires a written, signed, current, and valid authorization to release Protected Health Information (PHI) as follows:

Member Category	Required Signature
Adult Member	The Member or a duly authorized representative, such as a court-appointed guardian or attorney. Proof of authorized representation is required, such as notarized power of attorney.
Deceased Member	Next of kin or executor/administrator of the estate.
Un-emancipated Minor	A parent or legally appointed guardian /attorney (proof of relationship required)
Emancipated Minor	Same as Adult Member above.
Members for Psychiatric, Drug, and Alcohol Treatment	Same as Adult Member above.
Members for AIDS/HIV or other Sexually Transmitted Disease Treatment	Same as Adult Member above.
Members for Abnormal Birth, Fetal Death, or Other Deformity Treatment	Same as Adult Member above.

Written authorization is required for all uses and disclosures. Written authorization must contain detailed, specific information directing the release of member information. Authorizations must include the following information:

- Name and address of AstranaCare
- Name of the member
- Person or organization, including complete address, to whom the information is to be released
- Information to be released
- Purpose of Disclosure
- Signature of the member or duly authorized representative
- Date signed
- Signature of witness (if applicable)

EXERCISING PATIENT'S RIGHTS

Patients have a right to receive a copy of this notice upon request at any time. Patients can also view a copy of

the notice on our website at https://www.networkmedicalmanagement.com/. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to patients upon request and post it on our website.

If a patient has any questions about this notice or about how we use or share information, please contact the AstranaCare Compliance Officer at (844) 975-2651. The office is open Monday through Friday from 8:30 AM to 5 PM PST. Patients can also send us questions by e-mail to: MemberServicesHC@AstranaHealth.com.

If a patient believes their privacy rights have been violated, they may file a complaint to the *AstranaCare Compliance Officer, c/o AstranaCare, 1668 S. Garfield Ave., Alhambra, CA 91801.*

If the patient is not satisfied with how this office handles a complaint, the patient may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

The patient may also address a complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at: http://www.hhs.gov/about/agencies/regional-offices/#

All complaints must be submitted in writing. WE WILL NOT TAKE ANY ACTION AGAINST ANY PATIENTS FOR FILING A COMPLAINT.

We reserve the right to change our practices and to make the new provisions effective for all individually identifiable health information that we maintain.

SECTION 14 FORMS/ADDITIONAL RESOURCES