astiva HEALTH

2025 PROVIDER MANUAL



SERVICE AREA

LOS ANGELES • ORANGE • RIVERSIDE
SAN BERNARDINO • SAN DIEGO • SANTA CLARA

www.astivahealth.com

Table of Contents

Section I: Introduction 1

Section II: Glossary Terms 2

Section III: Enrollment, Disenrollment and Eligibility 10
- CMS's Required Enrollment Criteria 10
- Member Eligibility 11
- Member Ineligibility 11
- Temporarily Suspended New Enrollment Applications 12
- Eligibility Verification 13
- Member Not On Eligibility List 13
- Request for Practitioner Re-assignment of Members 13
- Sample of Member ID Card 14

Section IV: Member Grievances and Appeals 15
- What to Do If a Member Grievance Is Received 15
- Provider Response if a Complaint / Grievance Involves a Provider 15
- Purpose 15
- Information About Member Appeals 15
- Members Have the Right to Appeal 16
- Verbal requests 16
- Processing Timeframes 16
- What to Do If a Provider Receives an Appeal 16

Section V: Provider Operations 19
- Provider Relations Department 19
- Provider Services and Configuration Department 19
- Provider Responsibilities 21
- Providers Questions and Concerns 22

Section VI: Contract 22
- Disclosure of Ownership and Control Interest and Management Statement 25
- Delegate Entities 25
- Delegation and Pre-Delegation Oversight Process 25
- Opportunities for Improvement 26

Section VII: Credentialing 27
- Practitioner Selection Criteria 27
- HDO Credentialing Application Process 27
- Non-Discrimination Selection 28
- Site Visits for Unaccredited Facilities 28

Table of Contents

Section VIII: Claims Administration 26
- Member Billings 29
- Claims Definition 29
- Clean Claims – CMS 1500, UB04 29
- Claims Documentation 30
- Timely Filing of Claims 30
- Incomplete Professional and Hospital Claims 31
- Denied and Adjusted Claims 31
- Claims Denials 31
- Claims Adjustments 32
- Claims Investigation 32
- Corrected Claim Submission 32
- Claim Appeals 32
- Third Party Liability 33
- Audit and Recovery 35
- Encounter Data 35

Section IX: Capitation Payment and Reports 36
- Payment 36
- Reports 37
- Capitation File Layout 38

Section X: Prescription Drug Benefits and Pharmacy Services 39

Section XI: Emergency Care Services 41
- Emergency Services and Post Stabilization 42
- Text of Emergency Services and Post Stabilization 43
- Ambulance Service in Care of Emergency 43
- Expedited Organization Determinations 44
- Standard Organization Determinations 45
- Second Opinion 45
- Continuity of Care 46
- Continued Care with a Terminated Provider 46
- Hospitals Responsibility for Care in the Emergency Room 46

Section XII: Utilization Management 46
- Requesting an authorization/Referral 47
- Automatic Referrals Process 47
- Specialist Follow Up Visit 48
- Concurrent Review 48
- Patient Follow Up After Discharge 48
- Notice of Medicare Non-Coverage (NOMNC) 48
- Detailed Explanation of Non-Coverage (DENC) 49
- Notice of Hospital Discharge Appeal Rights 49

Table of Contents

Transition of Care 49
Medicare Data Exchange 49

Section XIII: Delegation of Utilization Management 51
Utilization Management Delegation Standards Overview 51
Standards for Programs Structure and Process 53
Denial Standards 55
Standards for Personal and Health Information 55

Section XIV: Quality Improvement Program 56
Access to Care 56
Annual QI Program Evaluation 57
Annual QI Work Plan 57
Committee Structure 58
Quality and Stars Rating 59
    Member Experience / Satisfaction 59
    Member Complaints - Appeals & Grievances 59
Clinical Care Measures 60
Service Measures 60
HealthCare Effectiveness Data and Information Set (HEDIS) 60
HEDIS Rates and Measures 60
Consumer Assessment of Healthcare Providers and Systems (CAHPS) 60
Provider Satisfaction 61
Quality Of Life (QOL) Survey 61
Medical Record Review 61

Section XV: Preventive Health 63
Annual Wellness Exam 64
Comprehensive Risk Assessment 66
Coordination of Medically Necessary Services 67

Section XVI: Health Education 68

Section XVII: Use of Interpreters 69

Section XVIII: Member Confidentiality, Privacy and HIPPA 74
Protecting Member Health Information 74
Core Elements of A " Patient Authorization" 75
Member Access to Personal Health Information 75
Uses/Disclosures of PHI Requiring Written Patient Authorization 76

Section XIX: Medicare Regulations Summary Links 79

Section XX: Marketing Event Procedures 80



Section I: Introduction

Welcome to Astiva Health. We are a Medicare Advantage Organization with Prescription Drug Plan (MAPD), that provides managed care services to individuals who obtain health insurance through government-sponsored programs such as Medicare and Medicaid. Astiva Health currently operates in Orange, Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara Counties. We have developed one of the most diverse networks, and we offer a selection of benefits tailored to the specialized needs of the individuals who partner with us.

Our Purpose

To bridge the gap between seniors and our physicians while providing an innovative, smart, and accessible quality healthcare model for our members.

Our Mission

To provide a community and social approach to healthcare and prevention while assisting our seniors to live well in their chosen community.

Our Vision

To work collaboratively with providers and cultivate strong relationships with stakeholders who share our vision to service our members.

This Provider Manual outlines our policies and procedures. It serves as a guide and is intended for contracted providers and their staff to comply. It is also an extension of the IPA/Medical Group Participating Provider Services Agreement. When the contents of Astiva Health's Provider Operations Manual conflict with the IPA/ Contracted Medical Group Services Agreement, the IPA/Medical Group Participating Provider Services Agreement takes precedence.

This Provider Operations Manual applies to IPAs, Medical Groups, and other Contracted Providers that Astiva Health has delegated to perform certain managed care functions, such as utilization management, claims payment and credentialing, as outlined in the agreement with Astiva Health.

A paper copy of this manual is available to providers upon request. In accordance with the agreement, Participating Providers must abide by all applicable provisions contained in this manual.

Section II. Glossary of Terms

Term	Description
Accreditation Organizations	Any organization engaged in accrediting Astiva Health
Access	The patient's ability to obtain medical care.
Actuary	A specialist trained in mathematics, statistics, and accounting who is responsible for rate, reserve, and dividend calculations and other statistical studies.
Agreement	The contracted medical groups/IPAs, and provider of service agreement between Astiva Health and any of the entities noted above, and any amendments, exhibits, and attachments.
Ambulatory Surgery	Surgery performed on an outpatient basis.
Ambulatory Surgical Center	A facility where health services are delivered on an outpatient without an overnight stay.
Appeal	Any actions that deal with the review of adverse determinations on the health services a member is entitled to, any amounts that a member must pay for services, and any amount that is in dispute by a provider of services.
Beneficiary	A Medicare member or former member.
Benefits	All services that are covered under Medicare Part A and Part B programs.
Calendar Year	The period beginning January 1 of any year through December 31 of the same year.
Capitation	Specified amount paid periodically to health provider for a group of specified health services, regardless of quantity rendered.
Case Management	Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost-effective manner.
Clean Claim	A claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
Claim	Information submitted by a practitioner or provider of service to establish that medical services were provided to a covered person.

Glossary of Terms Cont.

Claims Review	A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.
CMS 1500	The Health Care Finance Administration's standard form for submitting provider professional service claims to third program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis.
Downstream Entity (subcontracted entity)	Any party that enters into an acceptable written arrangement below the level of the arrangement between the Medicare contracting organization (and contract applicant) and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Durable Medical Equipment (DME)	Items of medical equipment owned or rented which are placed in the home of an insured to facilitate treatment and/or rehabilitation.
E & I	Experimental and Investigational
Electronic Data Interchange (EDI)	The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization.
Effective Date	The date the Health plan agreement becomes effective; the date health coverage begins.
EGHP	Employer Group Health Plan
Eligibility List (E-List)	The list of assigned members eligible with a Contracted Medical Group.
Emergency	Sudden unexpected onset of illness or injury which requires the immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize, or impair the health of the Member, as determined by a prudent layperson. No prior certification or authorization is needed for emergent or urgent care.
Encounter Data	Data relating to treatment or service rendered by a practitioner or provider of service to a patient, regardless of whether the provider was reimbursed on a capitated or fee- for-service basis. Also known as “risk adjustment data” because CMS pays per member based partially on the member’s health status as determined by these data.

Glossary of Terms Cont.

Enrollee (Subscriber)	Member; also known as “beneficiary”.
Enrollment	The number of lives covered by an HMO.
EOB	Explanation of Benefits accompanies payments and denial of payments.
EOC	Evidence of Coverage (mailed to members upon initial enrollment and annually thereafter).
EOMB	Explanation of Medicare Benefits.
ER	Emergency Room
ERISA	Employee Retirement Income Security Act protects members of employer group health plans.
Exclusions	Conditions or situations not considered covered under contract or plan.
Expedited	Urgent requests that must be handled within 72 hours. Applying the standard timeframe could seriously jeopardize the life or health of the member.
Experimental	Items determined by Medicare not to be generally accepted.
FBI	As an agency under the Department of Justice (DOJ), the FBI investigates violations of federal criminal law and provides law enforcement assistance to federal, state, local and international agencies. The FBI has investigated hospitals for fraud and abuse. (see Fraud)
Federally Qualified Health Center (FQHC)	A federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants, and certified nurse midwives.
Fee	A charge for professional services.
Fee Schedule	A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.
First-dollar coverage	Insurance coverage with no front-end deductible where coverage begins with the first dollar of expense incurred by the insured for any covered benefit.
First Tier Entity	Any party that enters into a written arrangement with a Medicare contracting organization or contract applicant to provide administrative services or health care services for a Medicare eligible individual.

Glossary of Terms Cont.

Formulary	An approved list of prescription drug: a list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Astiva Health only covers drugs on its formularies. Formularies can be changed without notice. Call member or provider services to determine if a drug is covered.
Fraud	Intentional misrepresentations that can result in criminal prosecution, civil liability, and administrative sanctions.
Grievance Procedures	The process by which an insured can air complaints and seek remedies.
HCC	Hierarchical Condition Category is determined by the ICD-9 diagnosis codes submitted to CMS through health plans for a specific member. HCCs indicate the health status (chronic conditions) of the member. The CMS monthly payment per member is determined by the multiple (cumulative) HCCs assigned to a member, based on data submitted the prior year.
Maximus	An independent review entity (IRE) under contract with CMS to review Medicare Managed Care members appeals.
Medicare Advantage	New name for Medicare Choice; Name was changed by Congress.
Medicare Advantage Prescription Drug Plan (MAPD)	This is a risk-based HMO that covers hospital (Part A), Professional (Part B) and Prescription Drugs (Part D) for its members.
Medically Necessary - Medical Necessity	Services or supplies which meet the following tests: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider; and They are the most appropriate level or supply of service which can safely be provided.
Member	One and the same as an enrollee.
Member Year	Twelve-month period following the effective date of the member.
Memorandum of Understanding (MOU)	MOUs act as an interim agreement between any two entities, i.e. the County and an HMO, the HMO and a CPP, etc.
MSE	Medical Screening Exam

Glossary of Terms Cont.

National Committee for Quality Assurance (NCQA)	A non-profit organization created to improve patient care quality and health plan performance in partnership with managed care plans, purchasers, consumers, and the public sector.
Network	An affiliation of providers through formal and informal contracts and agreements.
Non-participating Practitioner (or Provider)	A provider, doctor or hospital that does not sign a contract to participate in a health plan (not in the network).
Office of Inspector General (OIG)	The office responsible for auditing, evaluating, criminal, and civil investigating for HHS, as well as imposing sanctions, when necessary, against health care providers. (see also Fraud, FBI, Dept. of Justice).
Open Enrollment Period	A period of time which eligible subscribers may elect to enroll in, or transfer between, available programs providing health care coverage.
Outpatient Care	Care given a person who is not bedridden. Also called ambulatory care.
Part A Medicare	Refers to the inpatient portion of benefits under the Medicare Program, covering beneficiaries for inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and copayments. Part A services are financed by the Medicare HI Trust Fund, which consists of Medicare tax payments. Part B, on the other hand, refers to outpatient coverage.
Part B Medicare	Refers to the outpatient benefits of Medicare, "professional services." Medicare Supplementary Medical Insurance (SMI) under Part B of Title XVII of the Social Security Act covers Medicare beneficiaries for physician services, medical supplies, and other outpatient treatment.
Participating Physician or Participating Provider	Simply refers to a provider under a contract with a health plan (in the network).
Primary Care Physician (PCP)	A primary care physician in practice in the payer's managed care service area who has entered a contract to oversee and manage the health care of members.
Peer Review	The mechanism used by the medical staff to evaluate the quality of total health care provided by the Managed Care Organization. The evaluation covers how well all health personnel perform services and how appropriate the services are to meet the patients' needs.

Glossary of Terms Cont.

Per Diem Cost	Cost per day; hospital or other institutional cost for a day of care.
Per Member Per Month	Used by HMOs and their medical providers as an indicator of revenue, expenses, or utilization of services per member per one month period.
Physician Current Procedural Terminology (CPT)	List of services and procedures performed by providers, with each service/procedure having a unique 5-digit identifying code (also known as "Procedure Codes"). CPT is the health care industry is standard for reporting of physician services and procedures. Used in billing and records.
Principal Diagnosis	The medical condition that is ultimately determined to have caused a patient's admission to the hospital. The principal diagnosis is used to assign every patient to a diagnosis related group. This diagnosis may differ from the admitting and major diagnoses.
Prior Authorization	A formal process requiring a provider to obtain approval to provide particular services or procedures before they are done.
Quality Assurance (QA)	Activities and programs intended to assure the quality of care in a defined medical setting. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing its effectiveness and may measure care against pre-established standards.
Referral Authorization	A verbal or written approval of a request for a member to receive medical services or supplies outside of the participating medical group.
Referral Physician	A physician who has a patient referred to him by another Source for examination, surgery, or to have specific procedures performed on the patient.
Referring Physician	A physician who sends a patient to another source for examination, surgery, or to have specific procedures performed on the patient,

Glossary of Terms Cont.

Related Entity	Means any entity that is related to the Medicare Advantage organization by common ownership or control and: Performs some of the Medicare Advantage organization's management functions under contract or delegation. Furnishes services to Medicare enrollees under an oral or written agreement; or Leases real property or sells materials to the M+C organization at a cost of more than $2,500 during a contract period.
Reserves	Monies earmarked by health plans to cover anticipated claims and operating expenses.
Resource Based Relative Value Scale (RBRVS)	A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.
Sanction	Reprimand of an oversight entity, which may include certain temporary prohibitions. Sanctions can be from CMS to health plans, or from health plans to provider. A common sanction is to temporarily halt the marketing and enrollment of new members until a specified deficiency is resolved.
Service Area	The geographic area served by an insurer or health care provider.
Service Area Expansion (SAE)	A detailed filing to CMS to request an expansion into another area. SAEs must be fully approved by CMS prior to any marketing or enrollment activities.
Significant Business Transaction	Means any business transaction or series of transactions of the kind specified in the above definition of "business transaction"; that, during any fiscal year of the Medicare Advantage organization, have a total value that exceeds. $25,000 or five percent of the Medicare Advantage organization's total operating expenses, whichever is less.
Skilled Nursing Facility (SNF)	A licensed institution, as defined by Medicare, which is primarily engaged in the provision of skilled nursing care.
Specialty Care Provider (SCP)	Practitioner responsible for Specialty Care.
Subrogation	Procedure where insurance company recovers from a third party when the action resulting in medical expense (e.g., auto accident) was the fault of another person. The recovery of the cost of services and benefits provided to the insured of one health plan when other parties are liable.

Glossary of Terms Cont.

Subscriber	An individual meeting the health plans' eligibility requirement, who enrolls in the health plan and accepts the financial responsibility for any premiums, co-payments, or deductibles.
Supplemental Security Income (SSI)	A federal cash assistance program for low-income aged, blind, and disabled individuals established by Title XVI of the Social Security Act.
State and Federal Laws	All laws and regulations of the State of California and Federal Government as well as all government agencies that are applicable to Astiva Health, Astiva Health's Contracted Medical Groups, and Astiva Health Providers both as employees and subcontracted practitioners and providers of service.
Termination Date	Date that a group contract expires, or an individual is no longer eligible for benefits.
Tertiary Care	Medical care requiring a setting outside of the routine, community standard; care to be provided within a regional medical center having comprehensive training, specialists, and research training.
Title XVIII (Medicare)	The title of the Social Security Act, which contains the principal legislative authority for the Medicare program and therefore a common name for the program.
Uniform Billing Code of 2004 (UB-04)	Billing form used to submit hospital insurance claims for payment by third parties. Similar to CMS-1500, but reserved for the inpatient component of health services.
Urgent Services	Benefits covered in an Evidence of Coverage that are required in order to prevent serious deterioration of an insured's health that results from an unforeseen illness or injury.
Utilization Management (UM)	Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.
Workers' Compensation	A state-mandated program providing insurance coverage for work-related injuries and disabilities. Several states either have enacted or are considering changes to the Workers Compensation Laws to allow employers to cover occupational injuries and illnesses within their own existing group medical plans. See also Occupational Health.

Section III. Enrollment, Disenrollment and Eligibility

Astiva Health does not delegate the enrollment of Medicare Advantage Members. The Centers for Medicare and Medicaid Services prohibit the enrollment of Members in a physician's office. Patients who wish to enroll should be advised to call the Astiva Health Medicare Enrollment Department. The (CMS) also prohibits providers from encouraging a Member to disenroll.

A clear explanation of the requirements for enrollment, eligibility and disenrollment can help demystify Medicare Advantage Managed Care. The following section addresses the process of enrollment, the eligibility requirement(s) for recipients and it outlines the processes that must be followed to disenroll a Member.

Newly enrolled Members may not always appear on an eligibility list, however if:

A person is not on the eligibility list but has in his or her possession a Astiva Health ID Card, or A person is not on the eligibility list but has in his or her possession a copy of their completed and signed enrollment application.

Please call (866) 688-9021 to verify eligibility.

Astiva Health generally considers them to be effective as of the date on the ID card, or the first day of the month following the date they signed the enrollment application form.

It is advised that all Contracted Medical Groups (CMGs) verify a member's eligibility with Astiva Health prior to providing health care services by contacting Astiva Health Member Services at (866) 688-9021. We are open from Monday – Friday from 8am-8pm.

CMS's Required Enrollment Criteria

Required part A Entitlement and Part B Entitlement

Medicare Advantage organizations (like Astiva Health) are required to enroll only those individuals who are entitled to both Medicare Part A and Part B. Eligibility for enrollment in the Astiva Health program also requires that:

The Member must live in the approved Astiva Health service area as defined by the counties and ZIP codes in which the Centers for Medicare and Medicaid Services (CMS) and the state have approved Astiva Health to operate.

Enrollment, Disenrollment and Eligibility Cont.

In accordance with the federal regulations governing Medicare, members are entitled to the following:

Election period – times during which an eligible individual may elect a MA plan or Original Medicare. The type of election period determines the effective date of MA coverage. There are several types of election periods, all of which are defined under Evidence of Entitlement (Medicare Part A and Part B Coverage).

Annual Election Period – AEP is from October 15 through December 7 of every year. There is one AEP enrollment/disenrollment choice available for use during this period. An enrollment/disenrollment election cannot be changed after the end date of AEP.

Special Enrollment Period - for limited special exceptions such as you have a change in residence, you have Medicaid, you are eligible for extra help with Medicare prescriptions, and you live in an institution, you are enrolled in special plan PACE, CSNP.

Member Eligibility

The Enrollment effective date is the first of the month following the month in which the plan receives the enrollment request, and the enrollment has been approved by CMS. Astiva Health's Members may be processed with a retroactive date. The effective date will never be earlier than the signature date on the election form.

Astiva Health Members are notified of his/her effective date in writing.

Member Ineligibility

A Medicare-entitled Member becomes ineligible for coverage under the Astiva Health plan on the date when any one of the following occurs:
The Member is determined to be ineligible by CMS:

- The Member is no longer entitled to Medicare Part A and (or) Part B. Termination is effective the first day of the month following the month of occurrence.

- The Member requests disenrollment from Astiva Health.

- The Member permanently moves out of the Astiva Health service area. The Member is required to notify Astiva Health if moving out of the Astiva Health service area; The Member resides outside of the service area for more than 6 months. In the event you become aware that a member has been out of the Astiva Health services area for longer than 6 months, please notify the Astiva Health Member Services at 1-866-688-9021 Monday – Friday 8am-8pm.

Enrollment, Disenrollment and Eligibility Cont.

• The Member is temporarily out of the Astiva Health service area for 12 months or longer. Note that Medicare Advantage plans are required to provide emergency, out- of-area urgently needed services, and out-of-area renal dialysis if the Member is out of the Astiva Health service area only until the Member's termination is effective with the Centers for Medicare and Medicaid Services (CMS). Refer to your Provider Services Agreement (provider agreement) and Division of Financial Responsibility (DOFR) matrix for Contracted Medical Group (CMG) specific benefit payment information.

• The Member commits fraud or allows another person to use his or her Astiva Health identification card to obtain services.

• The Member is disruptive, abusive, unruly, or uncooperative to the extent that this behavior jeopardized the well-being of any Astiva Health provider, Member, or employee, and the Member's termination is approved by CMS.

• The Member knowingly omits or misrepresents a material fact on the application for membership.

• The Member enrolls in another Medicare Advantage plan.

• The Astiva Health (Medicare Advantage) contract with CMS is not renewed.

• The Member is deceased.

Members have the right to have their termination reviewed. Such termination, if not appealed or overruled, is effective on the date stated in the notice. Members disenrolled according to fraud or jeopardizing behavior provisions above are referred to the Inspector General and criminal prosecution may result.

Temporarily Suspended New Enrollment Applications
Astiva Health submits a list of beneficiaries, who have submitted an Individual Election form, to CMS in order to confirm enrollment. CMS may delay a beneficiary's enrollment or reject a beneficiary's enrollment due to the following reasons:

• Incorrect Medicare number
• Beneficiary's Medicare eligibility may be in question
• Incorrect spelling of a beneficiary name

The Astiva Health Enrollment Department will attempt to resolve the rejected enrollment and will resubmit the corrected data to CMS.

In the event an enrollee is determined to be ineligible by CMS for any of the above reasons, Astiva Health will adjust the capitation payments that are paid to the Contracted Medical Group (CMG).

Enrollment, Disenrollment and Eligibility Cont.

Services provided to a member deemed ineligible by CMS to enroll in the Astiva Health program must be billed directly to the Medicare Fee for Service Intermediary.

Eligibility Verification on Provider Portal

If you are a first-time user, you will need to request a user-ID and password. Providers should contact the Provider Services Representative to request this at (833) 300-0910 or by email at providersupport@astivahealth.com

Member Not on Eligibility List

If a Astiva Health Member arrives at the Capitated Contracted Provider's office and does not appear on the eligibility list, the physician's office staff should call the Astiva Health Member Services Department at (866) 688-9021, Monday – Friday 8am – 8pm. for eligibility status. If found to be ineligible and the Member still desires services, provider office will advise Member of status as well refer Member back to Astiva Health Member Services Department at (866) 688-9021. The call center will assist the member and provider.

Request for Practitioner Re-assignment of Members

Disruptive behavior may result when a patient perceives that a breakdown in communications or caring has occurred between themselves and their provider, we recommend that contracted providers contact Astiva Health's Member Services Department at (866) 688-9021 as soon as possible if they have trouble with a member. Our Member Services Representatives will work with both the Member and provider to resolve issues and prevent disintegration of the therapeutic relationship. In some cases, our Member Services Department will involve Astiva Health Case Management, Risk Management and/or Medical personnel. These resources should be able to provide valuable assistance to our contracted medical groups in the process of problem resolution.

We emphasize that informed refusal of specific treatment elements by a competent adult does not in and of itself constitute grounds upon which a CMG may refuse to continue managing the Member nor does filing a grievance or a notice of impending litigation indicate that the relationship between the provider and the Member need be terminated. However, Astiva Health will consider reassignment of the Member per this procedure if in these circumstances a Astiva Health contracted provider feels they can no longer effectively provide the Member's medical care and management.

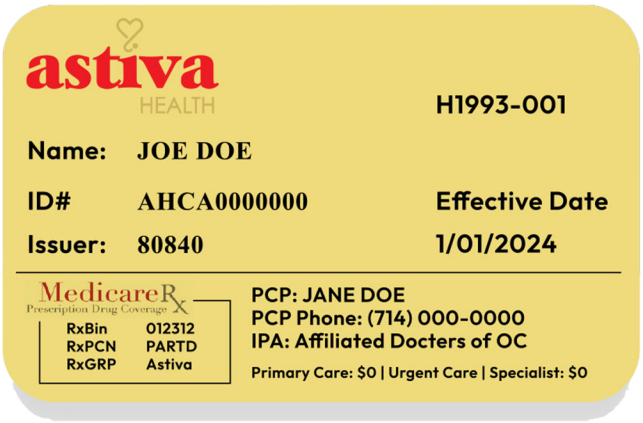
In all cases, Astiva Health will not implement reassignment until the CMG has given our member reasonable notice of and the opportunity to correct the behavior. We also require that the provider involved evaluate whether the behavior is a manifestation of a treatable medical conditions before requesting reassignment of the Member to another provider.

Astiva Health reserves the right to review all pertinent documentation, including the Member's medical record, if necessary, before approving the transfer. After that review, the Astiva Health medical and quality reviewers might suggest further options for resolution. During the process of this review of events by Astiva Health, we require that the Capitated Contract Providers continue medical management of our member until a final determination is made by Astiva Health.

Sample of Member ID Card

We hope this will make it easier for your staff to readily identify your new patients who are our members and contact our Call Center to verify eligibility.

As noted on the ID card, it is for identification purposes, and it does not prove eligibility as members may change plans. This information, however, will prove helpful as your staff completes your patient intake process.







Section IV: Member Grievances and Appeals

Definition of Grievance
The definition of a grievance per the Centers for Medicare and Medicaid (CMS) includes "...any expression of dissatisfaction...."

Members Have the Right to Grieve
Member grievances are based upon the member's perception and opinion. Sometimes a member's perception may not be a true representation of events. Nonetheless, members have the "right" to grieve (complain). Grieving is the member's opportunity to be heard on a matter. Members have the right to voice their grievances without fear of discrimination or reprisal from Astiva Health or its providers.

What to Do If a Member Grievance Is Received
Astiva Health does not delegate grievance processing to providers. If a member is "complaining" (grieving) to you or your staff, advise the member to call Astiva Health at (866) 688-9021 (TTY users 711) and speak with customer service. The Astiva Health staff will accept the member's complaint over the phone. You may also refer them to the Astiva Health website, which has instructions on how to file a grievance: https://astivahealth.com/en-us/grievances-appeals.

Provider Response if a Complaint / Grievance Involves a Provider
The Astiva Health Appeal and Grievance (A&G) Unit is required to process all grievances within 30 calendar days of receipt or as quickly as the member's health indicates. If the member's complaint happens to involve a provider, the A&G Unit will send a request to the provider giving the provider an opportunity to respond and give their perspective of the matter. Providers are required to respond to all requests for information from the A&G Unit.

Purpose
The purpose of the grievance system is to look for trends indicating a possible opportunity for improvement. For example: If a significant number of members complained that they were unable to receive a timely authorization from Astiva Health, we would assess our process and look for ways to improve it.

Information About Member Appeals

Definition of Appeal
An appeal is the procedure that is followed if a member disagrees with a decision to deny or modify

- A request for health care services; or
- A request for prescription drugs; or
- A payment for services or drugs already received.

Member Grievances and Appeals Cont.

Members Have the Right to Appeal

Astiva Health members have the right to appeal any decision(s) about coverage of services or prescription drugs and or failure to arrange or continue to arrange for covered services or prescription drugs. The member may appoint an individual to act as his/her representative to file an appeal. If designated to do so, a provider may appeal on behalf of a member. Member must complete and submit the Appointment of Representative (AOR) form along with the appeal. The AOR form will be kept on file for one year from the date it was signed.

Verbal requests

If member needs an appeal decided quickly, we call that a Fast Appeal. For fast appeals, Astiva Health will accept a verbal request. Standard appeals must be received in writing (per guidelines of the Centers for Medicare and Medicaid Services.) Members also have the option of using The Astiva Health Appeal form that can found on our website www.astivahealth.com/en-us/grievances-appeals or preparing their own written appeal. For assistance, please ask members to call Astiva health at the numbers below:

(866) 688-9021 (TTY users 711)
Hours of operation: Monday – Friday 8 a.m. – 8 p.m.

Processing Timeframes

There are various types of appeals. Medicare requires that some be processed within 72 hours of receipt. Most appeals for service are to be processed within 30 calendar days, while Claim appeals are required to be completed within 60 calendar days.

What to Do If a Provider Receives an Appeal

Astiva Health does not delegate the processing of appeals to providers. If a provider receives a written member grievance or appeal it should be faxed to the A&G Unit at Astiva Health at Fax number: (714) 908-8041. Because of the stringent timeframes for appeals, please fax to the attention of Astiva Health A&G Unit within an hour of receipt.

PART C APPEALS FORM

Request to file an Appeal Form For use by Astiva Health member or representative.	
Member Name:	Member ID#:
Address:	City, State, Zip Code:
Phone #:	Authorized Representative:
Complete portion for filing an Appeal	
Denied Service or Claim Number(s) you wish to appeal:	
Date(s) of Service(s):	Provider Name:
Total Amount in Dispute: $	Amount paid by Member (if any): $
Use the section below to provide additional detail for your appeal request. Please be sure to provide any information you feel may be helpful including copies of any claims/bills, medical records, or denial notices, if available:	
Standard appeal (reconsideration) requests must be submitted in writing within 60 days of the date of the notice of denial.	
Signature:	Date:
Member (or representative) signature: (If representative, please fill out an Appointment of Representative (AOR) Form)	
Please return this form to the Astiva Health Appeals & Grievances Department:	
Mail Form to: **Astiva Health** **Attn: Appeals & Grievances** **765 The City Drive South #200** **Orange, CA 92868** **Fax Form to:** **714-908-8041**	

There Are Two Kinds of Appeals You Can File:

Standard (30 days) - You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

Fast (72-hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if your plan needs additional information and the extension benefits you.)

- If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, your plan will automatically give you a fast appeal.
- If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30 days.

What Do I Include with My Appeal?

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service.
Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How Do I File an Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to your health plan at the address indicated on the Astiva Health Member Appeal Form.

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax using the plan contact information indicated on the Astiva Health Member Appeal Form.

What Happens Next? If you appeal, your plan will review our decision. After your plan review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your plan – Astiva Health if you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Other Contact Information:

If you need information or help, call us at: **866-688-9021**
Other Resources to Help You: Medicare Rights Center: Toll Free: 1**-888-HMO-9050 TTY/TTD:**

Elder Care Locator
Toll Free: **1-800-677-1116**
1-800-MEDICARE (1-800-633-4227) TTY/TTD: 1-877-486-2048

Section V: Provider Operations

Provider Relations Department

- Provider Relations Department is a main contact for all Contracted Medical Groups (CMGs)/IPAs and participating providers such as Primary Care Physicians, Specialists, Ancillary providers, and Hospitals to resolve any services issues.
- Provider Relations Department works closely and actively with other internal department such as Member Services, Utilization Department, Quality Improvement Department, Credentialing, Marketing, and Contracting to ensure smooth operation.
- Provider Relations Department conducts and provides training to CMGs/IPAs personnel to ensure all policies and procedures set forth in this manual are compiled and followed.
    - Orientations/Kick-off meetings are conducted by the Provider Relations, Utilization Management, and Quality Improvement department to train new CMGs, ancillary providers, hospitals, and direct contracted providers on operations, policies, and procedures within sixty days of executing a contract with Astiva Health.
    - In-services and training are provided by the Provider Relations department as needed with CMG's and participating providers on site to update information of Astiva Health's new programs and procedures.

- Provider Relations Department with Quality Department conducts Joint Operations Meetings to ensure administrators and staff are informed of updated policies and procedures.
    - Joint Operation Utilization Medical Committee (JOUMC) meetings are conducted by the Provider Relations Department, Quality and the Utilization Management Department quarterly or as needed to allow monitoring and oversight of delegated responsibilities, ensure effective problem resolution, and maintain ongoing communication between Astiva Health and its contracted CMGs. Astiva Health will maintain documentation of attendees and issues discussed.

Provider Services and Configuration Department

Provider Relations Department is responsible for tracking and investigating reports of inaccuracy related to the information displayed in the Provider Directory.

1. Provider Directories

- Providers must be fully contracted and credentialed to be included in Astiva Health's directory.

- To ensure timely and accurate representation of Astiva Health Physician Network that is accessible by our members and network partners, Astiva Health will update the provider search function and PDF/Print directories on a weekly basis or as required by Regulatory Agency(ies) needed. Provider search and PDF directories are located at https://astivahealth.com/en-us/provider-search/

Providers Operations Cont.

- Astiva Health requests all CMGs/IPAs and participating providers to provide us with the most current providers information, and notify us about any changes including demographic information, practice locations, and panel status updates at least 30 days in advanced. at least 30 days in advance via email at Provnet@astivahealth.com

Astiva Health requires all Medical Groups to validate and attest the provider directory information on a quarterly.

2. Adding New Provider

- CMGs/IPAs shall provide Astiva Health a complete provider profile of the new provider including all the required data elements such as full name, title, primary specialty, practice location(s), license number, license status, board certification status, hospital affiliations, etc.. Astiva Health will deny or return request with a reason if incomplete profile is received.

3. Provider Panel Closures

- CMGs/IPAs shall provide Astiva Health a written notice at least 30 days in advance of any PCP or specialist who will no longer accept members or at least within 5 business days of first learning of the closure.

4. Provider Termination

- CMGs/IPAs must provide written notice to Astiva Health at least 6o days in advance from the day CMG/IPA is notified, so membership notification letters can be sent out with a minimum of 30 days' notice. Membership PCP reassignment will be followed by IPA's redirection instructions. If no instructions are given, priority will be given for members to retain original PCP through another IPA affiliation, if not available will select the closest PCP available to the member.

- If member is assigned to a Federally Qualified Health Center (FQHC), or clinic the member will remain with the FQHC or clinic when such PCP termination happens and will be transferred to an existing PCP.

- If the terminating provider is a specialist, CMGs/IPAs are responsible for all transitions of care of all affected members due to such termination.

5. Provider Office closed/Relocation

- Contracted Medical Groups/IPAs must provide written notice to Astiva Health at least 30 days in advance from the day CMGs/IPAs are notified. CMGs/IPAs need to ensure affected members do not have to travel outside of geographic due to the change. Otherwise, Astiva Health will transfer members to a PCP that is within the previous office's geographic area.

6. Providers leave of absence or vacation

- CMGs/IPAs must arrange for coverage of services to ensure care is accessible as needed. Astiva Health requires a coverage plan if absence is more than 1 month, and members will be reassigned to a different PCP if absence is longer than 3 months.

Provider Operations Cont.

Provider Responsibilities

This manual addresses the respective responsibilities of PCPs. Participating providers shall adhere to the following terms.

PCP Responsibilities: Astiva Health recognizes Family Medicine, General Practice, Geriatric Medicine and Internal Medicine physicians as PCPs. Primary Care Services shall include, but are not limited to:

- Routine office visits (including after-hours office visits) and related services of a physician and other health care providers received by Enrollees in Providers office. This includes evaluation, diagnosis and treatment of illness and injury, including but not limited to: specimen collection; simple minor surgery and laceration repair; punch, excisional and shave biopsies; uncomplicated ingrown toenail removal; control of nasal hemorrhage; aspiration and injection or trigger points/joint; and all related written documentation.

- Visits and examinations. This includes consultation time and time for personal attendance with the patient at an emergency room (except for Emergency Room between 5:00 p.m. and 8:00 a.m.) or during a confinement in a hospital (including critical care visits), skilled nursing facility, or extended care facility.

- Immunizations and injections (including injectable) shall be provided by Provider

- Urinalysis and finger stick glucose and stool for occult blood and any other laboratory services that is provided in Providers office, is included in the capitation. All other laboratory services shall be performed by Plan's contracted laboratory(ies).

- Wellness Visit as customarily provided by Provider.

- Periodic health assessment/examinations, including all routine tests performed in Providers office, as determined pursuant to accepted practice guidelines as adopted by Plan.

- Miscellaneous supplies related to treatment in Providers office. This includes but is not limited to: gauze, tape, minor surgery trays, injection trays, band-aids, and other routine medical supplies.

- Professional home visits when the nature of illness dictates, as determined by Provider.

- Referral of Enrollee to appropriate consulting physician or ancillary services as medically necessary and according to guidelines established by Plan.

- Telephone consultations with Enrollees and referral physicians.

- Twenty-four (24) hour on-call coverage. Provider is responsible for making financial arrangements with the covering physician.

- All medical care (exclusive of procedures) provided to Enrollees by medical sub-specialists who execute this Agreement.

Providers Questions and Concerns.

- For any questions or concerns, providers may contact Astiva Health's Provider Relations Department by
    - Phone: 833-300-0910
    - Email: providersupport@astivahealth.com
    - Mail: Astiva Health, Inc.
      765 The City Drive South #200
      Orange, CA 92868.

1. Changes in Management Service Organizations (MSO)

- CMGs/IPAs shall notify Astiva Health about the change in MSO with a copy of the executed contract with a new MSO 90 days in advance.
  The new MSO must meet Astiva Health's contract and Delegation requirements such as on- site audits, MSO's policy and procedure for Claims, Credentialing, Health Education and Utilization Management functions. If the new MSO does not meet the criteria, the MSO is responsible for submitting a corrective action plan. Failure of the CMG /MSO to comply will result in panel closure of all providers.

2. Participation Provider Group Specialty Network Oversight

- Astiva Health actively monitors specialty network that is required by State and Federal regulatory to ensure that CMG's service area is covered. Astiva Health will identify and communicate with CMG if any deficiencies are found. The CMG is responsible for obtaining specialist contracts to correct these deficiencies. However, if the CMG is unable to do so, the CMG may utilize Astiva Health's directly contracted specialists.

Section VI: Contract

The Provider Operations/Contracting and Credentialing Departments is responsible for developing and negotiating financially sound contracts with IPAs/Medical Groups, hospitals, ancillary providers, and other health professionals in order to maintain a comprehensive network of health care providers for the provision of covered health care services to members.

Per the Centers for Medicare and Medicaid Services (CMS), contracts between Medicare Advantage Organizations (MAOs) and first tier entities, and first tier entities and downstream entities must contain provisions specifying MA delegation requirements specified at 422.504(i)(3)(iii) and 42 CFR 422.504(i)(4)(i)-(v). A written agreement specifies the delegated activities and reporting responsibilities of the entity and provides for revocation of the delegation or other remedies for inadequate performance. Contracts must indicate what functions have been delegated and must require the entity to comply with the requirements of these standards and of applicable law and regulations.

Per Chapter 11 of the Medicare Managed Care Manual, MAOs must include certain MA-related provisions in the policies and procedures that are distributed to providers and suppliers that constitute the organizations' health services delivery network. The following table summarizes these provisions. Access the CFR online.

CONTRACT REQUIREMENTS SET FORTH THROUGH POLICIES, STANDARDS, & MANUALS

Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for Emergency and Urgently Needed Services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hrs./day, 7 days/week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medical record if individual has executed advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) Administer & evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)
Must make good faith effort to notify all affected members of the termination of a provider contract 30 days before the termination by plan or provider	422.111(e)

CONTRACT REQUIREMENTS SET FORTH THROUGH POLICIES, STANDARDS, & MANUALS CONT.

Submission of data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, QI, and MM	422.202(b); 422.504(a)(5)
Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B
Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers in writing for reason for denial, suspension & termination	422.202(d)
Provide 60 days' notice (terminating contract without cause)	422.202(d)(4)
Comply with federal laws and regulations to include, but not limited to: federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

Contract Cont.

Disclosure of Ownership and Control Interest and Management Statement
Astiva Health providers must fully comply with all state and federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare and Medicaid programs, as described in 42 CFR § 455. A full and accurate disclosure of ownership and financial interest is required. Direct or indirect ownership interest must be reported if it equates to an ownership interest of five percent (5%) or more in the disclosing entity. See: Disclosure To D H C S (ca.gov)

Delegate Entities

Overview
Astiva Health may, by written contract, delegate certain functions under Astiva Health's contracts with CMS and/or applicable state governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales & marketing, utilization management, quality assurance, care management, disease management, claims processing, credentialing, network management, provider appeals and member services.

Astiva Health may delegate all or a portion of these activities to another entity (a Delegated Entity). Astiva Health oversees the provision of services provided by the Delegated Entity and/or subdelegate and is accountable to the federal and state agencies for the performance of all delegated functions. It is the sole responsibility of Astiva Health to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and Astiva Health policies and procedures.

Delegation and Pre-Delegation Oversight Process
Astiva Health's Delegation Oversight Committee (DOC) was formed to provide oversight for all subcontracted vendors where specific services are delegated to an entity. Astiva Health defines a "delegated entity" as a related entity, contractor, subcontractor, first-tier, and downstream entities which performs a delegated function. The Delegation Oversight Committee is chaired by the Compliance Officer. The committee members include appointed representatives from the following areas: Compliance, Legal, Contracting, Credentialing, Provider Relations, Clinical Medical/Pharmaceutical Services, Claims and Quality Improvement. The Chief Compliance Officer has ultimate authority as to the composition of the Delegation Oversight Committee membership. The Delegation Oversight Committee holds quarterly meetings, or more frequently as circumstances dictate.

Astiva Health ensures compliance through the delegation oversight process and the Delegation Oversight Committee by

- Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs
- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity's ability to perform the delegated function

Contract Cont.

- Providing guidance on written agreement standards with delegated entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity
- Conducting ongoing monitoring activities to evaluate an entity's performance and compliance with regulatory and accreditation requirements
- Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated
- Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements.
- Track and trend internal compliance with oversight standards, entity performance, and outcomes.

Opportunities for Improvement

- Astiva Health will identify and follow-up on opportunities and uses information from its pre-delegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.



Section VII: Credentialing

Overview of Credentialing Process

All applicants to Astiva Health must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider.

Astiva Health conducts primary source verification of the applicant's licensure, education and board certification, privileges, sanctions, or other disciplinary action. Astiva Health utilizes the Council for Affordable Quality Healthcare (CAQH) for primary source verification for physicians and allied health providers. The credentialing process may take up to 180-days to complete. Once credentialing has been completed and the applicant has been approved by the Credentialing Committee, the practitioner will be notified in writing.

Providers are required to recredential every 3 years. Providers are required to update and re-verify through CAQH every 3 years. Providers are required to submit recredentialing information in advance of their three-year credentialing anniversary date including the attestation signature date. CAQH will make 3 separate attempts to obtain or verify required information via email, fax, or telephone. Providers that fail to submit required information at least 45 days prior to their recredentialing anniversary date will be notified in writing of their termination from the network.

Note: Providers are responsible for notifying Astiva Health for any change in their medical licensure status in licensing state

Practitioner Selection Criteria
Providers who apply must meet basic credentialing and contract standards. At a minimum, but are not limited to:

- Hold appropriate, current, and unrestricted licensure in the state of practice as required by state and federal entities
- Holds a current, valid, and unrestricted federal DEA and State controlled-substance certificate as applicable
- Is board-certified/board-eligible or has completed appropriate and verifiable training in the requested practice specialty
- Maintains current malpractice coverage, commensurate with the state standard in which the provider practices
- Has a National Provider Identification Number
- Has admitting privileges at participating facilities or affiliations with providers who have admitting privileges

HDO Credentialing Application Process
IPAs, Hospitals, and other network providers must have a fully executed contract with Astiva Health on file with a completed and signed W-9.

Credentialing Cont.

A completed and signed Health Delivery Organization (HDO) Credentialing Application with copies of the following documents:

1. A valid, current, and unrestricted and non-probationary license to operate in the state where it will provide services to our members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. The HDO must not be currently debarred or excluded for participation in Medicare or Medicaid
4. The HDO's liability insurance must meet Astiva Health's minimum requirement of $1M:$3M.
5. If the HDO is not appropriately accredited, our credentialing committee must review a copy of its CMS or state site survey to determine if the HDO meets our quality and certification criteria standards.
6. Application and supporting documentation must not contain any material omissions or falsifications, including any additional information submitted or requested by Astiva Health.
7. Complaints received from members or other providers may be reviewed for compliance with Astiva Health's standards.
8. Performance indicators obtained during the credentialing or recredentialing process, if applicable, must meet Astiva Health's standards.

Non-Discrimination Selection

Astiva Health's credentialing process is in accordance with National Committee for Quality Assurance (NCQA) guidelines. Astiva Health ensures fair and impartial decision-making in the credentialing process and does not make credentialing decisions based on an applicant's race, gender, age, ethnic origin, nationality, sexual orientation, gender identity or due to the type of patients or procedures in which the provider specializes.

Astiva Health will conduct site visits and medical record-keeping practice reviews as deemed necessary. Situations such as patient complaints, quality of care issues, or other state or federal regulations may also warrant a site visit.

Site surveys will include:

- Physical appearance and accessibility
- Patient safety and risk management
- Medical record management and security of information
- Appointment availability

If a provider fails to pass the area specific to a complaint, they will be required to submit a corrective action plan and make corrections within 60 days of the initial site visit.

Site Visits for Unaccredited Facilities

Astiva Health in lieu of a site visit will request or accept a survey from CMS or the State from the Provider or agency, if a survey may not be available, Astiva Health will conduct a site visit when deemed necessary.

Section VIII. Claims Administration

Providers are required to document all services rendered to Astiva members. This requirement is fulfilled by submitting claim forms or encounter data, depending on the type of service involved and specific contractual agreements. Information on various encounter and claim types are included in this section, along with instructions for their submission.

Member Billings

Astiva Members may be billed for applicable co-payments; however, they must never receive a bill for services covered by their Astiva benefit plan.
Astiva members cannot be balanced billed for covered services.
Members must always be advised in advance if non-covered services are offered or will be performed.

Claims Definition

A "clean claim" is one that has no defect, impropriety, lack of required substantiating documentation including the substantiating documentation needed to meet the requirements of encounter data – or circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under original Medicare.

Clean Claims – CMS 1500, UB04

A "clean claim" includes all attachments and supplemental information or documentation that provides "reasonably relevant information" or "information necessary to determine payer liability." The information for a "clean claim" may vary somewhat based on the type of practitioner or provider of service.

The following information must be included on every claim for the claim to be considered complete:

- Provider name and address.
  Member name, date of birth, and/or MBI.
  Date(s) of service; • ICD-10 diagnoses code(s).
  Revenue, CPT, or HCPCS code.
  Billed charges for each service or item provided.
  Place of service or UB04 bill type.
  Provider Tax ID number and/or social security number
  Name and state license number of attending physician.

CMS does not view the lack of an authorization as a component that renders a claim "unclean." Although emergency services or out-of-area urgently needed services do not require authorization in order to be considered "CLEAN," the claim must include:

A diagnosis which is immediately identifiable as emergent or out-of-area urgent, and;
The medical records required to determine medical/necessity/urgency.

Claims Administration Cont.

Claims Documentation

Claim documentation allows Astiva to process claim(s) according to the timeframes defined under the claim processing regulations and guidelines for Medicare members. However, missing documentation can create a delay in adjudicating received claims.

The following is a list of required documentation for both the CMS 1500 and the UB04:

- All Practitioner and Providers of service - The explanation of benefits from all other health care coverage(s) a member has at the time service(s) is rendered. A copy of the authorization or medical records that prove medical necessity
- Dialysis Services - 2728 Form
- Home Health Care Form - No additional documentation required
- Physician (Specialist) - No additional documentation required
- Physician (Surgeons) - No additional documentation required
- Physician (Emergency Medicine) - A copy of the Emergency physician's notes
- Hospital (Emergency Services) - A copy of the Emergency physician's notes
- Physician (Anesthesiologist) - Anesthesia lo

Send all Claims to:

Astiva Health Plan
765 The City Drive South #200
Orange, CA 92868

Timely Filing of Claims

Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service. The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1834(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44.

Exceptions

Section 6404 of the PPACA also permits the Secretary of Health and Human Services to make certain exceptions to the one-year filing deadline. At the time of printing this manual, no exceptions had been established. Contracting providers will be advised of new information pertaining to the Patient Protection and Affordable Care Act as it becomes available through provider bulletins.

Interest Penalty Payment

Interest must be paid at the current rate for the period beginning on the day after the required payment date and ending on the date on which payment is made. The current rate is noted in the Federal Register and is subject to change semi-annually (January 1 and July 1).

Claims Administration Cont.

The following formula is provided as an example only:

365 days divided into an interest rate of 5.25% equals .000144, which is the daily interest rate.

The daily interest rate is multiplied by the number of days beyond 30 days.

The total figure from the previous step should be multiplied by the claim amount to determine the amount of interest payable for a specific claim.

Example: (Because interest rates change every six months, the actual amounts below are not accurate, but the methodology is accurate.)

Claim amount is $1500.00, which is 20 days late.

.000144 X 20=.00288.

00288 X 1500= $ 4.32

The total amount of interest due equals $4.32

Incomplete Professional and Hospital Claims
Claims that are noted as incomplete due to missing documentation are suspended. A letter is sent to the provider requesting the needed information. The claim remains suspended up to the fiftieth (55th) day from the date of receipt. If the requested information is not received, the claim is closed, and the provider is notified that the claim lacks the information required for the claim to be adjudicated.

The claim will be re-considered if the requested information is received within sixty days from the denial date of the claim.

Denied and Adjusted Claims
In the event a claim is denied or adjusted, the provider of service will be given a clear written explanation of cause through the explanation of Benefits (EOB).

Claims Denials
Notification of denied claims that could result in member financial responsibility must include a letter sent to the member with notification of the liability, the reason for the denial, and an explanation of Medicare appeal rights the letter must contain the approved CMS language as stated by the Health Care Industry Collaborative Effort (HICE). For further information, please refer to the HICE website at www.iceforhealth.org.

Claims Administration Cont.

Claims Adjustments
Providers requesting reconsideration of original claims adjustments (partial or complete) please refer to the appeals section of the provider manual for provider dispute resolution.

Claims Investigation
Astiva retains the right to question bills or items if the practitioner is notified of the bill or item in dispute within thirty (30) working days from the date of receipt. The notification from Astiva will be in writing and will identify the specific reasons the claim is being disputed.
In the case(s) of suspected fraud, Astiva has the right to question the bill or item in question for an unlimited period.

Corrected Claim Submission
If you feel that your claim submission has not been processed correctly, please resubmit the claim(s) in dispute with the following information.
Print or stamp "Correct Billed Amount" or" Resubmission" on each claim in dispute and/or;
Include a coversheet with an explanation regarding the reason for the claim resubmission as well as the contested amount.
Corrected claims are processed according to regulatory standards for claims re-submissions.

Claim Appeals
Please see separate section entitled, "Provider Appeals and Grievances."

Coordination of Benefit
When a claim is received for a member covered under both a commercial health plan and Medicare, the following rules will be applied:
The Explanation of Benefits (EOB) from the commercial health plan must be attached to the Claim in order to bill Medicare as the secondary payer.
The commercial plan is always primary, even if the Medicare recipient is the subscriber, spouse or dependent.

Exceptions:
- If the commercial group is less than 20 employees, or;
- If the member has end stage renal disease for more than 30 months.

Medicare Secondary Payer (MSP) Guidelines:
When a claim is received for a dually eligible member (Medi-Medi member with both Medi- Cal and Medicare coverage), Medicare is the primary payer and Medi-Cal is the secondary payer.
When a claim is received for a Medicare member with workers' compensation, Medicare is secondary.

Claims Administration Cont.

When a claim is received for a Medicare member with workers' compensation, Medicare is secondary.

When a claim is received for a Medicare member with other insurance liability, Medicare is secondary.

When Astiva is secondary, an explanation of benefits (EOB) from the primary carrier must be submitted with a copy of the bill for consideration.

If the bill is submitted to Astiva or the Contracted Medical Group first, and the other carrier is primary, Astiva or the Contracted Medical Group must notify the practitioner of service that the claim will be closed until the EOB is received from the primary carrier.

Third Party Liability

Subrogation - means to "substitute" one person for another. The subrogation provision in Astiva's contracts gives Astiva the right to make a legal claim for reimbursement of benefits paid on behalf of a member from a third party who has caused, or is responsible, for the member's injury or illness. Under subrogation, Astiva may initiate legal action such as a lawsuit, against the responsible (liable) third party.

Reimbursement - allows Astiva to be reimbursed by the member if he/she receives compensation from a third party. The difference between subrogation and reimbursement is that Astiva does not have the legal right to initiate a lawsuit against a third party who has caused, or is responsible, for the member's injury or illness, where such third party has already paid the member.

Potential subrogation/reimbursement claims include, but are not limited to:
- Injuries such as strains or sprains - ICD-10 range of 700.
- Any type of accidental injury, including motor vehicle accident, slip and fall, product/equipment defects.
- Any injury or illness related to member's employment injuries that occurred on property other than the members.
- Medical procedures that may be due to malpractice.
- Correspondence received from an attorney stating he represents the member in a third party or Workers' Compensation action.

Reimbursement and subrogation are similar in that they both seek to recover benefits paid (or payable) to a member for illnesses or injuries caused by a third party. In reimbursement, an HMO may pursue reimbursement only if the member chooses to sue for, or receives, a settlement, either with or without a lawsuit. If the member does sue, the HMO can file an intervention complaint in any pending lawsuit between the member and the liable third party at any time prior to the final disposition of such lawsuit. In subrogation, the HMO has the right to sue the third party directly whether the member chooses to do so.

Claims Administration Cont.

Workers' Compensation - is insurance coverage mandated by law for employers to carry for the direct benefit of their employees. In general, it provides medical benefits and disability benefits to employees as the result of work-related injury or illnesses. Health insurance benefits do not provide services for work-related conditions that are covered by workers' compensation insurance.

In cases where Astiva member has requested that the Provider treat work- related condition, Astiva may legally seek recovery from the member's employer's Workers' Compensation carrier to the extent of Astiva's medical expenditures and costs. The law provides for formal filing of liens in pending Workers' Compensation actions because the employers' Workers' Compensation coverage has primary responsibility for treatment or work-related conditions. Astiva may file its own action before the Workers' Compensation Appeals Board for reimbursement of benefits paid on behalf of a member if the member does not file an action.

No Fault - No-fault refers to automobile insurance laws that are in effect in many states. The automobile insurance company that covers the owner of the car in which the injured person was riding provide these laws mandate that compensation for injuries sustained in an automobile accident. There is usually a limit to the amount the no-fault carrier will cover; this limit varies from state to state. California is NOT a no-fault state; however, a person from California may get hurt by a third party who lives in a state that is a no-fault state. The California claimant files a lawsuit (if they are not the cause of the accident) directly against the negligent/liable third party to seek reimbursement for damages. Astiva recovers its financial outlay for medical care costs in such cases.

Uninsured Motorist automobile insurance coverage is covered under the No-Fault rules. If a member is involved in a motor vehicle collision and the third party, responsible for the collision and resulting injuries and damages, does not have automobile liability insurance, the insurance company covering the owner of the car in which the member was riding (or driving) "steps into the shoes" of the uninsured motorist, affording the member the same insurance benefits that would have been available had the third party been insured. Astitva's right of reimbursement in this case would be the same as for all other third-party liability situations.

Home Health Payments: Astiva Health adheres to Original Medicare payment requirements in most cases. With the phase out of Medicare RAP payments. Starting January 1, 2022, Medicare requires HHA to submit a one-time NOA, instead of RAPs. You will send NOAs using TOB 32A. Then, you will use TOB 329 for POCs following submission of the NOA.

CR 12256 updates Chapter 10 of the Medicare Claims Processing Manual to describe these changes and to give you detailed NOA submission instructions and revised billing instructions. HHAs must submit an NOA to their MAC or plan partner within 5 calendar days from the start of care date. There will be a non-timely submission reduction in payment amount tied to any late NOA submissions when you don't submit the NOA within 5 calendar days from the start of care. The reduction in payment amount would be equal to a 1/30th reduction to the wage adjusted, 30-day period payment amount for each day from the HH start of care date until the date you submit the NOA.

Claims Administration Cont.

If you fail to send the NOA timely, you may request an exception, which, if approved, waives the consequences of late filing.

Audit and Recovery
Should Astiva determine that it has overpaid a practitioner or provider of service, written notice that includes: the name of the patient, the date of service, the amount of the overpayment, all interest and/or penalties associated with the overpayment and the reasoning that determined an overpayment had been made must be mailed to the provider of service?

The provider of service must reimburse Astiva or provide a clear written explanation as to why the request for overpayment is being contested within thirty (30) working days, or according to applicable Federal Standards, of receipt of the notice of overpayment. The request for return of an overpayment must be made by Astiva within one (1) calendar year from the date of service.

If the practitioner or provider of service contests the notice of overpayment, the practitioner or provider of service must notify Astiva within thirty (30) working days of receipt of the notice of overpayment, identifying the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

Send to:

Astiva Claims Dept.
765 The City Drive South #200
Orange, CA 92868

Should the provider of service fail to notify Astiva of a contested overpayment or return an overpayment within thirty (30) working days, the amount of the overpayment will be deducted from all future claim(s) payment(s) until Astiva has been fully reimbursed. A written explanation will accompany all deductions made from future claims payments.

Encounter Data
An encounter, for our purposes, means a single “face to face” visit or medically related service rendered by (a) licensed provider(s) in an Ambulatory Care or an Inpatient Facility setting to an Eligible Beneficiary enrolled with Astiva during the date(s) of service. It includes all services rendered to an Astiva member. Services that are covered under the capitation agreement are submitted as encounter data, also known as “no pay claims” or “shadow claims.”

Claims Administration Cont.

The collection of encounter data is required by the Centers of Medicare and Medicaid (CMS or "Medicare") and services the following purposes:

- Allows Astiva to determine that all necessary medical services are provided to our members in a timely manner.
- Provides information required by CMS that the plan is required to forward to CMS for financial purposes including the capture of appropriate "HCCs" (Hierarchical Condition Categories)
- Provides Astiva and its Providers with comparative data.
  Supports HEDIS and Star activities required by CMS
- Supplies Astiva with information that would support the production of Provider profiles and quality indexes.
- Enables Astiva to submit required risk adjustment data to the Centers for Medicare and Medicaid (CMS) to insure appropriate monthly payments per member.

Medicare requires encounter data reporting. The amounts and types of encounters submitted may affects the capitation rates that CMS pays plans and indirectly affects the rates that plans pay providers.

Providers are required to submit encounter data, to Astiva, by the fifteenth (15th) of each month for the previous month. To obtain details regarding how to submit encounters, please call 833.300.0910.

Astiva does accept electronic encounters from Office Ally electronic data exchange. Contact your provider service representative to assist in the set-up of this service.

Section IX: Capitation Payment and Reports

Payment

Astiva Health remits payment to its Contracted Providers and Participating Providers on or after the tenth (10) day of the month. The capitation payment is based on an agreed-upon percentage of the Monthly Parts A and B portions of the payment or adjustment dollars as detailed in the Monthly Membership Report ("MMR") received monthly from CMS, in addition to the Parts A and B Cost-Sharing Reduction portions of payment or adjustment dollars and minus the Medicare Second Payer ("MSP") Reduction portions of the payment or adjustment dollars. Depending on the individual contract, some other rebates could also be included in the payment amount. Rate schedules are outlined on a per-contract basis in attachment D-1 ("Medicare Program Compensation") of the Provider and/or Medical Group services agreement. For further information regarding compensation, please refer to the Provider or Medical group services agreement.

Claims Administration Cont.

Reports

Capitation Reports are placed in a protected SFTP site assigned to the Provider on or before the 10th of each month. The Detail Report summarizes capitation by the Provider and/or practitioner and identifies currently active enrollees, capitation amounts, and months paid along with additional detail.

CAPITATION FILE LAYOUT

Field #	Field Name	Length	Field Type	Comments
1	LASTNM	40	CHAR	Member last name
2	FIRSTNM	30	CHAR	Member first name
3	MI	1	CHAR	Member middle inital
4	SEX	1	CHAR	Member gender (M or F)
5	DOB	8	NUMERIC	Member date of birth (YYYYMMDD)
6	PHONE NUMBER	10	NUMERIC	Member phone number (XXXXXXXXXX)
7	ADDRESS	80	CHAR/NUMERIC	Member address line 1
8	ADDRESS2	20	CHAR/NUMERIC	Member address line 2
9	CITY	20	CHAR	Member city
10	STATE	2	CHAR	Member state
11	ZIP	5	NUMERIC	Member zip code
12	MEMBID	12	CHAR/NUMERIC	Member Internal Health Plan ID
13	MBI	11	CHAR/NUMERIC	CMS Member Medicare Beneficiary Identifier
14	Contract Number	5	CHAR/NUMERIC	Plan Identifier from CMS (H1993)
15	PBP	3	NUMERIC	Plan Benefit Identifier (XXX)
16	Effective Dt	8	NUMERIC	Member Health Plan effective date (YYYYMMDD)
17	Term Dt	8	NUMERIC	Member Health Plan termination date (YYYYMMDD)
18	MEDICAID	1	CHAR	Member Medicaid/Medical Status from application (Y or N)
19	LANGUAGE	3	CHAR	Member preferred language
20	PCP NPI	10	NUMERIC	PCP 10 digit NPI number
21	PCPSTARTDT	8	NUMERIC	PCP start date with member (YYYYMMDD)
22	HOSPICE STATE DATE	8	NUMERIC	Hospice start date reported by CMS (YYYYMMDD)
23	HOSPICE END DATE	8	NUMERIC	Hospice end date reported by CMS (YYYYMMDD)
24	ESRD	1	CHAR	Member End Stage Renal Disease status (Y or N)
25	ESRD START	8	NUMERIC	Member ESRD Start Date (YYYYMMDD)
26	ESRD END	8	NUMERIC	Member ESRD End Date (YYYYMMDD)
27	MSP	1	CHAR	Medicare as Secondary Payer reported by CMS (Y or N)
28	INSTITUTIONAL	1	CHAR	Member admitted into skilled nursing or home health agency reported by CMS (Y or N)
29	NEW MEDICARE BENEFIARY MEDICAID STATUS FLAG	1	CHAR	Medicaid/Medical reported by CMS (Y or N)
30	LTI FLAG	1	CHAR	Long term institutional reported by CMS (Y or N)
31	PCP ID	13	CHAR/NUMERIC	PCP 13 digit internal identification
32	PCP FULLNAME	70	CHAR	PCP full name
33	COMPANY_ID	26	CHAR	IPA mnemonic identification
34	MEDICAIDID	20	CHAR	Medicaid ID

Section X: Prescription Drug Benefits and Pharmacy Services

Overview
Astiva Health operates Medicare Advantage Prescription Drug Plans, offering comprehensive pharmacy services, including formulary management, clinical programs, and pharmacy network management.

1. Formulary
Astiva Health's Part D formulary is a list of covered outpatient drugs approved by CMS. Consistent with Part D program requirements, the formulary provides access to an acceptable range of Part D drug choices.

Astiva Health's formulary includes brand and generic drugs on different pricing levels, a six-tiered copay structure. Drugs at the lowest copay tier level will cost less than drugs at the highest copay tier. Similarly, non-formulary drugs are placed at the higher copay tier. Prescribers and members are encouraged to adhere to drugs on the formulary for the most cost-effective coverages, whenever appropriate.

- **Tier 1:** Preferred Generic Drugs - Includes lower-cost, common generic drugs (lowest member cost share)
  Tier 2: Generic Drugs - Includes many generic drugs.
- **Tier 3:** Preferred Brand Drugs - Includes many common brand-name drugs.
- **Tier 4:** Non-Preferred Drugs - Includes non-preferred generic and non-preferred brand name drugs.
- **Tier 5:** Specialty Drugs - Includes unique and/or higher-cost drugs
- **Tier 6:** Select Care Drugs - ($0 member cost share)

Astiva Health's formulary is updated monthly, and negatively impacted members will be notified 30 days prior to the effective date of the change and a transitional fill up to 30-day supply of the drug. However, if a drug has been removed due to safety reasons, Astiva Health will not provide a 30-day advance notice before removing the drug from the formulary. Instead, we will remove the drug from the formulary immediately and notify members about the change as soon as possible.

To access latest formulary updates, prior authorization criteria and forms, and pharmacy directory, please visit https://astivahealth.com/en-us/resources. Formulary Information.

For a printable formulary, visit
https://astivahealth.com/en-us/resources.

Providers can also contact Member Experience Services at 1-866-688-9021

2. Coverage Determination and Exception Requests
Astiva Health delegates Part D utilization management to Medimpact to ensure safe and effective, as well as ensuring that Part D drugs are used only for medically accepted indications.

Prescription Drug Benefits and Pharmacy Services Cont.

Providers can find out if prescribed drugs are subject to utilization management edits by checking the formulary. Coverage Determinations request can be made to Medimpact verbally or electronically. Please include ALL pertinent clinical information including relevant labs with your Prior Authorization request to ensure complete prompt review.

• **Electronically (Preferred):**
- Cover My Meds -
https://www.covermymeds.com/main/prior-authorization-forms/elixirsolutions/
- Surescripts - https://providerportal.surescripts.net/ProviderPortal/login
• Phone: 833-674-6200
• Fax: 877-503-7231

A determination will be made no later than seventy-two (72) hours from the date the standard request is received. For urgent requests, a determination will be made no later than 24 hours from the date the request is received. The member and the member's provider will be given notice of the coverage determination decision.

3. Part D Vaccines
Astiva Health provides coverage for Part D vaccines through retail network pharmacies. Covered vaccines include, but are not limited to shingles, M-M-R II, flu vaccine, and T-DAP. Part D vaccines administered at retail network pharmacies provide convenience and reduce members' out-of-pocket costs.
A complete list of the Part D vaccines can be found on Astiva Health's Formulary.

4. Network Pharmacy
Astiva Health members must use network pharmacies to obtain their outpatient prescription drugs. Members can generally get up to a 90-day supply in Tiers 1, 2, 3, and 6. Tier 4 and 5 are limited to 30-day supply.
Providers can locate network pharmacies at:
https://www.envisionrx.com/clients/pharmacylocator.aspx

5. Medication Therapy Management Program
Astiva Health Medication Therapy Management Program (MTMP) is a no-cost service offered to members who use a number of Part D covered prescription drugs and have a number of medical conditions. The program helps members and doctors manage the prescribed drugs to optimize therapeutic outcomes and reduce potential risk of adverse drug problems through a comprehensive review of all medications.

Members are automatically enrolled in this voluntary program if they meet all of the following three criteria:

a) Have three or more of the following chronic conditions: Alzheimer's Disease, Bone Disease-Arthritis-Osteoporosis, Chronic Heart Failure (CHF), Diabetes, Dyslipidemia, Hypertension, Respiratory Disease-Asthma, Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD)

Prescription Drug Benefits and Pharmacy Services Cont.

b) Take eight or more Medicare Part D covered drugs
c) Expect to spend more than a $1,623 in 2025 on covered Medicare Part D prescriptions

The MTMP eligible Members' prescriber(s) is/are also provided with recommendations for drug-therapy changes to resolve medication-related problems or to optimize therapy. Astiva Health also performs targeted-drug-utilization reviews quarterly and may contact Members or their Providers directly if there are questions or recommendations for their medications.

6. Opioid Overutilization Policies
In accordance with CMS policy, Astiva Health implemented Opioid Drug Management Program (DMP). The DMP encourages interdisciplinary collaboration, as well as care coordination among Part D plans, pharmacies, prescribers, and patients in improving opioid utilization management, preventing opioid misuse, reducing serious adverse risks, and promoting safer prescribing practices. The new policies include improved safety alerts when opioid prescriptions are dispensed at the pharmacy and drug-management program for patients determined to be at risk for misuse or abuse of opioids or other frequently abused drugs.

If a member is identified as being potentially at risk for prescription drug abuse, as part of the case management process, Providers who prescribed opioids and benzodiazepines will be contacted for clinical information needed in order to decide on whether the member is at risk and should have his/ her access to frequently abused drugs limited. Prescribers are expected to respond to pharmacists' outreach in a timely manner and give the appropriate training to on-call prescribers when necessary to resolve opioid safety edits expeditiously and avoid disruption of therapy. Prescribers may also proactively request a coverage determination in advance of prescribing an opioid prescription to avoid a prescription being rejected at the pharmacy.

Section XI: Emergency Care Services

Astiva Health Care complies with California and/or Federal legislation, accreditation standards, regulations regarding emergency care, and post stabilization services.

Astiva Health covers emergency services necessary to screen and stabilize members without prior authorization in cases in which a prudent layperson, acting, would have believed that an emergency existed.

Post stabilization services in the emergency room are covered if an authorized representative acting for the managed care organization has authorized the provision of post stabilization services.

Emergency Care Services Cont.

Definitions

Emergency Medical Condition: means "a medical condition manifesting itself by acute symptoms of sufficient severity (includes severe pain) such that the absence of immediate medical attention could be expected to result in any of the following:

• Placing the patient's health in serious jeopardy.
• Serious impairment to bodily functions, and.
• Serious dysfunction of any bodily organ or part."

Emergency services and care means "medical screening examination (MSE), and evaluation by a practitioner, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and if it does, the care, treatment, and surgery by physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility."

Stabilization:
Astiva Health uses the definition of stabilization according to the California Task Force of Emergency Care to managed care plan members. The definition is as follows:

"The term to stabilize with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from the transfer or discharge of the individual from a facility."

Prudent Layperson: means "any person who could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm to the individual."
Active Labor: means "labor at a time at which either of the following would occur:

• There is inadequate time to affect safe transfer to another hospital prior to delivery per the American College of Obstetrics and Gynecology (ACOG) guidelines, and
• A transfer may pose a threat to the health and safety of the patient or unborn child per ACOG guidelines."

Emergency Services and Post Stabilization
Medicare guidelines prohibit a Provider and Astiva Health from requiring prior authorization for the provision of Emergency Services necessary to stabilize the Member's emergency medical condition. Astiva Health and its delegated CMGs affiliates are available to provide, or to provide authorization/ tracking number(s) for, post stabilization treatment requests on a twenty-four (24) hour call always.

Emergency Care Services Cont.

Astiva Health maintains an emergency telephone number by which members can contact Astiva Health plan 24-hours a day 365 days/year to obtain information regarding emergency treatment. If Astiva Health or the Provider does not respond with an authorization within thirty (30) minutes of notification by emergency room after stabilizing the patient, the emergency room and their physician(s) may proceed with any treatment they deem necessary and Astiva Health will be financially responsible for any ensuing necessary covered treatment. Please refer to the Division of Financial Responsibility (DOFR) Matrix in the Medical Group Services Agreement to determine the party financially responsible for providing or arranging these covered services.

Text of Emergency Services and Post Stabilization

Prior to stabilization of an enrollee's emergency medical condition, or during periods prior to stabilization when immediate medically necessary health care services are required, a health care service plan will pay for all medically necessary health care services rendered regardless of whether the health care provider is contracted or not contracted with Astiva Health for the provision of health care services.

In the case when an enrollee is stabilized and does not require additional immediate medically necessary health care services, the following applies:

- Astiva Health or delegated CMG shall respond to a health care practitioner's request for authorization to provide post-stabilization medical care within thirty

(30) minutes of the request, and Astiva Health or CMG shall pay for all medically necessary health care services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the health care service plan initiates the enrollee's transfer or discharge.

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on Astiva Health and the CMGs.

Ambulance Service in Care of Emergency

Emergency ambulance transportation is now defined as a "Basic Health Service" under the Health and Safety Code.

The Benefit Defined

The ambulance benefit is defined in title XVIII of the Social Security Act (the Act) in §1861(s)(7): "ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." This statutory definition incorporates by reference the regulations there under, which are those at 42 CFR §410.40 (Coverage of ambulance services) as well as the regulations at 42 CFR §410.41 (Requirements for ambulance suppliers) which are, themselves, incorporated into §410.40 by reference in §410.40(a)(1). Thus, in effect, §1861(s)(7) of the Act together with 42 CFR §§ 410.40-410.41 comprise the ambulance benefit definition.

Emergency Care Services Cont.

"Technical Denials" Where the Ambulance Definitions is not met

The key feature of the statutory definition is the clinical requirement "where the use of other methods of transportation is contraindicated by the individual's condition" which can be expressed as a "clinical medical necessity" requirement that defines the benefit. The cited regulations interpret and enunciate this clinical aspect of the benefit definition but do so most explicitly in §410.40(d) (Medical necessity requirements). It is important to understand that this clinical medical necessity aspect is a component of the definition of the benefit and that, therefore, clinical medical necessity of the ambulance service is determinative of whether a particular ambulance service is a covered Medicare benefit. That means that any such service which is not clinically medically necessary within the parameters of the definition in §1861(s)(7) & 42 CFR §§ 410.40-410.41 is not a benefit and payment is denied (a "technical denial") under §1861(s)(7). Such denials are not under §1862(a)(1); that is, they are not "medical necessity denials" in the commonly understood sense. The phrase "medical necessity" is used in connection both with the clinical aspect of the §1861(s)(7) benefit definition and with the Medicare program exclusion under §1862(a)(1), giving rise to considerable confusion as to the statutory basis for denials of ambulance claims and the attendant financial liability implications.

Medical Necessity Denials of Covered Ambulance Services

For a claim for an ambulance service to be denied by Medicare (in part or in full) as "not reasonable and necessary" under §1862(a)(1), two criteria must be met: that particular ambulance service would have to fully meet the benefit definition under §1861(s)(7), i.e., it would have to be a Medicare covered service; and That ambulance service (in part or in full) would have to be determined to be "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the criterion of §1862(a)(1)). Thus, for example, a transport by air ambulance (which is a covered benefit under §1861(s)(7)) when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation may entail a "medical necessity denial" under §1862(a)(1) of the "air component" of the service.

Physician Referral to Emergency Room

Upon primary care physician (PCP) notification by the member of the intent to use emergency care services:

The PCP (or on-call physician) is responsible for notifying the emergency room of the referral.

- The PCP (or on-call physician) is responsible for directing the member to the appropriate medical group affiliated hospital if patient condition does not require use of the closest facility regardless of contractual agreements.

Expedited Organization Determination

To better address the needs of our members and to improve compliance with the regulatory requirements of the Centers for Medicare and Medicaid Services (CMS), Astiva Health complies with the following Expedited Organization Determination (EOD) process:

- Members and Providers on behalf of the member are to contact Astiva Health with request for EODs
  - Phone 866-688-9021 or TTY: 711
  - Fax: 714-908-8055

Emergency Care Services Cont.

- Astiva Health will track the request to ensure completion within 72 continuous hours or 24-hours for Part B drugs, including weekends and holidays.
- Astiva Health will provide authorization or denial.
- Astiva Health will continue to make the decision (determination) to authorize or deny service(s) Astiva Health will notify the member of the decision (determination) by phone.Astiva Health processes all expedited requests in an accelerated manner, ensuring a decision and notification to the member within 72 hours or 24-hours for Part B drugs or less. Astiva may only extend the 72-hour timeframe for items and services up to 14 additional days if:
    - The enrollee requests the extension; or
      The extension is justified, in the enrollee's interest, and additional medical evidence from a non-contract provider is needed in order to make a decision favorable to the enrollee (i.e., the MA plan should not extend the timeframe to get evidence to deny the coverage request); or
    - The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest.

Part B drug timeframe cannot be extended

Standard Organization Determination
An organization determination will be made as expeditiously as the Member's health condition requires, but no later than 14 calendar days or 72 hours for Part B drugs after Astiva receives the request for service. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if Astiva justifies a need for additional information and documents how the delay is in the interest of the Member. Part B drug timeframes cannot be extended.

Second Opinion
Members have the right to a second surgical/medical opinion in any instance when the Member disagrees with his or her Provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness. The second surgical/medical opinion, if requested, is to come from a Provider chosen by the Member who may select:

- A Provider who is participating with Astiva, or
- If a network Provider is not available, a non-participating provider located in the same geographical service area of Astiva
- In the event the recommendations of the first and second physicians differ, a third opinion is also covered.

Emergency Care Services Cont.

Continuity of Care
When a member is in active treatment with a provider who is not part of Astiva's Provider network, Astiva will permit the Member to continue the ongoing course of treatment with the non-participating provider until the treatment concludes, or the Member has stabilized, and it is clinically appropriate for the Member to transition to an in-network Provider if one is available.

Continued Care with a Terminated Provider
When a Provider terminates participation in Astiva's network, or is terminated by Astiva without cause, Astiva will provide coverage for Members in active treatment to continue either through the completion of their condition (up to 90 calendar days) or until the Member selects a new Provider. Care provided after termination shall continue under the same terms, conditions, and payment arrangements as in the terminated contract.

Hospitals Responsibility for Care in the Emergency Room
Hospitals are required to provide Astiva Health with an Emergency Room Report along with the claim prior to payment. The appropriate co-payment for the emergency room treatment is to be collected by the hospital at the time of treatment unless the emergency room evaluation results in a hospital admission, in which case the emergency room co- payment is waived (in most cases) and the inpatient co-payment/deductible applies.

The hospital is responsible for notifying Astiva Health immediately upon the decision to admit a patient to verify coverage for all admissions. Members must be directed back to their PCP for ALL follow up care after an emergency room visit or hospital admission.
Astiva Health's Utilization Management Department can be reached at 949-393-8871 from 8am to 5pm.

The Triage Advice Line is available twenty-four (24) hours a day, 7 days a week to assist in the above processes.

Section XII: Utilization Management

The purpose of the Utilization Management (UM) Department is to maintain a comprehensive, coordinated process, which promotes and monitors the effective utilization of health care resources within Astiva Health delivery system through prospective, concurrent, and retrospective review. The UM process influences the continuum of care by evaluating the necessity and efficiency of health care services and effecting patient care decisions through assessments of the appropriateness of care. The UM process puts systems in place to monitor those services are available in a timely manner, provided in appropriate settings and that services are planned, individualized, and evaluated for effectiveness. UM evaluates medical necessity, medical appropriateness and efficient use of medical services, procedures, and facilities, including specialty care, inpatient, outpatient, home care, skilled nursing services and ancillary services

Utilization Management Cont.

Requesting an authorization/Referral

You may contact us via telephone: 949-393-8871 or TTY: 711 or fax: 714-908-8055
Please see the authorization request form at back of this Chapter, it must be completed in entirety, to avoid a delay in the provision of a requested service.

The following services require prior authorization (services must be authorized prior to provision of a service):

Inpatient admissions
Ambulance
Bariatric related services
Behavioral health and substance abuse outpatient services
Clinical trials
Dermatology services

Experimental/investigational services and new technologies
Home health
Occupational/speech therapy
Orthotics
Outpatient diagnostic procedures
Outpatient physical therapy, chiropractic care and acupuncture
Prosthetics
Self -Administered injectables

- Specialty care referrals
- Surgical procedures
- Transplant related services

Automatic Referrals Process

It is the policy of Astiva Health to provide PCP(s) with automatic referral access to a limited panel of specialists when the following conditions are met:

- The request is for initial consultation only
- The PCP is contracted with Astiva Health
- The member must visit his/her PCP first; the PCP may refer the member to a specialist identified on the EZ Cap System; or the PCP may submit a regular referral form.
  The PCP should use all available resources (within Astiva's Network, and other providers within the medical group; or second opinions within a scope of practice of other providers within the medical group).
  The direct referral form and any pertinent medical records must be given to the patient prior to the patient leaving the PCP(s) office. Additional copies must be given to the following:
  Fax a copy to the specialists
  The member must be eligible on the date of service. Follow-up visits requested by the specialists must be sent to the members PCP(s). The PCP must determine medical necessity of the request for follow up. If the PCP deems that it is medically necessary, then the PCP shall forward the request to the UM Department for authorization referral.

Utilization Management Cont.

Automatic referral exclusions include but are not limited to the following:

- Genetics and Genetic testing
- Plastic Surgery
- Cosmetic Procedure
- Infertility
- Weight Control
- Pain Management
- Transplant Services
- Experimental/investigational Consultation
- DME
- Home Health
- Dental Anesthesia
- Non-Emergency Ambulance
- Non- Contracted Referral Requests

The automatic referral expires ninety days (90) from the initial authorization date by the PCP

Specialist Follow Up Visit

The member's PCP will be asked to determine when a follow-up visit can be provided by the PCP or required follow-up by the specialist. The specialist is expected to provide a timely report to the PCP after the visit.

Concurrent Review

Concurrent reviews are reviews for extension of a previously approved course of treatment over a period or number of treatments. This includes services such as inpatient care, ongoing home health, durable medical equipment needs, pharmacy needs. Inpatient concurrent review for continued stay is considered urgent. SB 59: Care shall not be discontinued until the enrollee's treating provider has been notified of the Plan's decision, and the treating provider that is appropriate for the medical needs of that patient has agreed upon a care plan.

Patient Follow Up After Discharge

Astiva Health UM Department maintains a log of current inpatient admissions. Upon discharge, the UM Concurrent Review Coordinator is verbally notified, and a follow-up appointment is scheduled within seven (7) days of discharge.

Notice of Medicare Non-Coverage (NOMNC)

All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end:

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Skilled Nursing Facilities (SNFs)

Utilization Management Cont.

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers (HHAs, CORFs or SNFs) are responsible for the delivery of the NOMNC

The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or no later than the next to last time Covered Services are Provided.

Detailed Explanation of Non-Coverage (DENC)
Medicare providers are responsible for the delivery of the DENC to beneficiaries who request an expedited determination by the Quality Improvement Organization (QIO). The DENC explains the specific reasons for the end of covered services. The DENC must contain the following information:

- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.
  A specific and detailed explanation of why services are both no longer reasonable and necessary or no longer covered.
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.

Notice of Hospital Discharge Appeal Rights
Hospitals must issue the Important Message within two calendar days of admission, obtain signature of the patient or the signature of their authorized representative, and provide a signed follow-up copy to the patient as far in advance of discharge as possible, but not more than two calendar days before discharge

Transition of Care
Astiva Health makes a special effort to coordinate care when members move from one setting of care to another: moving from hospital to home, hospital to skilled nursing facility, hospital to home for home health care, etc. Without coordination, such transitions often result in poor quality care and risks to patient safety. The Astiva Health transition of Care Process is focused on managing planned and unplanned care setting transitions, identifying unplanned transitions, and reducing transitions.

Astiva manages care transitions, identifies problems that may result in unplanned transitions, where possible prevents unplanned transitions, and educates members regarding ways to avoid having a transition. Astiva makes a special effort to coordinate care when members transition from one level of care to a higher or lower acuity.

Medicare Data Exchange
Primary Care and Specialists may share medical information for Astiva members. Astiva also uses encounter, claims, and pharmacy and lab data to disperse information.

Direct Prior Authorization Referral

765 The City Drive South, Suite 200
Orange, CA 92868
Phone: (949) 393-8871
Fax: (714) 908-8055

☐ Standard (decision time 14 calendar days / 72 hours for Part B drugs)

☐ Expedited (decision time 72 hours / 24 hours for Part B drugs)

Member Demographics

Member Name: _____ **DOB:** _____ **Male/Female (circle one)**

Member address: _____

Phone number: _____**Member ID:** _____**PCP name:** _____

Referring Physician: _____ **ICD 10 codes:** _____ _____ _____

Phone number: _____**Fax Number:** _____

Office instructions:
Fax this form to Astiva Health UM dept. (714) 908-8055, complete the "Reason for Referral" section below and submit all clinical records to support this referral request.

Reason for Referral

Referred to Provider: _____**Provider phone:** _____**Fax:** _____**Contracted:** ☐ **Yes** ☐ **No**

Provider Address: _____**NPI/Tax ID:** _____

Specialty Service Request (check one): ☐ **Procedure** ☐ **DME** ☐ **Consult** ☐ **Follow up** ☐ **Radiology**

Place of Service: _____ **Diagnosis/ICD 10 codes:** _____

CPT Code: _____ _____ **NCD codes:** _____ _____ _____ **Service Requested:** _____

Clinical reason for referral: _____

Attached information: Labs _____**Radiology:** _____**Progress notes:** _____**Other:** _____

Requesting Provider Signature: _____**Date:** _____

******If the physician would like to discuss this case with the Medical Director or would like a copy of the criteria used to make this decision, please call the number listed on the fax cover sheet of your decision letter. AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE Do not schedule non-emergent services until authorization is obtained.**

Section XIII: Delegation of Utilization Management

Delegation of Utilization Management (UM) will be granted only to those Contracted Medical Groups that meet the standards outlined in the Contracted Medical Group UM Delegation Standards.

Astiva reviews the plans, policies, and procedures to evaluate each Contracted Medical Group when conducting semi-annual performance and outcomes monitoring and the annual audit. Activities, which may be monitored and reviewed for the delegated entity throughout the year, will include:

- UM meeting minutes for the past year
- UM Program
- Policies and procedures for UM
  Denial letters with Medical Records
  Authorizations with Medical Records
  Case Management Records if a delegated function and/or upon request by the health plan
  UM Workplan / Evaluation reports
  UM statistics including, but not limited to:
  Bed days per 1,000 members
  Average length of stay per 1,000 members
  Emergency room visits per 1,000 members
  Percentage of service denials
  Under- and over-utilization, including analysis of trends and documented actions to improve performance
  Readmission rates of inpatient hospitalizations
  Documented process to provide access to practitioners and members interested in information about UM decisions and the UM program
  Data pertinent to determining compliance with federal and state regulations
- Job descriptions for UM staff and physicians require education, training, and professional expertise in clinical medical practice. All clinical staff must have evidence of clinical licensure and an unrestricted California license.

Utilization Management Delegation Standards Overview
Astiva Health as the Managed Care Organization (MCO) is responsible for the management and provision of care to all contracted members. A large portion of this health care is provided through contractual arrangements with Independent Provider Association/Medical Groups (Contracted Medical Groups) throughout Southern California. Additionally, contractual arrangements have been established with other vendors such as Optometry and Dental services. These entities, based on our monitoring of their demonstrated performance to comply with the requirements of the Astiva Health UM Program, will be delegated for certain Utilization Management (UM) administrative functions.

Delegation of Utilization Management Cont.

When a group is delegated for UM, it is responsible for all UM functions delegated to them, for all Astiva Health members assigned to them, unless the services are excluded from delegation by the Delegation Agreement or Contract.

Contracted Medical Groups are not delegated for appeals, experimental and investigational procedure determinations, cancer clinical trials, specific major organ transplants, and any prescriptions which require prior authorization from Elixir. Reference specific DOFR regarding financial responsibility.

For the entities to qualify for initial delegation status, pre-delegation audits are performed. Delegation status, whether in total or in part, is renewable annually but can be revoked upon Astiva Health's determination that the entities are no longer able to meet the delegation requirements. In addition, the group may qualify for delegation with corrective actions.

Additional auditing and review of compliance is conducted at least annually in conjunction with other oversight measures, and more often as appropriate, to evaluate the entity's ability to continue in the delegated status.

An evaluation of the entities' abilities to perform delegated utilization management activities is conducted within twelve months prior to contracting, or prior to delegation for entities already contracted with Astiva Health and at least once annually thereafter. The outcome of the evaluation determines the delegation status. This process ensures that the standards set by Astiva, and all appropriate governing regulatory agencies, are met.

As part of the ongoing oversight, the entities must comply with reporting requirements and submit required documentation. Astiva Health Delegation Oversight auditor reviews the submitted documentation for compliance once a year prior to the annual evaluation. Entities will be evaluated for their compliance with legislative, CMS and NCQA standards for delegation of utilization management functions using Astiva Health Standardized Utilization Management Audit Tool and Scoring Guidelines.

Timely Submission of Corrective Action Plans
Upon identification of deficiencies, Astiva Health will outline the deficiencies in writing and send a "Request for Corrective Action" letter to the Contracted Medical Group. The entities are required to submit a written and signed Corrective Action Plan (CAP) for approval within 30 calendar days. The submitted CAP must define time frames, specific measurable actions, and identify key staff responsible for implementation and oversight.

Submission of a CAP within agreed upon time frames will be tracked by Astiva Health.

Delegation of Utilization Management Cont.

Astiva Health will review the implementation of the CAP to ensure correction of the deficiencies within 60 days or an agreed timeframe from the date of receipt of the CAP response. If the CAP is in compliance with the Astiva Health requirements, a letter will be sent to the group confirming receipt and approval. If the CAP is not in compliance with Astiva Health requirements, a follow-up letter will be sent outlining the areas of deficiency and further requirements for compliance. Failure to correct deficiencies within stated timeframes will lead to further action, including additional audits or monitoring and revocation of specific delegated functions. Revocation of specific delegated functions may be required until the entity can demonstrate the ability to perform the function in compliance with standards.

Standards for Programs Structure and Process
Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria

The entities must have a written annual UM Program Description which clearly defines UM structures and processes. The UM Program Description may be contained in a separate document or included in the UM/Case Management Policies and Procedures Manual.

Evidence that the UM Program, Policies & Procedures, and Review criteria are being followed may be requested.

The Program Description or the Policies and Procedures (P&P) should include the following elements for all activities performed:

- Approval date and signature by the appropriate senior management or the chairperson of the group's Utilization Review/Quality Management Committee.
- Confidentiality statement.
  Structure and accountability outlined.
  Defined scope of program, processes, and information sources to make appropriate benefit coverage and medical appropriateness determinations.
  Designated senior physician involvement. There must be evidence that this physician has a California license with no restrictions.
  Description of the specific behavioral health aspects of the UM program. This description should include the processes for centralized triage and referral, as applicable.
  Involvement of a designated behavioral health practitioner in the implementation of the behavioral health aspects of the UM program (e.g., behavioral healthcare physician or doctoral level behavioral healthcare practitioner).
  Clearly defined staff responsibilities and qualifications.
  Appropriately licensed health professionals supervise all the review decisions, including a physician review of any medical necessity denial determination. A psychiatrist or doctoral-level clinical psychologist must review any denial of behavioral health care based on medical necessity. The group must be able to provide evidence of physician review either with electronic or written documentation.
  Qualified licensed health professionals assess the clinical information used to support UM decisions. UM functions and a list of services covered by each UM function or protocol.
  Description of authorization/review process.

Delegation of Utilization Management Cont.

Process for redirecting requests for non-delegated functions, including cancer clinical trials, specific major organ transplants, non-formulary drugs.

- A description of the procedures by which the entities facilitate the ability of a member and practitioner to appeal to the health plan and Department of Managed Health Care (DMHC) or Centers for Medicare & Medicaid Services (CMS) for a determination.

A description of the process of how practitioners and members can obtain the UM criteria and how the criteria are made available upon request.
Participating practitioners are involved in development or adoption of the criteria
Use of board-certified physician consultants from appropriate specialty areas of medicine and surgery for review of cases when necessary.
Disclosure of the general processes and criteria used to approve or deny care, to anyone, upon request.
Guidelines, criteria, or substantiated documentation of rationale must be used for making utilization review (UR) decisions. That criteria and source of the criteria must be described in the denial letter sent to the member with documentation of what criteria was not met.
A description of the role of the UM program in the Quality Improvement Program.
Description of case management program, if applicable.
Documentation of referral process to notify the Health Plan about authorization requests for services which are investigational or experimental for Health Plan determination.
Description of denial process, and the use of Astiva Health approved denial letter language including CMS appeal language informing the member of the right to appeal and referring the member to Astiva Health Member Services department.
Process for communicating information back to the Health Plan.
Process for determining inter-rater reliability IRR (consistency of review decision making) regarding the application of clinical review criteria, including (at a minimum):
Annual performance goals for inter-rater reliability (IRR)
Review of physician and non-physician staff involved in UM decision-making

- Documented evidence that the entities have evaluated conformity with Health Plan medical policy, including conformity with Health Plan clinical practice guidelines, preventive health guidelines and other published policy

Review Committees are strongly encouraged to utilize nationally developed evidence-based, acceptable review criteria, e.g., Milliman Care Guidelines, HAI-CA, a Magellan Health Services company, California Best Practice Guidelines and Level of Care Guidelines for behavioral health services, and InterQual®, Centers for Medicare & Medicaid Services (CMS) national and local coverage guidelines.

On an exception basis only, entities may also develop their own criteria with the involvement of participating practitioners. Such criteria must be based on documented scientific medical evidence that covers the broad scope of services provided and approved by the Contracted Medical Group UM Committee. In addition, there must be evidence that criteria were reviewed by physicians with sufficient expertise in the criteria being adopted and the criteria must encompass a full scope of services. The medical group's own criteria must be available to Astiva Health for review.

Delegation of Utilization Management Cont.

Astiva Health retains the ultimate responsibility and authority for UM determinations, however, it is the policy of Astiva Health to abide by the decisions (initial organization determinations) of the entities' UM Committee if the Committee functions effectively, utilizing appropriate review criteria which has been approved by Astiva annual review process. Review decisions must be reasonable and promote the provision of cost effective, quality health care to members. Astiva Health will monitor determinations on an ongoing basis and provide technical assistance to facilitate the activities of the entities' UM Committees to ensure that the UM Committee maintains an organized and complete review process.

Astiva Health may overturn any entity's decision that does not meet Astiva Health approved medical policy or recommended medical necessity review criteria. A decision to overturn the determination of the entities will be made by the Medical Director or a designated physician advisor, involving discussion with and/or notification to the entity's Medical Director. Groups are required to submit any information that is related to a denial when it is requested by the plan

Denial Standards
Each entity shall provide evidence of use of approved denial letter language to communicate service denials (adverse initial determinations) to members and practitioners. The delegated entities must be certain their process allows for the selection and issuance of the correct denial letter format, given the product and the circumstances surrounding the denial.

The written notification of a denial must be sent to members and practitioners within specified notification timeframes, as appropriate, explaining the reason for the denial and must inform the member of the right to appeal, including their right to external review, and refer the member to Astiva Health's appeal process.

Standards for Personal and Health Information
Entities are required to sign a Business Associate Agreement that includes, but is not limited to:

- A list of the permitted uses and disclosures of Protected Health information.
- A description of information safeguards to preserve the confidentiality of and prevent inappropriate use or unauthorized disclosure.
- A stipulation that the delegate will provide individuals (or individual's personal representative) with access to their protected health information.
- A stipulation that the delegate will inform Astiva Health of illegal, inadvertent, or wrongful disclosure or inappropriate uses of the information when it occurs.
- Upon termination of the delegation agreement, the delegate will return, destroy, or protect Personal and Health information within 30 days of the termination.

Utilization Management Resources:
- Utilization Management Contact List
- Referral Forms
- Pre-Service Request
- Case Management
- Reporting Requirements
- Reporting Logs /Templates
- Letter Templates
- Applicable Policies and Procedures*

Section XIV: Quality Improvement Program

Astiva Health annually prepares a Quality Improvement Program that clearly defines QI structures and processes for all Astiva Health processes, products, and health plan's administrative functions. They are designed to improve the quality and safety of clinical care and services for its membership.

Astiva Health Quality Program Will:
- Define, oversee, continuously evaluate, and improve the quality and efficiency of health care delivered through organizational commitment to the goals and principles of our organization.
  Ensure medically necessary covered services are available and accessible to members taking into consideration the member's cultural and linguistic needs.
  Ensure Astiva Health contracted network of providers cooperate with the quality initiatives.
  Ensure that timely, safe, medically necessary, and appropriate care is available.
  Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry, and community standards.
  Promote health education and disease prevention designed to promote life-long wellness by encouraging and empowering the member to adopt and maintain optimal health behaviors.
- Maintain a well-credentialed network of providers based on recognized and mandated credentialing standards.
- Safeguard members' protected health information (PHI).

Access to Care
This section summarizes the access to care requirements for Astiva Health Contracted provider groups for all direct product lines.

Responsibility of Participating Providers
All Astiva Contacted providers groups are responsible for fulfilling the access standards below. Astiva monitors the ability of its members to access these services according to the Medicare/Medi-Cal guidelines. Hard copies are available upon request for faxing/mailing.

Quality Improvement Plan Cont.

Physician Group Access Requirements

Service Access Standard	
Availability of ancillary services	Available within 30 miles from the primary care physician
Availability of hospitals	Travel time and distance standards of 30 miles travel distance
Availability of primary care physician distance requirements using CMS standards.	Travel Time and Distance Standards of the from 5 miles Large Metro Area, 10 miles metro area, and 30 miles rural area travel distance
Primary Care Physician Minimum Site Hour Requirement	PCP must be physically on site eight (8) hours per week per site with a maximum of four (4) sites Each site must be available a minimum of sixteen (16) hours per week to see Astiva Health members
Availability of specialty care	Travel time and distance standards of 30 miles travel distance.
Member requested primary care physician changes.	Members can request a PCP change monthly Astiva Health will process the member requested PCP change
Routine specialty referral authorization	Within 14 working days, except for Part B Drugs which are processed within 72 hours.

Annual QI Program Evaluation

Annually, Astiva reviews data reports and other performance measures regarding program activities to assess the effectiveness of its QI Program. This evaluation includes a review of completed and continuing program activities and audit results; trending of performance data; analysis of the results of QI initiatives including barriers, successes, and challenges; an assessment of the effectiveness of monitoring activities and identifying and acting upon quality of care and service issues; an evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices; and the goals and plans for the next year.

Annual QI Work Plan

The annual QI Work Plan is developed in collaboration with staff and is based, in part upon the results of the prior year's QI Program evaluation. Each of the elements identified on the Work Plan has activities defined, responsibility assigned and the date by which completion is expected. Quarterly updates to the Work Plan are documented and reported to the Quality Oversight Committee and the Compliance and Quality Committee of the Board.

Quality Improvement Plan Cont.

Committee Structure

Astiva Health quality committees oversee various functions of the QI program. The committees serve as the major mechanism for intradepartmental collaboration for the Quality Program. The following committees oversee quality of service, quality of care, and quality of the program. Various committees are comprised of a variety of participants including compliance and operations departments.

Board of Directors
Peer Review Committee
Medicare Compliance, Operations, Quality, and Service Improvement
Credentialing Committee
Appeals & Grievances Review Team
Utilization Management Committee
Complex Case Management Clinical Review Team

If you have questions or would like more information, please call the Member Service Department at 866-688-9021 and ask to speak with the Quality Improvement (QI) Vice President.

The Quality Oversight Committee, a cross functional staff committee of Astiva Health is the cornerstone for communication within the organization. It is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of Astiva Quality improvement infrastructure. The Quality Committee conducts the following activities:

- Review current strategic projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
  Review quantitative and qualitative analysis of performance data of subcommittees through formal reports as needed.
  Identify opportunities for improvement based on analysis of performance data and prioritize these opportunities.
  Track and trend quality measures though quarterly updates of the QI work plan.
  Review and make recommendations regarding quality delegated oversight activities such as reporting requirements on a quarterly basis.
  Review, modify, and approve policies and procedures.
- Review and approve the QI and UM program descriptions, QI and UM work plans, quarterly QI work plan reports, and evaluations of the QI and UM programs.

Quality Improvement Plan Cont.

Quality and Stars Rating

Components of the Quality improvement Program are shared with providers during Joint Operating Meetings and may be addressed using written materials. Information regarding CMS-approved "Rewards & Incentives, quality bonus information, Patient Safety data, and provider specific HEDIS measurements and Star Rating information are shared during joint meeting to help Providers, Groups understand where they are excelling and where they may need to take additional steps for improvement. Additionally Quality Improvement information will be addressed later in the manual.

Member Experience / Satisfaction

Member Satisfaction, which CMS measures and monitors via Member surveys, appeals, grievances, and the CMS 1-800-MEDICARE complaint tracking module (CTM). Medicare conducts three major surveys annually:

- Consumer Assessment of Health Plans (Member's satisfaction with the Plan and Providers)
- Health Outcome Survey (Member's opinion regarding the improvement in their health with the Plan and Provider); and
  Member Disenrollment Survey (to determine the reasons that Members left the Plan)

Member Complaints - Appeals & Grievances

Appeals and Grievances are not delegated to Medical Group / IPA. Medicare has very strict and time-consuming requirements that are routinely audited by CMS. It is critical that your staff be trained to forward grievances promptly to Astiva by email at memberservices@astivahealth.com. within 24 hours of receipt. You may also direct the Member to call the Member Services toll-free phone number, 866.688.9021 or TTY for hearing impaired dial 711 and report their complaints directly to a friendly customer service representative who will document and forward the case to the Appeals and Grievance Department for a prompt response. Provider is responsible to relay the complaint to the Plan by phone (numbers above) or by email to Astiva email here. The Plan sends Member notices regarding their complaints per Medicare requirements. The Plan is required by Medicare to "trend" the complaints to see if the Plan has systemic issues that need to be addressed.

Medicare has expectations regarding the minimum number of grievances a Plan should receive from Members. If the volume of grievances is too low, Medicare will issue deficiencies during audits and assumes that the grievances are not being forward or not being documented and handled by the Plan. Deficiencies can result in Civil Monetary Penalties (CMPs) and/or Corrective Action Requirements. It is important to train your staff to forward all grievances even if the issue was resolved. Include the resolution in the message

Quality Improvement Plan Cont.

Reminder:

Grievances are merely "allegations," They are not evidence of wrongdoing. They are a member's opinion. Do not be alarmed upon receipt of a request from the Plan for a response to a grievance. As required, the Plan is simply allowing you to report the incident from your perspective.

There are at least two sides to every complaint. Please respond to Grievances promptly, within the time frame given in the request for Provider Information Request. Grievances are not forwarded to CMS except as aggregated summary data. CMS is only involved when a member complains to 1-800-MEDICARE.

Clinical Care Measures

Astiva Health measures clinical performance through Healthcare Effectiveness Data and Information Set (HEDIS). Astiva Health contracted primary care provider network comply with the plan to continuously improving its HEDIS rates. The network is responsible to work with the annual HEDIS data collection efforts and keep encounter data current and accurate.

Service Measures

Astiva Health monitors services and member satisfaction by collecting, analyzing, and acting on numerous sources of data such as Member Satisfaction (CAHPS), Complaints and Appeals, Access to and Availability of Practitioners, and Provider Satisfaction. As required by CMS, the following measures will be collected annually.

HealthCare Effectiveness Data and Information Set (HEDIS)

Per requirements of Medicare, Astiva Health participates annually in HEDIS monitoring and reporting. Results from these measurements are posted by CMS on their public website and reported to Congress as part of their quality oversight of C- SNPs. They believe this full disclosure allows members to select health plans and providers who score better than others. Providers can score well by submitting complete and timely encounter or claims data, and by keeping complete and current progress notes in the member's medical record. Astiva Health may request medical record copies, but if there are more than a few, Astiva Health will send a staff member to scan a copy of the records needed, or work with the group regarding an alternate way of data submission.

HEDIS Rates and Measures

Annually CMS / Medicare instructs NCQA regarding which HEDIS measures it would like reported. These change only slightly from year to year allowing providers and health plans to improve their processes, health screening, care follow up, and documentation / record keeping. For additional information please call 866-688-9021 and ask for the QI Department.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

As required by Medicare, Astiva Health contracts with a vendor to conduct the Medicare CAHPS, a survey conducted by mail and phone with members to assess the member's satisfaction with the plan and providers. Astiva Health will share analysis when data are received from Medicare that would be of value to the providers.

Quality Improvement Plan Cont.

Provider Satisfaction

Provider satisfaction is important to Astiva Health. The Plan may from time-to-time call or send a short survey to find out how the Plan is doing in supporting your work and meeting your needs as a Provider. Please respond to the Survey so the Plan can identify where it needs to improve to become your preferred Plan.

Quality Of Life (QOL) Survey

Upon enrollment and every 6 months thereafter, members are surveyed to assess and compare their QoL every 6 months. Members complete the survey by mail. Analysis takes place to determine areas in which members believe their QoL is low or not improving. Astiva Health develops interventions to try to raise the QoL for members overall as well as individually.

Medical Record Review

Medicare requires providers to maintain current, legible, and complete medical records for all members. Astiva conducts peer review to ensure industry standards for medical records are met by all providers. To ease the burden on providers, Astiva Health will utilize records received for other purposes (HEDIS, Sentinel Event Review, Case Management, etc. rather than additionally requesting records. Should there be any findings or recommendations, they will be discussed between the provider and the Astiva Chief Medical Officer (CMO).

The Model of Care aims to delay institutional placement and manage the complex chronic health conditions of Medicare and Dual Eligible beneficiaries. The Astiva provides a comprehensive approach to health care delivery in our network to members in danger of premature institutionalization, via the following:

- Network - To ensure an adequate network of primary and specialty care practitioners. Astiva Health promotes comprehensive and consistent standards for accessibility to, and availability of, health care services for all members.
  Health Risk Assessment – Astiva Health contacts members via initial outreach calls and while performing the health risk assessments that ensure assessment and referral to the appropriate health plan program and access to plan benefits that are structured at maintaining independence in the community. This includes referrals to various social service programs, such as LTSS, Community Based Centers.
  Cultural and Linguistic Services – The comprehensive program ensures medically necessary covered services are available and accessible to members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
  Integrated Benefits Sets – Astiva Health member access to care is improved by providing specialized care through combining the benefits available through Medicare and Dual Medicare/Medi-Cal. The ability to integrate benefit sets and provide enhanced or supplemental benefits improves the coordination of health care services.
- Appropriate Utilization, Coordination, and Transition of Care – Appropriate utilization of services is assured by monitoring and measuring hospital-based care goals such as reducing

Quality Improvement Plan Cont.

inappropriate/preventable or avoidable admissions, emergency room utilization, and premature institutionalization. Every member will be offered a seamless, person-centered plan of care that integrates physical health, and LTSS. The immediate goal is for every member to have a Care Manager as a clearly identified point of contact for all coordination of care. Astiva receive our Transition of Care Program when they are discharged from a hospital stay with a licensed nurse and a pharmacist for medication reconciliation. Preventive Benefits – Astiva Health promotes the appropriate use of preventive benefits to provide early disease detection and intervene in the disease process to avoid complications.

Program Objectives

The Objectives of Astiva Disease Management programs are to:

- Improve member knowledge and disease self-management
- Improve appropriate medication adherence, self-monitoring, and appropriate lifestyle changes
  Improve adherence to recommended clinical practice guidelines, and
- Track and measure clinical outcomes studies.
- Advanced Care Planning (POLST Form) – Astiva can assist members and their familymembers with end-of-life decisions. Case managers will meet face to face with a member and their family.

Section XV: Preventive Health

Astiva Health identifies and measures each contracted primary care provider's performance to the HEDIS standards.

Astiva follows the National HEDIS benchmarks for Medicare: The proposed Clinical Improvement measures include the CMS HEDIS measures along with additional measures, but are not limited to:

- Adult BMI Assessment (ABA)
  Breast Cancer Screening (BCS)
  Colorectal Cancer Screening (COL)
  Care for Older Adults (COA)
  Use of Spirometry Testing in the Assessment & Dx. of CODP (SPR)
  Pharmacotherapy Management of COPD Exacerbation (PCE)
  Medication Management for People with Asthma (MMA)
  Comprehensive Diabetes Care (CDC)
  Controlling High Blood Pressure (CBP)
  Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
  Statin Therapy for Patients with Cardiovascular Disease (SPC)
  Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
  Plan All Cause Readmission (PCR)
  Medication Reconciliation Post Discharge (MRP)
  Use of High-Risk Medication in the Elderly (DAE)
  Annual Monitoring of Persistent Medications (MPM)
  Identification of Alcohol and other Drug Services (IAD)
  Antidepressant Medication Management (AMM)
  Follow-up After Hospitalization for Mental Illness (FUH)
  Medicare Health Outcomes Survey (HOS)
  Fall Risk Management (FRM)
  Management of Urinary Incontinence in Older Adults (MUI)
  Reduce Member Grievances
  Improve Member Satisfaction
  Reduce Incidence of Decubitus Ulcer development
  Reduce Incidence of Dehydration
  Reduce Incidence of Falls
  Reduce Incidence of preventable infections
  Reduce Rate of institutionalization
  Increase the number of members receiving coordinated care
  Antidepressant Medical Management (AMM) – HEDIS measure

Preventive Health Cont.

Emergency room encounter data received are analyzed. Trends in emergency room department utilization by member may indicate access, education or under-utilization issues indicating overutilization at the emergency room level.

Hospitalization admit and re-admit data will be studied by utilizing encounter data and analyzing reports that indicate a trend of re-admit for same/similar diagnosis.

Review of disenrollment (voluntary and involuntary), out of plan service or grievance trends which may indicate access or quality issues will be conducted routinely and the results reviewed by the COO, CMO, UM and QI directors reported with recommendations to the QOC Committee.

Report results from the UM Committee to the QOC Committee for identification of performance improvement follow-up activities when needed based on results of the data analysis, discussion and plans for improvement as needed.

Annual Wellness Exam

Astiva Health contracted primary care providers shall have processes in place to ensure an AWE (complete history and physical examination) to each newly assigned member within the 90 days of their effective date of enrollment and annually thereafter. This exam includes a thorough review of:

- Current health issues
- Past health history
  Preventive care services and any additional referrals for all screenings due by age, gender, and any tests due from chronic illness.
- Health Education

Astiva Health contracted network primary care providers shall ensure that the performance of the initial complete history and physician exam for adults includes, but is not limited to

- Blood pressure.
  Height and weight and Body Mass Index (BMI)
  Total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
  Clinical breast examination for women.
  Screening mammogram for women ages 50-74.
  Pap smear (or arrangements made for performance) on all women determined to be sexually active or be at high risk for vaginal or cervical cancer,
  Colon cancer screening for members 50-75 years of age (fecal occult blood test, flexible sigmoidoscopy, or colonoscopy)
  Prostate Cancer Screening for men 50-75 years
  Bone Mass Measurements for members at risk for osteoporosis
  Diabetes screening, hemoglobin A1c, micro-Albumin
  Diabetic retinal eye exam for all diagnosed with diabetes
  Glaucoma screening for members at high risk for glaucoma

Preventive Health Cont.

Medication Reconciliation at least annually, if not at every visit
- Pain assessment for the older adult age 65 and older
- Advanced Directives for all adults
- Activity for Daily Living (ADLs)
- Depression Screening (PHQ-9)

Adult Preventive Services
Astiva Health contracted network primary care providers shall cover and ensure the delivery of all preventive services and medically necessary diagnostic and treatment services for adult members.

Astiva Health contracted network primary care providers shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, health adult.

As a result of the AWE or other examinations, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services.

In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the AWE for adults described above shall be provided in the frequency required by the USPSTF Guide to Clinical Preventive Services.

Astiva Health contracted network primary care providers shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services that are necessary given the finding or risk factors identified in the AWE or during visits for routine, urgent, or emergent health care situations.

Immunizations for Adults
Astiva Health contracted network primary care providers are responsible for ensuring all adults are fully immunized and shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

In addition, Astiva Health contracted network primary care providers shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the finding of the AWE, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

Preventive Health Cont.

Comprehensive Risk Assessment

The HRA is an essential component of the care management process. Astiva Health will maintain an assessment process to:

- Assess each new enrollee's risk level and needs based on an interactive process such as telephonic, web based or in-person communication with the member
- Address the care needs and coordinate the Medicare and Medical benefits across all settings Review historical Medicare and Medicaid utilization data
- Follow timeframes for reassessment

The HRA is a standardized self-reported screening tool conducted with each member upon enrollment. Non-clinical staff members, who conduct telephone interviews with members or caregivers and make follow-up phone calls, when needed, to clarify any questions from previous calls, administer the HRA. When staff is unable to reach a member, the member mails a written form with a self-addressed stamped envelope for completion. A follow up call is made to the member to confirm receipt of the mailing.

HRA screening questions are included to assess members for substance abuse issues or conditions. The responses to the questions trigger staff responsible for care planning to further screen and provide members with health education information or information on self-referral program and services specific to their needs. The HRA identifies Medical, psychosocial, functional needs and cognitive needs, documents Medical and mental health history, etc. The health risk assessment screens for:

Health status, chronic health conditions/health care needs
Clinical history
Mental health and cognitive status activities of daily living (ADLs)/Instrumental activities of daily living (IADLs)Depression
Medication review
Cultural and linguistic needs, preferences, or limitations
Evaluate visual and health needs, preferences, or limitations
Quality of Life
Life planning activities
Caregiver support
Available benefits
Continuity of care needs
Fall prevention
Long Term Services and Supports, including HCBS

Preventive Health Cont.

Coordination of Medically Necessary Services

The PCP is responsible for providing members with routine medical care and serve as the medical case manager within each managed care system. Referrals are made when services are medically necessary, outside the PCP's scope of practice, or when members are unresponsive to treatments, develop complications, or specialty services are needed. The PCP is responsible for making referrals and coordinating all medically necessary services required by the member. The PCP should transfer pertinent summaries of the member's record to the specialist. Authorization flow charts are provided at the end of this section.

If a member requests a change of provider, Astiva Health collaborates with the member to find a provider in the network who meets the needs of the member, such as language preferences and proximity to the member's home, etc. With the member's permission, the member's individualized Care Plan is shared with the new PCP by Astiva Health case manager. The care plan will include a member's medical, psychosocial and medication information.

Preventive Health Care Guideline Resource Links

Preventive Services Chart | Medicare Learning Network® | MLN006559 May 2022 (cms.gov)

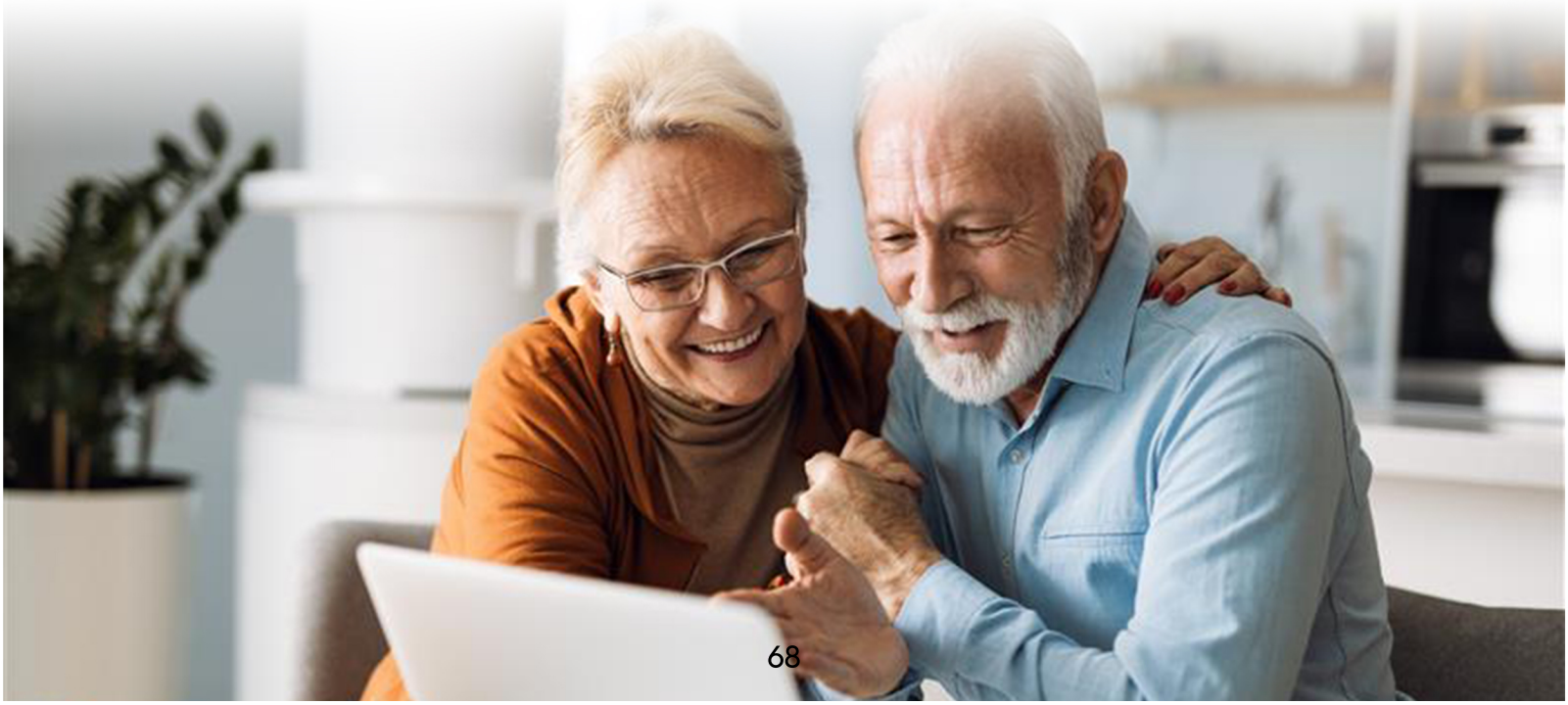
Section XVI: Health Education

Health education is the process of providing health information, skill training, and support to individuals to enable and empower them to modify their behaviors and improve their health status. Astiva Health is responsible for the planning, implementation, and evaluation of member health education, health promotion, and patient education for our direct lines of business members.

Primary Care Providers (PCPs) are responsible for delivering individual education during member doctor visits, continually reinforcing positive health behavior change in patients, documenting the delivery of health education services in the patient's medical record, and administering any health questionnaires that can best support the provider to refer the member to any services needed such as the PHQ-9, SF-36 or Katz6, Depression screening and Activities for Daily Living (ADL).

The mission of Astiva Health Education Department including Cultural and Linguistic Services is to improve the member's health status through the delivery of wellness and disease prevention programs and to ensure access to culturally and linguistically appropriate resources and health care. This is achieved through assisting Astiva Health members to:

- Effectively use primary and preventive health care services, including health education services
  Modify personal health behaviors, achieve, and maintain healthier lifestyles, and promote positive health outcomes
  Learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases, or other health conditions.
  Navigate the health system to ensure access to preventive health services



Section XVII: Use of Interpreters

Astiva Health provides timely, 24- hour, 7 day a week healthcare interpreting services, including American Sign Language (ASL), at medical and non-medical points of contact, at no cost to members.

Astiva Health LEP members must be informed of their right to interpreter services at no cost to them. State and Federal laws state that it is never permissible to turn a member away or limit the service 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 service that is lower in quality than those offered in English.

It is the practitioner's responsibility to provide access and coordinate interpreter services. In some cases, qualified bilingual staff may meet these needs. If a bilingual staff is not available, practitioners may use contracted telephonic or face-to-face interpreter services. Qualified interpreters can be accessed through Astiva Health. Providers may choose to contract with a professional interpreting services vendor to communicate with members. If a Provider chooses to contract with an interpreting services vendor, the Provider must ensure that qualified interpreters provide services.

Astiva Health and its providers must not require or suggest that LEP or hard of hearing or deaf members provide their own interpreters or use family members or friends as interpreters. The use of such persons may compromise the reliability of medical information and could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. Use of minors as interpreters is not allowed except in extraordinary circumstances such as medical emergencies.

If a member insists on using a friend or family member as an interpreter, after being notified of the availability of interpreters, providers may accept the request. However, the use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiaries' confidentiality.

Documentation
Providers must document the request or refusal of language interpreting services by a LEP or hard of hearing or deaf members in medical record. Providers should document who provided the interpretation service.

Methods that can be used to document request/refusal of interpreting services include:
- Intake form/registration
- Medical chart (use of colored labels)
- Request/refusal form
- Stamp

Use of Interpreters Cont.

*Forms are available in a variety of languages, including threshold languages.
This will be monitored during facility site review and medical records review audit.

CLAS Related Grievances
Members have the right to file a complaint or grievance if their cultural and or linguistics needs are not met (i.e., have been denied interpreting services or if the member information was not available in the preferred langue in written format or over the phone). All complaints are filed with Astiva Health Member Services Department and are routed to the appropriate areas within the organization.

Grievance forms in threshold languages are available on the Astiva Health website

Telephonic Interpretation Services
A telephonic interpreter service is an important tool to communicate with LEP members when on-site qualified bilingual staff or interpreters are not available.

To access telephonic interpreter services through Astiva Health, follow these simple steps:
Call Astiva Health's Member Services Department at: 866.688.9021, speak to a member service representative.
Give the Member Services Representative the following information:
Language being requested
Member's name
Member's ID number
Wait for the representative to connect you with an interpreter through Pacific Interpreters.
When the interpreter joins the line, brief the interpreter:

- Explain the purpose of the call
- Give any special instructions you may have

California Relay Services (CRS) for Members with Hearing or Speech Loss
California Relay (CRS) is a Marketplace service that can be used to contact a member. A member can also use the services to contact his/her provider. CRS enables a person using a TTU to communicate with a person who does not use a TTY by phone. The service also works in reverse by allowing a non-TTY user to call a TTY user. Trained relay operator is online to relay the conversation as it takes place. CMG's and network providers can call the CRS directly for members with hearing or speech loss. The statewide access for voice or Teletypewriter / Telecommunications Device for the Deaf (TTY/TDD) is indicated below. All calls made through the CRS are confidential.

Use of Interpreters Cont.

If a practitioner needs to contact a hearing and/or speech-impaired member using the CRS please follow these simple steps:

- If you initiate the call to a hearing-impaired member:
  Dial the voice telephone number 1-888-877-5379 (SPRINT) or 1-800-735-2922 (MCI).
- You will hear "Sprint CRS Communication Assistant (CA) 1234" (four-digit numbers are their ID#). They will ask for the phone number you want to call.
  Give the CA the area code and telephone number you wish to call, and any other important instructions.
  The CA processes your call, relaying what the TTY (teletype) member is typing. The CA relays what you say to the patient using the TTY.
  Be sure to talk directly to the person you are calling. Try to avoid saying, "tell him" or "tell her," and always say "GA" (GA stands for Go Ahead) at the end of your response.
  If a hearing-impaired member initiates the call to you have them follow these steps:
  The member calls the California Relay Service first at 1-800-735-2929 or 1-888-877- 5378 (for Spanish call 1-800-855-3000).
  The member tells the CRS CA their practitioner phone number to initiate the call.
  The CA processes the member's call, relaying to you what the TTY member is typing. The CA relays what you say back to the member using the TTY.
  Members must avoid saying, "tell him" or "tell her," and should always say "GA" (GA stands for Go Ahead) at the end of your response.

To ensure that hearing and/or speech impaired members have the same access to health services, Astiva Health has a dedicated TTY Line that members may call and leave a text message. The teletype machine is set up in the Member Services Department where staff can assist hearing and/or speech impaired members. If you have a patient who could benefit from using the TTY line, the number is:

Astiva Health TTY Line: (866) 688-9021, TTY 711

Interpreter Services Poster
Astiva Health makes available and routinely distributes translated signage promoting interpreting services to provider offices. Provider offices are required to post the signage prominently in the medical office. Copies of the translated poster can be downloaded through the Astiva Health website http://www.astivahealth.com or contact the Provider Services Department to request a copy.

Provider Toolkit for Serving Diverse Populations
In collaboration with the HICE collaborative, Astiva Health has adopted a C&L Provider Toolkit to assist provider is providing high quality, effective, and compassionate care while meeting the changing service requirements of state and federal regulatory agencies. This Provider C&L Toolkit is available through Astiva Health's website at www.astivahealth.com

Use of Interpreters Cont.

Language Skills Assessment Tool
Astiva Health and the HICE collaborative have developed an Employee Language Skills Assessment Tool for provider offices to use in documenting language proficiency of providers and staff. The tool can be downloaded through Astiva Health's website at www.astivahealth.com

Translation Services
Astiva Health provides limited English proficient (LEP) members with written member informing materials in the member's identified primary threshold language. Any material that is sent in English includes a notice that has been translated into the threshold language(s) informing the member of the availability of translation and interpreting services.

Astiva Health also provides written member informing materials in alternative formats, upon request.

Assessing Proficiency of Bilingual Staff
Provider office staff members who communicate with members in a language other than English must be qualified and formally assess for their capabilities. Provider offices must keep evidence of the results of formal assessment on file. This information must be updated annually.

Provider and bilingual staff providing interpreting services must maintain, "Employee Language Skill Self-Assessment" form, certification of language proficiency or interpreting training on file. Bilingual staff providing medical interpreting services are encourages to take a language proficiency test by a qualified agency (e.g., Cyracom, Berlitz, and Pacific Interpreters) to determine if the candidate is qualified for medical interpreting. Bilingual staff with limited bilingual capabilities or who rate "Poor "on a language proficiency test should not provide interpreting services to members and are required to use telephonic interpreting service or schedule a face-to-face interpreter for Astiva Health members. This will help avoid possible liability issues due to improper care and will be monitored during the facility site review.

Cultural and Linguistic Services Trainings
Astiva Health offers ongoing language access, cultural competency, and disability literacy trainings on a variety of topic to network providers and their staff. Trainings are conducted on an as needed basis and cover topics such as:

- Knowledge of Astiva policies and procedures for language assistance
- How to access interpreting services and written materials in threshold languages and alternative formats
- Working effectively with LEP members
- Working effectively with interpreters
  Working with special needs populations, including seniors and people with disabilities
  Providing Culturally and Linguistically competent services

Use of Interpreters Cont.

Requirements Provider Education & Training

The provider network must receive ongoing education on cultural and linguistic requirements, services, and available resources.

Provider education methods include, but are not limited to, provider orientations, and in- services, meetings provider newsletters, faxes mailing and special trainings.

CMG /IPA's are required to educate providers on the following topics:

- Upcoming C&L related training offered by Astiva Health
- C&L requirements, including, but not limited:
  - Posting of the interpreter poster at provider office sites
  - Maintaining language proficiency and qualifications of bilingual staff on file
    Ensuring 24-hour, 7day a week access to interpreting services, including ASL at all points of contact, including after-hours
    Discouraging the use of family and friends, particularly minors, as interpreters
    Documentation of the member's preferred language written & spoken in the medical record
    Documenting request/refusal of interpreting services in the medical record
    Processes for filing a grievance if the patients cultural and or linguistics needs are not met.
  - C&L resources including online searchable Social Services Directory

CMG/IPA's are responsible for educating network providers on cultural and linguistic requirements, programs, and services. CMG/IPA's are also required to attend and promote cultural competency trainings made available by Astiva Health.

Supporting documentation of provider education must be available for review and must include:

- Copies of program handouts or correspondence
- Sign in Sheets
- Agenda/ Training Outline
- Meeting Minutes
- Evaluation

Section XVIII: Member Confidentiality, Privacy and HIPPA

Astiva Health's contractors, subcontractors and trading partners must maintain the privacy and confidentiality of our members and their protected health information (hereinafter "PHI") and, to every reasonable extent, protect their privacy rights in accordance with current state and federal laws. Astiva Health and all providers, are considered "covered entities" under the Health Insurance Portability and Accountability Act ("HIPAA") and, as such, are all equally obligated to protect our member's, and their patient's, privacy, and the confidentiality of their PHI. Moreover, where California law is more stringent in any requirement than HIPAA, California law governing the use and disclosure of patient health information will apply.

A copy of the Astiva Health Notice of Privacy Practices is available to members and providers upon verbal or written request through the Astiva Health Member Services Department and in designated areas, such as Astiva Health's dental and medical facilities.

Unless otherwise provided by federal and state law, a written authorization for the use and disclosure of PHI is necessary where such information is used for purposes other than medical evaluation and treatment, payment of health-related services, or health care operations.

If you have any questions, thoughts concerns, or require any additional privacy related information, please feel free to contact us at 1-866-688-9021. You can choose to leave either an anonymous message or leave your name and contact information and a privacy program professional will return your call.

Protecting Member Health Information
Astiva Health, its Business Associates and Trading Partners do not disclose PHI without written authorization of the patient or their authorized representative except where necessary for the purpose of medical treatment, payment of medical services, to conduct necessary health plan operations, or where required by state or federal law. Although the Privacy Rule permits broad use and disclosure of PHI for treatment purposes, uses related to payment and health care operations are limited to those activities of the Covered Entity itself.

Astiva Health is committed to protecting the confidentiality and security of PHI and maintains physical, electronic, and process safeguards that restrict unauthorized access to such information and requires the same commitment from their Business Associates and Trading Partners. Security measures may include, but are not limited to, locked files where such contain PHI, separately staffed storage areas for both live and archived medical records, shredding of information when it is lawfully purged, and information security mechanisms such as user passwords, data encryption and encoding, and firewall technology. Access by staff to the medical, financial, and demographic information related to Astiva Health Members must be limited to only those with the 'need to know' and 'minimum necessary' basis in order to perform functions related to treatment, payment for medical services, and health care operations, or where required by state or federal law. The same conditions apply when using or disclosing PHI for any other reason where specific written authorization has been obtained from the individual to whom the PHI relates.

Member Confidentiality, Privacy and HIPPA Cont.

In addition to use/disclosure for the purpose of treatment, payment of claims, and health care operations, PHI can be used/disclosed without written patient authorization, but with patient agreement as evidenced by an acknowledgement of a Notice of Privacy Practices, for the following activities:

- To maintain a provider or facility directory.
- To inform family members or other identified persons involved in the patient's care, or notify them about patient location, condition, or death.
  To inform appropriate relief agencies during disaster operations.
  To provide public health agencies with information related to disease prevention or control.
  To report victims of abuse, neglect, or domestic violence.
  For health oversight activities, such as audits, legal investigations, licensure, or for certain law enforcement purposes or government functions.
  For coroners, medical examiners, funeral directors, tissue/organ donations, or certain research purposes.
  To avert a serious threat to public health and safety.

Core Elements of A "Patient Authorization"

- To be a valid authorization for use/disclosure of PHI, the authorization form must contain:
- A description of the PHI to be used/disclosed, in clear language.
- Who will use/disclose PHI and for what purpose?
- Whether or not use or disclosure will result in financial gain for the Covered Entity.
  A statement that the authorization may be revoked at any time and will govern any PHI not already used/disclosed based on the submitted authorization.
- The signature of the patient or their authorized representative, and the date of signing.
- The time frame when the authorization expires, such as 90 days from date of signature. Such a written authorization is only valid for the specific PHI described.
- A new authorization must be obtained if any further PHI is to be used/disclosed.

Member Access to Personal Health Information

Astiva Health receives information about our members in order to provide customer service, render medical care where the member is assigned to the Astiva Health Medical Group, offer new products and services, evaluate benefits and claims, administer benefit plans, and fulfill existing regulatory and legal requirements. Members must be given the opportunity by the custodian of their record to have access to their designated record set in order to review, amend, correct, or copy this information were allowed under state or federal law and where such review, amendment, correction, or copying will not compromise their mental health or their medical or mental health treatment, as determined by the Member's medical provider. The custodian of record for a specific member belongs to Astiva Health if the member is assigned to a n Astiva Health Medical Group for their care, or the contracted network provider they are assigned to in the Astiva Health provider network.

Member Confidentiality, Privacy and HIPPA Cont.

Members who do not want their protected health information shared with third parties involved in marketing or research activities may contact the Astiva Health Member Services Department to "opt-out," or if assigned in the Astiva Health contract provider network, may make such request to their primary care provider. This option does not apply to PHI that is necessary for medical care and treatment, payment of claims, health plan operations, or for compliance with a subpoena, fraud investigation, inquiries from state or federal agencies, or where use and disclosure is otherwise required by state or federal law.

Members who wish to review information contained in their medical record may make such request to the Astiva Health Member Services if Astiva Health is the custodian of their designated record set. If the member is assigned to the Astiva Health contract provider network, their assigned primary care physician is the custodian of record and must have a process by which a Astiva Health member may make such a request.

While Section 164.524 of the Privacy Rule provides patients with the right to access, inspect, copy, or amend their PHI in their designated record set, the following is not included in this right:
for which the provision of access to the individual is prohibited by law, specifically, the Clinical Laboratory Improvement (CLIA) Amendments of 1988, 42 Code of Federal Regulations, Sections 263(a) and 493.3(a)(2).

Access may be suspended when the PHI is created or obtained in the course of research in progress, provided that the individual agreed to such denial of access when consenting to participate in the research and the provider has informed the individual that access will be reinstated upon completion of the research.

Uses/Disclosures of PHI Requiring Written Patient Authorization
While there is a long list of permitted disclosures outlined in the Privacy Rule, there are also situations in which use and disclosure of PHI is prohibited unless specific, written patient authorization for that use/disclosure is obtained. Such situations include:

- Disclosure of records related to the evaluation and treatment of mental health disorders, unless for the purpose of treatment, payment, or health-care operations).
  Use or disclosure of PHI for marketing, or the selling of member information to another party for the purpose of marketing, goods, or services. However, the health plan may provide information regarding goods, benefits and services offered by the health plan.
  Use or disclosure of PHI for fundraising purposes.
  The use or disclosure of PHI for research purposes.

In addition to compliance with existing state and Federal laws governing the privacy and confidentiality of member health information, Astiva Health meets or exceeds standards consistent with those promulgated by CMS and the National Committee on Quality Assurance (NCQA).

Member Confidentiality, Privacy and HIPPA Cont.

Please be aware that changes in the HIPAA regulations and laws were enacted in 2009 that made Astiva Health's contractors, subcontractors, and trading partners equally liable for violations of the HIPAA laws and regulations. In other words, the liability that was imposed only on Astiva Health to meet the requirements of HIPAA is no longer limited to Astiva Health, but now applies equally to its contractors, subcontractors, and trading partners. As such, all Astiva Health contractors, subcontractors and trading partners must review their privacy and confidentiality policies and procedures (including establishing a Privacy Officer) to ensure that they meet or exceed the requirements of HIPAA and its regulations.

Astiva Health has a process through which it monitors and audits privacy and confidentiality matters, with part of those reviews including a review of our contractor, subcontractor and trading partner privacy and confidentiality matters.

Please also be aware that this Section of the Astiva Health Provider Manual is intended only to ensure that give an overview of the requirements that Astiva Health, its contractors and subcontractors must meet with regard to member privacy and confidentiality. If any individual or entity that is bound by this Provider Manual would like more detailed information with regard to patient privacy and confidentiality issues, please contact Member Services at 866-688-9021.

Definitions

Important definitions related to HIPAA requirements are provided here for reference. They do not by any means constitute all terms of importance that are in the Privacy Rule with which providers must be familiar.

Covered Entity means an entity that, as part of their business function, transmits or receives individually identifiable protected health information electronically. HIPAA defines a Covered Entity, for the purpose of the Privacy Rule, as a:

- Health plan
- Health-care clearinghouse
- Health-care provider

De-Identified PHI: Any PHI that has a member's personal identifying information removed, such as name, social security number, home address, date of birth.

Designated Record Set: A group of records maintained by or for the Covered Entity that include:

- The medical records and billing records about individuals maintained by or for a Covered Entity; or,
- The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a Covered Entity; or, Records/Information used in whole or in part, by or for the Covered Entity to make decisions about individuals.

Member Confidentiality, Privacy and HIPPA Cont.

Disclosure: Release or transfer of PHI, or allowing access to PHI, outside the company for any purpose.

Minimum Necessary: Only the amount of PHI that is necessary in order to perform the functions of treatment, payment of services, and health care operations.

Protected Health Information (PHI): Any individually identifiable health information in electronic, written, oral, or any other form or medium is protected under the HIPAA Privacy Rule, effective December 2000 and, as modified, on August 14, 2002 in 45CFR, Parts 160-
PHI includes but is not limited to:

Personal information provided by the member to the health plan or their primary care provider on applications, forms, surveys, and Web sites. This includes their name, birth date, address, social security number, gender, marital status, and similar information about dependents.
Information provided by a member's employer, benefits plan sponsor, or association related to a group product.
Information about transactions and experiences with Astiva Health or their contract providers, such as services utilized, account balances, payment history, claims history, policy coverage, and premiums.

- Information from consumer or medical reporting agencies, medical providers, or other third parties such as credit unions, collection agencies, medical information, and demographic information

Use: The sharing, examining, analysis of, or application of PHI for any purpose.

Once again, if you have any questions, thoughts concerns, or require any additional privacy related information, please feel free to contact Member Services at 866-688-9021. You can choose to leave either an anonymous message or leave your name and contact information and a privacy program professional will return your call.

Section XIX: Medicare Regulations Summary Links

Below are some links your organization may find to be both helpful and useful. For assistance in the area of regulations, please contact the Astiva Health at 866-688-9021

- Benefit Information for Astiva Health www.astivahealth.com
- Centers for Medicare and Medicaid Services (CMS) www.cms.hhs.gov
- Department Of Managed Health Care (DMHC) www.dmhc.ca.gov
- Health Industry Collaboration Effort www.ICEforHealth.org

This non-profit website has opportunities to participate with health care leaders in standardizing and simplifying requirements to reduce duplication and reduce costs for providers. ICE has teams that meet monthly to discuss common challenges that providers and health plans face in complying with regulatory guidance. All providers and health plans are welcome to join.

Medicare Managed Care Policy Manuals
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

Medicare Policy Manuals contain important information organized conveniently in "Chapters". They are routinely updated and available on the CMS website via the link above. Some chapters that would be most relevant to providers are the following chapters:

- **Chapter 3** Marketing Guidelines
- **Chapter 4** Benefits and Beneficiary Protections
- **Chapter 5** Quality Assessment
- **Chapter 6** Relationships with Providers
- **Chapter 7** Risk Adjustment
- **Chapter 10** Medicare Advantage Organization Compliance with State Law and Preemption by Federal Law
- **Chapter 13** Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals

Medicare Appeals and Grievances
See previous links for Medicare Managed Care Policy Manuals [Chapter 13]

Medicare Claims Processing Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
Medicare National Coverage Determination Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961

Section XX: Marketing Event Procedures

Astiva Health will work with our providers in coordinating joint marketing events for the purpose of business development and brand exposure. Our trained marketing staff is your primary contact for any co-marketing opportunities that you the participation of Astiva would be beneficial to both your office and the health plan.

Prior to approaching Astiva with a co-marketing opportunity, we are asking for your help in identifying the type of event that the health plan is being invited to participate in:

Event Types

- **Educational Formal:** 'Presentation-style' event with speakers and only educational materials are available or distributed. State-licensed sales agents and brokers are not invited to participate in this type of event.

  Educational Informal: 'Tables or Booth-style' event without a formal presentation from a speaker and only educational materials are available or distributed. State-licensed sales agents and brokers are not invited to participate in this type of event.

  Sales Formal: 'Presentation-style' event with speakers and includes materials or business cards available for distribution. Distributed materials will include information about Astiva Health and its benefits and programs. This event will have a State-licensed sales agent present.

  Sales Informal: 'Tables or Booth-style' event without a formal presentation from a speaker. Distributed materials will include information about Astiva Health and its benefits and programs. This event will have a State-licensed sales agent present.



Marketing Event Procedures Cont.

STEP 1:
EVENT REQUEST

Submit your request to Astiva Health for event participation via email to events@astivahealth.com

Include event name, date, type, and all other required information on the CMS template.

Medicare requires health plans to notify the Centers for Medicare & Medicaid Services (CMS) of all formal and informal marketing/sales events prior to advertising the event.

Astiva Health requests that events be submitted thirty (30) days in advance and prior to any advertising. Changes to marketing/sales events (e.g., cancellations and room changes) are required be updated to CMS at least forty-eight (48) hours prior to the scheduled event so please notify Astiva Health as soon as you become aware of a cancellation.

STEP 2:
PRE-APPROVAL

Once your request has been received, Astiva Health will send a written acknowledgement of receipt and a CMS/Medicare event template for you to complete.

The event cannot move forward if the required information from CMS is missing.

STEP 3:
POST APPROVAL & PRE-EVENT

Upon approval by Astiva Health and CMS, we will notify you via email and by telephone. Our trained marketing staff will work with you directly to ensure a successful event.

STEP 4:
ANALYSIS AND EVENT RECAP

An Event Recap is to be submitted to brokersupport@astivahealth.com within five (5) business days after the close of the event. All Agents and Broker Agents are required to complete a Lead Analysis and submit to brokersupport@astivahealth.com within fifteen (15) days after the close of the event.