AltaMed

WORK BOLDLY. LIVE BRILLIANTLY.

Provider Manual

2020

A Message from the President and Chief Executive Officer

Welcome to AltaMed's Provider Network

This Network Manual is designed as a reference for you, a valued member of AltaMed's provider network, so that you may have access to important information regarding AltaMed's programs and services, quality improvement and management activities, utilization management (UM) and case management processes, health education programs, community outreach and other contract related topic.

AltaMed Health Services Corporation, a Federally Qualified Community Health Center (FQHC), has been a leader in responding to unmet health care needs of the underserved communities for 50 years. AltaMed currently operates 44 sites, which include more than 24 primary care, three HIV clinics AltaMed also has 8 Program for All-Inclusive Care for the Elderly (P.A.C.E.) programs and other senior services. AltaMed's comprehensive array of services for individuals and families is available to all economic levels within a culturally sensitive environment.

With a mission "to eliminate disparities in health care access and outcomes by providing superior quality health and human services through an integrated world-class delivery system for Latino, multi-ethnic and underserved communities in Southern California". AltaMed's commitment to quality is exemplified by the accreditation from the Joint Commission on Accreditation since 2012.

AltaMed values your participation in our provider network. It is AltaMed's desire that this tool, along with our ongoing provider communications will foster engagement between AltaMed and our provider network as each of us strive towards delivering high quality health and human services to our patients.

I personally would like to thank you for your participation in AltaMed's provider network.Your involvement exemplifies your commitment to serve communities in need.

Sincerely,

Cástulo de la Rocha, JD
President & CEO

About AltaMed

AltaMed Health Services Corporation

Founded in 1969 as the East Los Angeles Barrio Free Clinic, AltaMed Health Services Corporation ("AltaMed") is a private non-profit organization that provides health and human services to uninsured and underserved residents of Los Angeles and Orange Counties.

AltaMed is the largest independent Federally Qualified Community Health Center in the U.S., delivering more than one million annual patient visits and serving more than 270,000 families every year through its 43 sites in Los Angeles and Orange Counties.

Mission:

To eliminate disparities in health care access and outcomes by providing superior quality health and human services through an integrated world-class delivery system for Latino, multi- ethnic and underserved communities in Southern California.

Organizational Overview

AltaMed is divided into three (3) main sections

a. **Primary Care Medical, Dental and HIV Services (FQHC)**

   Staff-model outpatient clinics and multiple mobile units provide medical, dental, HIV prevention and treatment, and behavioral health services. AltaMed's FQHC clinics serve a mix of Medi-Cal, Medicare, Dually eligible Medi-Cal and Medicare members, Commercial and uninsured patients.

b. **Senior Care**

   The PACE program provides all necessary acute, primary, consultative and chronic care for frail, elderly patients allowing them to remain at home and in the community. This risk-bearing, capitated program provides a full array of services including medical, psycho-social, rehabilitation services with a strong social component that includes the family and caregivers.

c. **The AltaMed Independent-Practice Association (IPA) Network-Model**

   AltaMed, acting as a risk bearing organization, contracts with payers, including health plans, to provide services to plan members by contracting with individual or groups of physicians. This network of 194 Primary Care physicians plus Specialty physicians allows AltaMed to increase access and expand services.

Our Commitment

To our patients/participants/clients: We are committed to providing quality care that is sensitive, compassionate, promptly delivered, and cost effective service in a culturally appropriate manner.

To our employees: We are committed to providing a work environment, which has excellent facilities, necessary equipment, and outstanding professional support.

To our third-party payers: We are committed to dealing with our third-party payers in a way that demonstrates our commitment to contractual obligations and reflects our shared concern for quality healthcare and bringing efficiency and cost effectiveness to healthcare.

To our regulators: We are committed to an environment in which compliance with rules, regulations and sound business practices is woven into the corporate culture. We accept the responsibility to aggressively self-govern and monitor adherence to the requirements of law and to our Business Code of Conduct.

To the communities we serve: We are committed to understanding the particular needs of the communities we serve and providing these communities quality, cost-effective healthcare. We realize as an organization that we have a responsibility to help those in need.

Table of Contents

Table of Contents

Table of Contents

Table of Contents

AltaMed Programs & Services

AltaMed provides a broad range of health services to meet the needs of individuals and families in our community. We promote regular and continuous care, where the patient — and if appropriate, the family — are at the center of care. Patient chose from a network of AltaMed doctors and work closely with a team to ensure comprehensive care from birth through the senior years, regardless of ability to pay. Our fully integrated system of care improves health outcomes, reduces health care disparities and encourages prevention and healthy living.

With a staff of more than 2,300 professional, paraprofessional, and administrative employees, AltaMed prides itself in the provision of services that are linguistically and culturally appropriate. The services provided by AltaMed include:

1. Adolescent health care services
2. Adult day health care services
3. Geriatric long-term health care
4. Geriatric primary health care
5. HIV/AIDS medical and case management services
6. Pediatric health care services
7. Primary Care
8. PACE, Program of All-Inclusive Care for the Elderly (“PACE”)
9. Sexually Transmitted Disease testing and treatment
10. Women’s health and Children’s Specialty services
11. Health Education classes and support
12. Dental services
13. Comprehensive chronic disease care management and pharmacy services
14. Free health insurance program application assistance
15. Chronic Care Management Programs
16. Youth Programs
17. Behavioral Health counseling and support

Additional information about each program is included in the appendices at the end of this manual. Additional information may be obtained by contacting each program/site directly as listed in the enclosed AltaMed Services Matrix under the referenced appendix.

Network Administration

AltaMed's Provider Contracts

Under AltaMed's contracts with health plans, government agencies and private payors, the organization is responsible for providing and for arranging for the provision of services covered under each AltaMed/Payor Contract.

AltaMed's primary care services are provided through our own Staff Model facilities, or through contracted AltaMed IPA physicians. Specialty, ancillary and supplemental services are provided through AltaMed's contracted network, which consists of more than 1000 specialists and over 150 healthcare facilities.

All agreements with participating providers include specific provisions required by our Payor Contracts. Contracting activities are integrated and coordinated by the Contracting Department, in collaboration with the Corporation's business support units. AltaMed's major contract networks are:

Managed Care Network

Under AltaMed's managed care contracts with health plans, AltaMed is responsible for varying levels of professional medical care. Most primary care is provided to Health Plan members at AltaMed's twenty two (22) medical clinics in Los Angeles and Orange County, while specialty care is provided through AltaMed's "Managed Care Contract Provider Network." The "standard" HMO benefits are summarized in the next section. Please contact our Utilization Management Department for specific benefits under each Health Plan and each Line of Business (Commercial, Medi-Cal, Healthy Families, Healthy Kids, Senior, etc.).

Our Managed Care Network

AltaMed currently contracts with eleven (11) Knox Keene-licensed health plans in Los Angeles and Orange Counties. Under these contracts, AltaMed serves approximately 230,000 total managed care members in all lines of business offered by the health plans including: Commercial HMO, Commercial PPO, Medi-Cal, Medi-Medi, and Senior HMO Plans. The Health Plans currently contracted with AltaMed include:

- Aetna
- Anthem Blue Cross of California
- Blue Shield of California
- CalOptima

- Care 1st.
- Wellcare Medicare
- L.A. Care Health Plan
- Health Net
- Molina Healthcare
- Universal Care Dba Brand New Day
- Scan
- Central Health Plan
- United Healthcare

Dental Services

AltaMed offers complete dental services in four (4) different locations Boyle Heights, Bell, Garden Grove, and Huntington Beach. We have a full range of general dentistry services. We currently serve Medi-Cal, Healthy Families, and Fee for Service Medi-Cal patients. The Dental Plans currently contracted with AltaMed include:

- Access Dental Health Plan
- Liberty Dental Plan of California
- SafeGuard Dental

Other AltaMed Contracts

AltaMed also maintains other contracts for each of its programs, consistent with the corresponding AltaMed/Payor Contracts. Some contracts are site-specific to meet the requirements of the funding source.

- HIV Services (Various Grants)
- Long Term Care – Adult Day Health Centers (ADHC)
- Long Term Care – Case Management:
- Multipurpose Senior Services Program (MSSP)
- Integrated Care Management Program (ICMP)

Network Operations

The Contracting Department is responsible for overseeing contract operations, which include managing the following activities:

- Contracting with health plans, physicians, physician groups, hospitals,

nursing facilities, ancillary providers, and supporting services (clinical and non-clinical) to ensure comprehensive and adequate coverage of services according to each AltaMed/Payor Contract

- Communicating and educating contracted providers regarding applicable AltaMed policies and procedures
- Resolving provider issues, complaints, and grievances (in collaboration with the Medical Management and Client Services Departments)
- Acting as the AltaMed liaison with contracted health plans and providers
- Monitoring provider compliance according to contractual provisions (in collaboration with the Medical Management Department)
- Maintaining provider contracting information and records

Contract/Credentialing Requirement:
If you are contracted with AltaMed please ensure all of your providers that are treating AltaMed patients are credentialed. Quality Care begins with connecting our patients to quality providers such as yourself. Our goal is to ensure all providers, covering providers, and physician extenders within your practice are contracted and credentialed with AltaMed. Network participation not only increases access to patient care but also allows us to remain compliant with our contracted health plan partners. Failure to do so may result in claim denials with the sole remedy to terminate the Agreement in accordance with the provisions of the agreement.

Provider Communications

Provider mailings are coordinated by the Contracting Department to ensure that information necessary to effectively serve and support the provision of services to AltaMed Patients/Participants/Clients is provided in a timely basis.

In addition, the launch of the new AltaMed Web Site in January 2010, will give providers access to information via the Web. A few items that will be available are: the Provider Manual, Authorization Request Forms, Provider Bulletins, and Network Updates, among others.

AltaMed's Provider Communications Plan ensures that key information is shared with in-house providers, impacted departments, and external/contracted providers, regarding issues including but not limited those listed below.

- Health Plan/Benefit Changes
- Key Administrative Changes
- Procedural Changes
- Programmatic Changes
- Provider Network Changes
- Relevant Policies & Procedures
- Service Guidelines
- Strategic Planning Initiatives

Provider Education

Provider education of contracted providers and their staff is coordinated by the Contracting Department. Structured provider trainings include the topics listed below. Additionally, Department staff may provide general information, and address concerns informally, as requested or as deemed necessary.

- Administrative Procedures
- Claims & Billing Procedures
- Contractual Roles & Responsibilities
- Covered Services/Benefit Information
- Credentialing & Recredentialing Guidelines
- Quality Management Program
- Referrals/Utilization Management
- Regulatory Updates and Health Plan Communications

Provider Requirements

All Contracted Providers must render services in accordance with the highest standards of competence, care and concern for the welfare and needs of Patient/Participant/Clients and in accordance with the laws, rules and regulations of all governmental authorities having jurisdiction.

Authority and Responsibility Retained by AltaMed

The AltaMed Health Services Board of Directors has the ultimate responsibility for the performance of the organization. The Board of Directors has delegated the ongoing and continuous oversight of all operations to the Executive Committee through the President and Chief Executive Officer. AltaMed does not through its contracts, or other arrangements, delegate authority of its decision-making process and authority. AltaMed retains the right and authority over all key decisions affecting the corporation and its contracted provider operations and management.

AltaMed has the authority and responsibility to implement, maintain, and enforce AltaMed policies governing Contractors' duties under their agreement(s) with AltaMed and/or governing AltaMed's oversight role. AltaMed has the right and responsibility to conduct audits, inspections and/or investigations in order to oversee contractors' performance of duties described in their AltaMed agreement(s) and to require Contractors to take corrective action if AltaMed or the applicable federal or state regulator determines that corrective action is needed with regard to Contractors' duties under their AltaMed agreement, and/or if Contractors fail to meet AltaMed standards in the performance of those duties.

Contractors must cooperate with AltaMed in its oversight efforts and must take corrective action as AltaMed determines necessary to comply with the laws, accreditation standards, Payor Contract requirements and/or AltaMed policies governing the duties of the Contractor or the oversight of those duties.

Medical Decision and Financial Statement

There is an established AltaMed policy requiring practitioners and licensed utilization management staff responsible for utilization decisions to affirm that utilization decisions are based solely on appropriateness of care and services. AltaMed Health Services does not reward practitioners or other individuals conducting utilization review decisions that result in under-utilization (also stated in our Quality Management Program, refer to Section 5).

Open Communication with Patients

Providers are required to participate in candid discussions with their patients regarding all decisions about their care, including but not limited to, diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, and estimates of the benefits associated with available treatment options, regardless of the cost or coverage. Furthermore, patients must be provided clear explanations about the risks from recommended treatments, the length of expected disability, and the qualifications of the physicians and

other health care providers who participate in their care. Moreover, providers must inform Medi-Cal members that they have the freedom of choice in obtaining Family Planning, Abortion Services, Sexually Transmitted Disease (STD) treatment, and Sensitive Services for Minors without prior authorization. For the aforementioned services, the member may self-refer to any willing provider including out- of-network providers.

Contract Provisions

Additionally, Contracted Providers must comply with the following provisions, which are part of the provider's official contract:

1.1 Provision of Services:

- Contracted Providers must agree to render professional medical services to Patients/Participants/Clients referred to the Contracted Provider by AltaMed (provided that the Contracted Provider's application for participation has been approved by the AltaMed Credentialing Committee)
- Contracted Providers may not provide services to AltaMed Patients/ Participants/Clients, except in an emergency, without first securing authorization from AltaMed's Utilization Management Department
- Contracted Providers must consult with AltaMed physicians and other health professionals when so requested and must participate in AltaMed's peer review activities

1.2 Standards of Practice and Compliance with Laws:

- Contracted Providers must comply with all applicable laws, rules and regulations of all governmental authorities relating to the licensure and regulation of health care providers and the provision of health care services
- Contracted Providers must at all times conduct a professional medical practice that is consistent with the applicable State and Federal laws and with the prevailing standards of medical practice in the community
- Contracted Providers are expected to adhere strictly to the canons of professional ethics

If a single Contracted Provider is compensated more than $100,000 per year, the Contracted Provider must agree to:

- File all certification and/or necessary disclosures regarding lobbying activities to the appropriate Federal, State, County or City agency in the forms set forth in their implementing regulations
- Submit a copy of such certification and disclosures to AltaMed
- AltaMed shall periodically conduct an evaluation of such agreements and relevant files to ensure that such certification and disclosure requirements have been met

1.3 Availability:

- Contracted Providers must provide available and accessible services to AltaMed Patient/ Participant/ Clients at all times, as defined in Section 3, "Access to Care Guidelines"
- Contracted Providers must agree to permit AltaMed to monitor and evaluate accessibility of care and to address problems that develop, which shall include but not be limited to, waiting time and appointments

1.4 Covering Providers:

- Contracted Providers must give AltaMed reasonable, advance, written notice of any periods of unavailability (e.g., vacation)
- In such cases, Contracted Providers must agree to arrange for the services of another qualified professional in the same specialty, satisfactory to AltaMed, to render services to any AltaMed Patient/ Participant/Clients referred during the term of the absence
- Compensation for services rendered during such absence will be paid only to Contracted Providers and he/she must accordingly compensate the Covering Provider

1.5 Surgery and Hospital Admissions:

- If a Contracted Provider is a physician or other health care professional who possesses hospital privileges, the Contracted Provider must maintain throughout the term of his/her agreement with AltaMed, his/her medical staff membership at said hospital(s), and other privileges, which are deemed reasonably necessary by AltaMed for the performance of the duties under the contract(s) with AltaMed

- Whenever a Contracted Provider recommends surgery for an AltaMed Patient/ Participant/ Client, the Contracted Provider must contact AltaMed to obtain prior authorization for the proposed treatment.

The Provider must work to perform said surgery at an AltaMed or the financially responsible Health Plan contracted Hospital

1.6 Medical Documentation:

- After the initial office consultation with an AltaMed Patient/Participant/Client, Contracted Providers must submit to AltaMed an Initial Consultation and Follow- Up report
- Contracted Providers must submit to AltaMed, in a timely manner summary reports of findings as deemed necessary by the Contracted Provider and the referring AltaMed provider
- Health records must contain all information necessary to comply with documentation standards as outlined in Section 3, "Health Record Standards"

1.7 Confidentiality of Records:

- Contracted providers (physicians and non-physicians) must comply with all applicable confidentiality requirements imposed by Federal and State law. This includes the development of specific policies and procedures to demonstrate compliance
- All information, records, data collected and maintained for the operation of the health care service plans or other payors with which AltaMed is associated, and information pertaining to Contracted Providers, AltaMed Patient/Participant/Clients, facilities and associations, will be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations
- AltaMed agreements may not be construed to require confidential

  treatment for any information that is subject to disclosure under the California Public Records Act

1.8 Quality Management:

- AltaMed maintains a Quality Management/Improvement Program in order to assure a standard of care consistent with State and Federal laws, with the applicable contractual obligations of health care service plans and payers, and with the prevailing standards of medical practice and health care in the community
- Contracted Providers must cooperate and comply with AltaMed quality assurance requirements, credentialing and peer review processes

1.9 Continuing Care Obligation:

- In instances where a provider contract is terminated "without cause" and any AltaMed Patients/Participants/Clients are receiving care for acute or serious chronic conditions, California state law (SB1129) requires that such Patients/ Participants/ Clients have the right to continue to be treated by their terminated provider for up to 90 days, if they so request
- In accordance with CA Health and Safety Code 1373.65(f), AltaMed notifies members of the termination of specialists in the preferred network. The notification to members states "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated period. Please contact your HMO's customer service department, and if you have any questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll- free number, 1-888-HMO-2219, or at TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov"
- "Without cause" includes terminations NOT attributable to quality of care issues, fraud, or other criminal activity
- AltaMed Patients/Participants/Clients may continue to be treated by the physician for up to 90 days, as long as the physician agrees to reasonable contract terms proposed by AltaMed. This time period may be extended if the transfer of services is not considered safe. Some examples of acute medical conditions or serious conditions include, but are not limited to:
  i. Second or third trimester of pregnancy (as applicable)
  ii. High-risk pregnancy (as applicable)
  iii. Recent surgery with subsequent complications requiring the patient to receive ongoing home health services
  iv. Outpatient critical cases in the process of stabilization (such as intensive radiation therapy or treatment of uncontrolled diabetes)
  v. Terminal cases

- Outpatient critical cases in the process of stabilization (such as intensive

  radiation therapy or treatment of To assist AltaMed in maintaining continuity of care for its Patients/ Participants/ Clients, Contracted Providers are required to share the medical records of services rendered to AltaMed Patients/Participants/Clients, provided that the appropriate release of information has been obtained
- Upon a member reassignment or transfer, Contracted Providers must provide one copy of these records, at no charge, to the member's new physician. Upon request, additional copies must be provided at

reasonable and customary copying costs, as defined by California Health and Safety Code 1792.12

1.10 Reporting of Grievances / Unusual incidents:

Contracted Providers must agree to immediately report to AltaMed, by telephone and in writing, any complaints received from AltaMed Patient/Participant/Clients and any incidents or unusual occurrences at or in a Contracted Provider's office

1.11 Compensation:

- Contracted Providers must bill only AltaMed for all approved services he/she provides to AltaMed Patients/Participants/Clients, with the exception of applicable copayments or deductibles
- Contracted Providers may not seek any reimbursement for authorized services provided to AltaMed Patient/Participant/Clients from the Payors with which AltaMed contracts
- Surcharges to AltaMed Patient/Participant/Clients are strictly prohibited
- In the event that AltaMed fails to pay Contracted Providers for authorized health care services rendered to an AltaMed Patient/Participant/Client, including but not limited to AltaMed's insolvency, the Patient/Participant/Client will not be liable for any sums owed to Contracted Providers by AltaMed
- Under no circumstances may Contracted Providers or their agents, trustees or assignees maintain any action at law against any AltaMed Patient/ Participant/Client to collect sums owed to Contracted Providers by AltaMed

1.12 Indemnify and Hold Harmless:

- Contracted Providers must hold harmless the Payors with whom AltaMed contracts as well as the corresponding AltaMed Patient/Participant/Clients in the event AltaMed cannot or will not pay for authorized services performed by Contracted Providers pursuant to his/her agreement(s) with AltaMed
- Contracted Providers must agree to indemnify and hold AltaMed harmless against any and all actions, claims, demands and expenses of all kinds which result in or arise out of any dispute with an AltaMed Patient/Participant/Client, or malpractice or neglect caused by Contracted Providers or their agents, employees or representatives in the performance or omission of any act or responsibility of the Contracted Provider under his/her contract with AltaMed

1.13 Recovery from Third Parties; Lien Rights:

- Where duplicate coverage exists, Contracted Providers must assist AltaMed in pursuing coordination of benefits or other permitted method of third party recovery. Contracted Providers must identify and notify AltaMed of all instances or cases in which Contracted Providers believe that an action by a Patient/ Participant/ Client involving the tort or workers' compensation liability of a third party or estate recovery could result in recovery
- Contracted Providers may not claim recovery of the value of covered services rendered to a Patient/Participant/Client in such cases or instances and must refer all cases or instances to AltaMed within five (5) days of discovery

1.14 Books and Records:

- Contracted Providers must agree to maintain its books and records pertaining to the goods and services furnished under his/her agreement(s) with AltaMed, to the cost thereof, in a form consistent with the general standards applicable to such book or record keeping
- Contracted Providers must cooperate with AltaMed in order to enable AltaMed to fulfill its contractual and statutory obligations, by allowing AltaMed access to Contracted Providers' books, records, and other papers
    i. Retain such books and records for a term of at least ten (10) years from the close of the fiscal year in which the provider contract is in effect
    ii. Comply with all requirements of AltaMed's contracts with Payers, as applicable
- These obligations are not terminated upon termination of the respective agreement(s) with AltaMed whether by rescission or otherwise

1.15 Independent Contractors:

- Contracted Providers are at all times acting and performing as independent contractors
- The sole interest and responsibility of AltaMed with respect to such performance is to ensure that the services are rendered in a competent, efficient, and satisfactory manner
- The legal relationship between AltaMed and Contracted Providers or any of Contracted Providers' employees, associates or subcontractors, may not be construed to cause any such employee, associate or subcontractor to become or to be treated as an employee of AltaMed

1.16 Assignment and Delegation:

Contracted Providers may not assign or delegate any of the duties covered in his/her contract(s) with AltaMed without the prior written consent from AltaMed and its Payors, as applicable

1.17 Non-Discrimination:

- Contracted Providers may not discriminate against AltaMed Patient/ Participant/ Clients in the rendition of services on the basis of race, color, national origin, ancestry, sex, marital status, sexual orientation or age
- Contracted Providers may not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and/or family care leave
- Contracted Providers must insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment
- Contracted Providers must comply with the provisions of the Fair Employment and Housing Act and the applicable regulations promulgated thereunder

Managed Care:

Managed Care 101
Please refer to Exhibit I “Scan Managed Care 101”

Managed Care Basics
Please refer to Exhibit II “Health Net Basics of Managed Care”

Managed Care Risk
Please refer to Exhibit III “Managed Care Risk”

Access Standards Requirements

Access Standard Requirement	Medi-Cal	SNP/Cal-Mediconnect	HMO/Commercial
PCP: Initial Health Assessment and Individual Health Assessment and Individual Health Education Behavioral Health Assessment (IHEBA) "Staying Healthy *(see footnote)	LA: < 90 calendar days from when the member becomes eligible Members <18 months of age < 60 calendar days of enrollment or within periodicity timelines as established by the American Academy of Pediatrics (AAP) for ages two and under, whichever is less	LA: < 90 calendar days from when the member becomes eligible	LA: < 90 calendar days from when the member becomes eligible. Members <18 months of age < 60 calendar days of enrollment or within periodicity timelines as established by the American Academy of Pediatrics (AAP) for ages two and under, whichever is less
PCP: First Prenatal Visit A periodic health evaluation for a member with no acute medical problem. ** (see footnote)	· < 14 calendar days of request · < 7 calendar days of request for Healthy Kid	N/A	·< 14 calendar days of request
PCP: Routine preventive health examination	< 10 business days of request	< 30 calendar days of request	< 10 business days of request
PCP: Routine Primary Care (non-urgent): Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment.	< 10 business days of request	< 10 business days of request	< 10 business days of request
Access Standard Requirement	Medi-Cal	SNP/ Cal-Mediconnect	HMO/Commercial

PCP: Urgent Care: Services for a non-life threatening condition that could lead to a potentially harmful outcome if not Treated in a timely manner. *** (see footnote)	• < 48 hours of request if no authorization is required • < 96 hours if prior authorization is required	• < 48 hours of request if no authorization is required • < 96 hours if prior authorization is required	• < 48 hours of request if no authorization is required • < 96 hours if prior authorization is required
PCP: Emergency Care: Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	Immediate, 24 hours a day, 7 days per week	Immediate, 24 hours a day, 7 days per week	Immediate, 24 hours a day, 7 days per week
PCP: In-Office Waiting Room Time: The time after a scheduled medical appointment a patient is waiting to see a practitioner once in the office.	Within 45 minutes of arrival	Within 45 minutes of arrival	Within 45 minutes of arrival
PCP: Speed of Telephone Answer (Practitioner's Office) The maximum length of time for practitioner office staff to answer the phone.	< 30 seconds	< 30 seconds	< 30 seconds
Urgent Message during Business hours:	Return Call within 30 minutes	Return Call within 30 minutes	Return Call within 30 minutes
Access Standard Requirement	**Medi-Cal**	**SNP/ Cal-Mediconnect**	**HMO/Commercial**

PCP: After Hours Care: Physicians are required by contract to provide 24 hours, 7 days a week coverage to members. Physicians, or his/her on-call coverage must return urgent calls to members, upon request within 30 minutes.	• Automated systems must provide emergency 911 instructions • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, covering practitioner or offer a call-back from the PCP or covering practitioner within 30 minutes • If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner for both, urgent and non-urgent calls	• Automated systems must provide emergency 911 instructions • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, covering practitioner or offer a call-back from the PCP or covering practitioner within 30 minutes • If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner for both urgent and non-urgent calls	• Automated systems must provide emergency 911 instructions • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, covering practitioner or offer a call-back from the PCP or covering practitioner within 30 minutes. • If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner for both urgent and non-urgent calls.
*SCP: Routine Specialty Care Physician Appointment ****(see footnote)	LA: < 15 business days of request, not to exceed 30 calendar days	LA: < 30 calendar days of request, not to exceed 30 calendar days	LA: < 15 business days of request, not to exceed 30 calendar days
SPC: Urgent Care: Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	• < 48 hours of request if no authorizationis required • < 96 hours if prior authorization is required	• < 48 hours of request if no authorization is required • < 96 hours if prior authorization is required	• < 48 hours of request if no authorization is required • < 96 hours if prior authorization is required

Access Standard Requirement	Medi-Cal	SNP/ Cal-Mediconnect	HMO/Commercial
*Ancillary Care: Non-Emergent Ancillary Appt.	< 15 business days of request	< 15 business days of request	< 15 business days of request
Behavioral Health Telephone Responsiveness Average Speed to Answer Abandonment Rate	< 30 seconds < 5%	< 30 seconds < 5%	< 30 seconds < 3%
Behavioral Health Care: Routine Appointment	< 10 business days of request	< 10 business days of request, not to exceed 30 calendar days	< 10 business days of request
Behavioral Health Care: Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful out-come if not treated in a timely manner.	< 48 hours of request	< 48 hours of request	< 48 hours of request
Behavioral Health Care: Life Threatening Emergency	Immediately	Immediately	Immediately
Behavioral Health Care: Non-Life Threatening Emergency	< 6 hours of request	< 6 hours of request	< 6 hours of request
Behavioral Health Care: Emergency Services	Immediate, 24 hours a day, 7 days per week	Immediate, 24 hours a day, 7 days per week	Immediate, 24 hours a day, 7 days per week

CalOptima Standards:

*Initial Health Assessment: Within 120 calendar days after becoming a CalOptima member.

**First Prenantal Visit: within 10 business days after request

***Urgent care services for a non-life threatening condition: within 24 hours

****SPC Routine Specialty Care appointment: within 15 business days

Grievance and Dispute Procedure

1. Contracted Providers must comply with the Patient/Participant/Client grievance procedures, as described in Section 5, "Grievances and Appeals"
2. Contracted Providers must abide by AltaMed's adjudication process for provider grievances as described in Section 5, consistent with the applicable AltaMed/Payor contracts
3. All disputes regarding the denial or modification of payments for authorized services provided by Contracted Provider, or a denial or modification of a Contracted Provider's request to obtain authorization for services, shall be resolved according to AltaMed's Provider Grievance and Appeals Procedures as outlined under Section 4, "Denials and Appeals"

Arbitration:

1. Any controversy or claim arising out of or relating to provider contracts, or the breach thereof, which the parties cannot resolve through the dispute resolution process must be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association

Due Process:

1. AltaMed offers its contracted providers "due process" by notifying providers in writing of the reason(s) for participation denial, suspension or termination from AltaMed's contracted network
2. Contracted Providers have the right to request and to be offered due process in appealing initial determinations
3. AltaMed processes reports to the Medical Board of California (MBC-805 report) and/or the National Practitioner Data Bank (NPDB) when required to do so by State and Federal law

Insurance Coverage:

1. Contracted Providers must provide, at their own expense (unless otherwise defined in their contract), a policy of general liability, professional liability insurance and other insurance, as applicable
2. Contracted Providers' Professional Liability Insurance (unless the parties otherwise designate in writing) shall provide for limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate
3. Such insurance must cover Contracted Provider and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any services provided by Contracted Providers
4. Insurance coverage must be maintained by Contracted Providers throughout the entire term of his/her agreement(s) with AltaMed
5. Contracted Providers must provide AltaMed with certificates of insurance or evidence of self-insurance demonstrating the insurance coverage, and must provide for no less than thirty (30) days written notice to AltaMed of any cancellation, reduction, or other material change in the amount or scope of any coverage(s)

HMO Benefits

AltaMed is responsible for providing and for arranging for the provision of services covered under each of its contracts with health plans. The "standard" HMO benefits are summarized below.

Please contact our Utilization Management department at (855) 848-5252 (you may contact the Authorizations Coordinator or the Nurse Case Manager) for specific benefits under each Health Plan and Line of Business (Commercial, Medi-Cal, Healthy Families, etc.).

"STANDARD HMO COVERED SEVICES" This is a SAMPLE Only	
SERVICE CATEGORY	HOW TO OBTAIN
Health Education Program: Provided by AltaMed, the capitated hospital and the health plan when requested for or by members.	Members should contact AltaMed or their Health Plan.
Home Health Agency: Provided by the capitated hospital or arranged through the member's health plan. Provided as medically indicated.	Must be ordered by the AltaMed Primary Care Physician and sometimes requires approval from the Member's Health Plan.
Hospice: Provided by the capitated hospital or arranged through the member's health plan. Provided as a less costly alternative to hospital care for terminal illness.	Must be ordered by the AltaMed Primary Care Physician.
Hospital Care: Provided by the capitated hospital or arranged through the member's health plan. Includes patient, room and board, intensive care, and other hospital-based services.	Must be ordered by an AltaMed Physician, except for emergencies.
Infant and Child Care: Provided by AltaMed and/or inpatient facility services provided by the capitated hospital or arranged through the member's health plan.	Advance appointment recommended except in emergencies.
Injections and Immunizations: Provided by AltaMed in most cases as medically indicated.	Advance appointment recommended, except in emergencies
Maternity Care: Provided by AltaMed. Care during and after pregnancy: delivery and care after delivery, including Cesarean.	Advance appointment recommended except in emergencies. No referral is needed from the Primary Care Physician to see an AltaMed OB/GYN.
Mental Health Services: Limited assessments provided by AltaMed. (Call AltaMed Authorizations Department for additional information).	Limited Services. Call AltaMed or the specific Health Plan.

Miscarriage: Provided by AltaMed and/or inpatient facility services provided by the capitated hospital or arranged through the member's health plan.	The AltaMed Primary Care Physician should be contacted for instructions, except in emergencies.

"STANDARD HMO COVERED SEVICES"
This is a SAMPLE Only

SERVICE CATEGORY	HOW TO OBTAIN
Newborn Care: Provided by AltaMed.	Advance appointment recommended except in emergencies.
Primary Care Physician Services: Provided by AltaMed. Includes office visits, examinations, treatment, operation and consultations.	Provided onsite at the three (3) AltaMed primary care clinics (East Los Angeles, El Monte, and Pico Rivera). Advance appointment recommended except in emergencies.
Prostate and Other Cancer Screening: Provided by AltaMed or by referral to a contracted provider.	Must be ordered by an AltaMed Physician.
Prosthetic Devices: Provided by the capitated hospital or arranged through the member's health plan.(Artificial limbs/braces) and Durable Medical Equipment: Provided as medically indicated.	Must be ordered by an AltaMed Physician.
Skilled Nursing Care: Provided by the capitated hospital or arranged through the member's health plan. Provided as a less costly alternative to hospital care.	Must be ordered by an AltaMed Physician.
Specialty Care: Provided by referral to a contracted specialist.	Provided only after referral by an AltaMed physician, except in emergencies. Referrals are not needed to see the OB/GYN doctor that contracts with AltaMed.
Speech, Physical and Occupational Therapy and Audiology-Audiometry: Provided by AltaMed or by referral to a contracted provider.	Must be ordered by an AltaMed Physician.

X-Ray and Lab Services: Provided by AltaMed or by referral to a contracted provider.	Must be ordered by an AltaMed Physician.

Access to Care

PATIENTS' RIGHTS AND RESPONSIBILITIES

You may speak with the Clinic Administrator at any AltaMed site if you have any questions about the care or services you received. You may also call Member Services at: 1 (855) 848-5252.

As a Patient, You Have the Right To:

1. Be treated with dignity and respect
2. Get care without discrimination based on: age, race, ethnicity, country of origin, sex, religion, sexual orientation, genetic information (family health history), claims experience, medical history including End Stage Renal Disease (ESRD), evidence of insurability (including conditions arising out of domestic violence), source of payment, health problem, mental or physical disability or your ability to pay
3. Get facts and care in a way that doesn't make you feel different because of your culture or language
4. Ask for an interpreter in your language. We also offer American Sign Language (ASL)
5. If you are blind or have trouble reading, documents can be read out loud or given to you in Braille
6. Be given information in a way that you know what is being said
7. Learn about our AltaMed doctors and services at the time you start coming to AltaMed and during the time you are a member
8. Know the name of your doctor and know about their training
9. Choose or change your doctor within the AltaMed network
10. Take part in your care. You and your family (when appropriate) work closely with your health care team. This team approach makes sure you have well planned care

11. Talk about all your health choices with your doctor and not worry about the cost of your health plan coverage

12. Get a second opinion from another doctor of your choice within AltaMed

13. Say no to any tests or care offered to you, if you choose

14. Know what's in the forms you need to sign

15. Know all risks of and benefits to taking part in any research study or clinical trial. A clinical trial is a study that uses patients for testing new medications (or meds). To take part in such a study, you would have to give your approval in writing. If you do not want to take part in such a study, you would also have to let us know in writing

16. Get help with making an Advance Health Care Directive. An Advance Health Care Directive puts your wishes in writing about your health care and the decisions you'd like made for you if you cannot speak for yourself. It also lets you write down the name of the person you want to make health care decisions for you if you cannot speak for yourself

17. Get a timely answer for services that you have asked for. Services can mean tests or exams and referrals to specialists

18. Get needed health care and education to help you prevent disease

19. Get urgent health care

20. Have your pain treated and managed

21. Seek specialty care within AltaMed

22. Privacy in receiving your care and with all of your personal needs

23. Privacy in handling all your personal, health, and social records. AltaMed cannot give out these records to anyone without your written approval. AltaMed may only use or make known this information if it is needed in an emergency situation, because of state and federal laws or in the event you express the will to harm yourself or others

24. Get a copy of your health records with enough notice. You can let your doctor know in writing if something is missing or wrong with your record

25. Allow us to use your health information in a Health Information Exchange (HIE) that shares health records with participating doctors, hospitals, labs, radiology centers, and other health care providers in a secure and electronic manner
26. Give your written approval or consent to AltaMed for the use of any sound, video, or film recording of you
27. Make a formal complaint ("grievance") and/or challenge the care provided to you ("appeal")

Complaints & appeals can be sent to:

AltaMed Health Services Corporation

Member Services Department

2040 Camfield Avenue

Los Angeles, CA 90040

Tel: 1 (855) 848-5252

28. Ask for a State Hearing. A Hearing is a legal procedure where you can present your concern to the State of California. At the Hearing, you may represent yourself or have another person such as an attorney, friend, relative or any person you choose
29. Offer your thoughts on how to make these Patient Rights and Responsibilities better

As A Patient, You Have The Responsibility To:

1. Show identification and/or insurance cards at each visit. This proof lets your doctor know that s/he has the right health record
2. Tell your doctors if you do not understand what they are telling you
3. Tell your doctors about past illnesses. We may also ask you about hospital stays, medications, and other information about your health
4. Work with your doctors to care for your health care
5. Learn about your health problems. Help set goals that both you and your doctor agree on as much as possible

6. Follow instructions about your care and let your doctor know if you cannot follow the instructions or choose not to
7. Tell us about changes in your address, phone number, insurance coverage, and changes in income as soon as you know
8. Make and keep your doctor's visit. Please come to your visit on-time. Dial the Patient Contact Center at 1-888-499-9303 when you think you might be late or need to cancel an appointment. If you are late, you may have to reschedule your appointment
9. Be respectful when calling or visiting AltaMed, which includes respecting doctors, staff, visitors, and property
10. Respect the privacy of others
11. Use AltaMed's grievance and appeals process to best address your concerns about the services you receive from AltaMed:

Grievances and appeals can be sent to:

AltaMed Health Services Corporation
Member Services Department
2040 Camfield Avenue
Los Angeles, CA 90040
Tel: 1 (855) 848-5252

AltaMed wants to give you the best possible service. We also want to give you the chance to talk openly about your care with us. If you have a concern or need help, please call our Member Services Department at: 1 (855) 848-5252.

As proof that we care, AltaMed goes through a national approval process in safety and quality. This process is sponsored by The Joint Commission, an outside agency of healthcare workers that includes doctors, nurses, and patients. This group sets the standards for health care quality and service across the United States.

The Joint Commission surveys AltaMed without notice to see how well AltaMed follows the Joint Commission Standards. The survey results will be used to judge whether AltaMed meets The Joint Commission's standards for safety and quality.

You may reach out to the Joint Commission if you have any questions or concerns that still need answers:

Division of Accreditation Operations

Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Tel: 1-800-994-6610
Fax: 1-630-792-5636

Confidentiality

Information about our patients/participants/clients/practitioners must be maintained in the strictest confidence with Sections 1374.8 and 1399.900 et seq. of the California Health and Safety Code and Section 56.10 of the California Civil Code and the HIPAA Privacy and Security Rules.

Definition: Senate Bill (SB) 1903, Chapter 1066, Sections 56.10, 56.11 and 56.07 of the Civil Code and Section 12311 of the Health and Safety Code – "Confidentiality of Medical Information Act" – that except for specified circumstances, would require a valid authorization for release of medical information to a person or entity not otherwise authorized by law to obtain such information.

This law also provides that an adult patient/participant/client shall be entitled to inspect and receive copies of his/her health records upon written request to the health care practitioner.

1. The bill also authorized an adult patient/participant/client to request a specified amendment to his/her health record if the patient/participant/client believes that the records are incomplete or inaccurate and requires the health care practitioner to review the amendment request before attaching that addendum to the patients/participants/clients health records. The health care practitioner is not required to accept all requests for amendment submitted by the patient/participant/client

2. Protected Health Information (PHI) of a patient/participant/client is specific medical information is data related to a patient/participant/client physical or mental condition, medical history or medical treatment, that provides sufficient detail to allow identification of the individual member. HIPAA requires that the following data elements (shown below) be protected from unauthorized access as they are considered PHI:

- Names
- Medical Record Numbers/ Account Numbers
- Address
- Social Security Number
- License/Certification Numbers
- Vehicle Identifiers/Serial Numbers/License Plate Numbers
- Internet Protocol Addresses
- Health Plan Numbers
- Full Face Photographic Images and any comparable images
- Web Universal Resource Locators (URL's)
- Any Dates Related to any Individual (Date of Birth and Dates of Service)
- Telephone/Fax Numbers
- Email Addresses
- Biometric Identifiers including Finger and Voice Prints
- Any Other Unique Identifying Number, Characteristic or Code
- NPI-National Provider Identifier
- Any other patient/participant/ client identification number

3. Except to the extent expressly authorized by the patient/participant/ client, AltaMed may not intentionally share, sell or otherwise use any medical information for any purpose not necessary to provide the health care services to the patient/participant/client

4. All personal and clinical information related to patients/participants/ clients is considered confidential. This may include, but is not limited to:

    i. Medical information relating to his or her physical or medical condition

    ii. Medical history or medical treatment that provides sufficient detail to allow identification of the patient/participant/client and/or any one of the following:

        a. Social Security Number

        b. Family Identification number

        c. Patient/participation/client name

        d. Medical information collected during the utilization management process for the purposes of managing the quality of health care resources

        e. Claims records or files containing data pertaining to claims or certification of requested services. This includes patient/

participant/client grievance materials

f. Patient/Participant/Client data collected during the enrollment and underwriting process

g. All information of a personal nature acquired by AltaMed

1. The fact that a patient/participant/client is established with AltaMed Health Services is not considered confidential

2. AltaMed Health Services staff is responsible for maintaining confidential information

3. Clinical information received verbally or written must be documented in the

4. Electronic Health Record. The EHR must include a secured system restricting access to only those with authorized entry. Computers must be protected by a password known only to the computer user assigned to that computer. Computers will not be left on unattended if any computer screen displays member or practitioner information

5. Electronic, facsimile, or written clinical information received is secured, with limited access to employees to facilitate appropriate participant/patient/client care. No confidential information or documents will be left unattended, i.e. open carts, bins or trays at any time. Hard copies of all documents will not be visible during breaks, lunches, or after hours

6. Confidential information will be stored in a secure area and medical information will be disposed of in a manner that maintains confidentiality, i.e., paper documents containing PHI must be disposed in designated shred bins

7. Any confidential information used within AltaMed Health Services for health care operation activities such as to assist with training, statistical reporting, and population management will be “de-identified” (i.e., all identifying information blacked out), to prevent the disclosure of confidential medical information

8. All records related to quality of care, unexpected incidence investigations, or other peer review matters are privileged communications under California Health & Safety Code section 1370 and California Evidence Code section 1157. These records are maintained as confidential and

should not be filed in the patients' medical record but instead filed as administrative records

HIPAA Rights — Patient/Participant/Client:

Under HIPAA, health care organizations are required to provide notice to individuals regarding how the organization will use and disclose protected health information, as well as the individual's rights and the organization's legal duties with respect to protected health information. Below is a list of HIPAA Rights that a patient can request:

1. Obtain an electronic or paper copy of the medical record
2. Request an amendment to their health information
3. Request confidential communications for sensitive or non-sensitive services
4. Request a limit to the sharing of certain health information for treatment, payment or healthcare operations
5. Request to limit the sharing of health information to the health insurer if the patient pays for services of a health care item out of pocket in full
6. Obtain a list of accounting of disclosures which details what health information has been shared and with whom
7. Obtain a copy of the notice of privacy practices which details patients HIPAA rights as it relates to privacy and security of health information
8. Give authorization to another individual to have medical power of attorney that can exercise the patient's rights to make choices about their health information
9. File a complaint to the Privacy Officer if the patient feels their rights have been violated

Confidential Information — Release to the Patient/ Participant/Client

AltaMed will take reasonable efforts to substantiate the identity of the individual patient/ participant/ client, e.g., ID number, date of service, etc., before releasing any information

a) Acceptable forms of identification include:

i. Valid driver's license with picture

ii. Valid state/country identification card with picture

iii. Employee identification badge with picture

iv. Passport

b) Acceptable forms stating authority to have access to PHI when the request is not made by the P/P/C:

i. Durable Power of Attorney

ii. Health Care Advanced Directive

iii. Court Order (Evidence of Foster Parent or Legal Guardianship)

iv. Authorization of Law to Act on Behalf of a Deceased P/P/C

c) If photo identification is not available or if additional information is needed, staff may question the P/P/C concerning personal information such as date of birth, address, next of kin, mother's maiden name, dates of service, SSN etc. to further verify the identity of the individual

i. A written authorization signed by the patient/participant/client or their personal representative will be required to release medical records

1. Definition: Personal Representative is a person who, under applicable law, has the authority to act on behalf of an individual in making decisions related to health care; or a person who, under applicable law, has authority to act as an executor or administrator on behalf of a deceased individual for the purposes of the Privacy Rule

ii. All request for sensitive information such as behavioral health records, substance abuse records must have a written authorization signed by the patient/participant/client and the approval of the treating health care practitioner prior to being released

iii. All requests for other sensitive information such as HIV/AIDS, STD, and Genetic testing results must have a written authorization signed by the patient/participant/client prior to being released

iv. Information will be limited to person(s) who have a need to know and/

or as required by the minimum necessary law

v. No additional information will be released other than that which is authorized or required by law

Informed Consent:

1. A patient/participation/client must give "informed consent" prior to certain procedures. In order to give informed consent, the patient/participant/client must be informed of:
    - The patient's/participant's/client's condition
    - Proposed intervention, treatment or medications
    - The potential benefits, risks and side effects of proposed interventions, treatment, or medications
    - Problems related to recovery
    - The likelihood of success
    - Any alternative interventions, treatments or medications
    - The individual's rights, to the extent permitted by law, to refuse interventions, treatments or medications
    - If the translation is requested, the translator must sign the consent form and document acknowledgment of the patient/participant/client's understanding
    - If a person other than the adult patient/participant/client signs the form their relationship must be noted below the signature
    - A witness will need to be present and is required to sign the consent form
    - It is the treating physician's responsibility to obtain informed consent. The physician may inform the patient/participant/client by verbal discussion, written information, audio, and videocassette to obtain informed consent. However, it is recommended that the physician will always give a personal explanation of a procedure and its possible complications, risks, problems related to

recuperation and alternatives

- The informed consent form signed by the patient/participant/client is documented in the health record. The original form is filed in the health record and the copy is to be given to the patient/participant/client
- The informed consent form must be obtained in the patient's/participant's/client's primary language or it must be translated and documented on the form
- If Informed Consent is obtained by an interpreter, that interpreter will document the translation, sign and date the consent form in the health record
- If the patient/participant/client agrees to a procedure, the patient/participant/client will acknowledge agreement by signing the consent form

Translation:

When the informed consent is translated, the person translating will sign the consent form and if the patient/ participant/ client understood the procedure. If a patient/participation/client gives authorization for a family member to translate, this approval will be documented on the progress note by the treating physician. If a translation service is used, the service will be documented in the health record.

Signature of Person Consenting:

When a person other than the patient/participant/client signs a form, their relationship to the patient/participant/client will be noted below the signature. (For example: a parent, guardian, conservator).

If an adult patient/participant/client/participant/client is required to sign a consent form and has a physical disability or is illiterate a mark will be obtained on the consent form. The treating physician will document the patient/participant/ client's/participant's/client's name in full and will have the patient/participant/ client/ participant/client place an "X" beneath it; in this situation two staff members will sign as witnesses.

Witnesses:

A witness will be present when the consent form is signed by the patient/ participant/client or legal representative and will sign their name in the designated space on the consent form.

Health Record Standards:

A health record (medical record) must be initiated and maintained for each AltaMed patient/ participant/ client. The health records serve as a detailed analysis of the patient's history, a means of communication to assist the multidisciplinary health care team in providing quality medical care, a resource for statistical analysis, and a potential source of defense support information in a law suit. It is the health care professional's responsibility to ensure not only completeness and accuracy of content, but also the confidentiality of the health record.

Documentation Guidelines:

1. Every entry will be recorded promptly as the events or observation occurs
2. All entries will be complete, concise, descriptive and accurate
3. Persons who administer treatment, make assessments or observations, provide information or are otherwise familiar with the patient/ participant/ client's case are authorized to enter data into the health record
4. All entries will be written in chronological sequence and all like forms filed chronologically
5. All entries will include date, (month, day, year) time of the day and be signed by the author
6. Documentation is required where regulations are not specific, based on frequency defined in each program's policy, patient/participant/client's condition, changes in the condition, and standards of the community and based on clinical judgment
7. Record pertinent observations, psychosocial and physical manifestations, unusual occurrence and abnormal behavior
8. Avoid flippant or funny remarks and do not use the record to settle

grudges

9. Symbols and abbreviations may be used only when approved by the program
10. Do not mention in the health record that an Incident Report or Notification Form was completed and/or submitted
11. Do not file the incident report in the clinical record
12. All entries will be permanent, electronically written, typewritten or legibly written in permanent ink and capable of being photocopied
13. All staff documenting in the health record will sign or authenticate all entries
14. Signatures must include the first initial, full last name, and title
15. A standardized order of filing will be followed for all health records
16. Each form must contain at least two patient identifiers. The recommendation is to include the patient/participant/client's name, date of birth and/or medical record number
17. Verbal orders will be received, transcribed and authenticated according to Nursing policies and procedures
18. Only a Registered Nurse (RN) or a Physician Assistant (PA) may take verbal orders
19. Countersignatures of mid-level practitioners, non-licensed independent practitioners, students, etc., will be in accordance with state and federal laws and regulations and as outlined in the programs policies and procedures
20. The patient/participant/client's name, gender, address, telephone number, date of birth, height and weight, and the name of and the telephone number of any legally authorized representative
21. Legal status of patient/participant/client's receiving mental health services
22. Evidence of informed consent for procedures and treatments as required by program policy
23. Diagnostic and therapeutic orders

24. Medication allergies and adverse reactions noted in a consistent, prominent place. Otherwise, no known allergies or history of adverse reactions are noted
25. Past medical history. This documentation contains serious accidents, operations and childhood illnesses
26. For children and adolescents, seventeen (17) years and younger, past medical history relating to prenatal care, birth, operations and childhood illnesses
27. Documentation of use of cigarettes, alcohol and substance abuse of patient/ participant/clients age twelve (12) years and older
28. Problem lists that indicate significant illnesses and/or conditions, which should be monitored. A chief complaint and diagnosis or probable diagnosis included
29. History and physical records that include appropriate subjective and objective information pertinent to the patient/participant/client's presenting complaints
30. Documentation of an exam appropriate for the condition
31. All medications prescribed including name, dosage, frequency and duration
32. Medications given on-site including name, dosage, route as well as the site given and whether the patient/participant/client had a reaction to the medication
33. Laboratory and other studies as ordered
34. Diagnosis, treatment procedures, tests and results
35. Practitioner informs member of test results and medical interventions
36. Practitioner documents the results, conversation and medical interventions with the member in the health record
37. Progress notes with, when indicated, notation regarding follow-up care, calls, after hour calls or visits. The specific time of the return is noted in weeks, months or as needed
38. Do not document "PRN"

39. Unresolved problems from previous office visits, which are addressed in subsequent visits
40. Documentation of patient/participant/client education, recommendations and instructions given
41. Immunization records of pediatric patient/participant/clients, age twelve (12) and under, records as well as Adult immunizations history
42. Documentation of preventive screening and services offered in accordance with clinical practice guidelines
43. Consultant notes
44. Laboratory reports are initialed by the physician upon review. Abnormal results include notation of follow-up plans
45. For adults over the age of eighteen (18) years, there is documentation that the patient/participant/clients have been apprised of their right to formulate Advance Directives
46. Advance Directives are included in the charts

Additional Guidelines:

a. Everything in the health record, including signatures, must be legible
b. No portion of the record is to be obliterated, erased, altered or destroyed
c. Never sign for another person
d. Do not leave blank spaces on forms designed for chronological sequential notes
e. When adding or enter at a later date, clearly identify the date and time of entry as well as the date and time of the occurrence. Example 04/10/01 charting for 04/08/01 0900 hours
f. Do not document before an event occurs
g. If a documentation error has been made in the record, take the follow steps:
    1. Draw one (1) line through the error (do not obliterate the error)
    2. Designate the entry as an error

3. Initial and date the error
4. Chart the correct information

Confidentiality of Health Records:

i. Disclosures made for treatment, payment, and healthcare operation purposes (§164.502). All employees and business associates are required to adhere to law regulations, and policies at all time

AltaMed maintains and requires its contracted providers to maintain policies and procedures in place to govern the confidentiality of medical records and release of medical information addressing levels of security as follows:

1. Ensure that files are secure and not accessible to unauthorized users
2. Ensure that the medical records meet Federal and State Retention Requirements
3. Security guidelines indicating who has access to the medical record
4. Staff with access to medical records has a signed confidentiality agreement on file
5. Photocopies or printouts are subject to same controls as the original record and some is designated to destroy the record when required
6. Release of medical information guidelines must address the following:
    1. Request for confidential member information via the telephone
    2. Requests made by
        a. Subpoena Duces Tecum
        b. Court Order
        c. Search Warrant
        d. Coroner's Case
        e. Law Enforcement
        f. Workman's Compensation
        g. Other Circumstances Required By Law

(a) Elements of properly executed authorization, including:

a. Name of provider that is to release the medical information

   b. Name of individual or institution that is to receive the information
   c. Patient's full name, address, and date of birth
   d. Description of information to be released, with inclusive dates of treatment
   e. Purpose or need for information
   f. Date that authorization is signed
   g. Expiration Date for when the authorization is no longer valid
   h. Signature of patient or their legal representative

1. A provider is prohibited from releasing medical information about a member's psychotherapy outpatient treatment to a requesting party without a written request to the practitioner and a notice to the patient within thirty (30) days of the request
2. Timely transfer of medical records to ensure continuity of care when a member chooses a new primary care physician
3. Availability and accessibility of patient medical records to Health Plans and to state and federal authorities or their delegates involved in assessing quality of care or investigating a member's grievance or other complaints
4. Requests for medical record information between providers of care:
   a. A provider making a member referral will transmit necessary medical record information to the physician receiving the medical referral
   b. A physician furnishing a referral service provides appropriate information back to the referring provider
   c. A physician requesting information from other treating physicians as necessary to provide care. Treating providers may include those from any organization with which the member may subsequently enroll

Submission of Medical Records to AltaMed:

There are several different methods where a treating physician can submit medical record documentation to AltaMed Health Services Corporation. The methods are through our secure provider portal, mail, or e-fax.

1. Secure Provider Portal — All documents uploaded to the secure provider portal should be uploaded with the below recommended naming conventions
    a. Specialty Notes/Office Notes
        i. (These are specialty/office notes completed by contracted provider that need to be reviewed by the AltaMed PCP)
    b. Hospital Notes
        i. (These are hospital discharge notes obtained from the discharging hospital that need to be reviewed by the AltaMed PCP)
    c. Authorizations/Referrals
        i. (These are documents related to the authorization and referral process that need to be reviewed by the AltaMed Utilization/ Medical Management Department)
2. Mail — All documents sent to AltaMed via mail should be sent to the AltaMed Health Services specific clinic location address or to the corporate office
3. E-fax — All specialty notes and hospital records can be sent directly to the AltaMed clinic PCP Medical Records Department by using the below e-fax list

AltaMed Clinic Location	E-fax
AltaMed Health Services Garden Grove	(323) 201-3231
AltaMed Health Services West Covina	(323) 201-3232
AltaMed Huntington Beach	(323) 201-3233
AltaMed Health Services Bell	(323) 201-3234
AltaMed Health Services Westlake	(323) 201-3234
AltaMed Health Services CHLA & Hollywood Pres. & Westlake	(323) 201-3236

AltaMed Health Services El Monte	(323) 201-3251
AltaMed Pico Rivera	(323) 201-3237
AltaMed Pico Passons	(323) 201-3254
1st Street	(323) 201-3258
Boyle Heights & Estrada, Ramona, William Mead	(323) 201-3238
Boyle Heights Zonal	(323) 201-3239
AltaMed Anaheim West	(323) 201-3240
AltaMed Anaheim Lincoln	(323) 201-3257
AltaMed Commerce & Montebello	(323) 201-3241
AltaMed Commerce-HIV	(323) 201-3256
AltaMed Santa Ana Bristol	(323) 201-3242
AltaMed Santa Ana Main	(323) 201-3244
AltaMed 17th Street	(323) 201-3245
AltaMed PACE Downey	(323) 201-3246
AltaMed PACE Covina	(323) 201-3206
AltaMed PACE Pomona, East LA	(323) 201-3247
AltaMed PACE Grand Plaza	(323) 201-3248
AltaMed PACE Lynwood Golden Age	(323) 201-3249
AltaMed PACE Huntington Park-Rugby	(323) 201-3233
AltaMed PACE El Monte	(323) 201-3251
AltaMed Orange	(323) 201-3243
AltaMed PACE South LA	(323) 201-3267

Any questions related to HIPAA Privacy or Health Records can be directed to the HIM Director for AltaMed Health Services.

Phone: 323-622-2444

Fax: 323-201-3212

Section V — Credentialing Appendix A

11. Medicare/Medicaid Sanctions (180-day time limit)

    NPDB

    AltaMed prohibits employment or contracting with individuals that are excluded form participation under Medicare and Medi-Cal; employment or contracting with individuals who “opt out” of Medicare; practitioners, who are excluded, sanctioned, or “opt out” of Medicare may not receive CMS

funds for care rendered to Medicare beneficiaries

NPDB takes up to 1 business day

12. Peer References
    - Three (3) Peer References to be obtained
    - Written verifications may take up to 10-15 business days

Ongoing Credentialing Update

1. Licenses, DEAs/CDCs, malpractice insurance certificates, and board certification status are tracked on a continuous basis
2. Providers are notified within 60 calendar days of credentials expiration
3. Second notifications are sent after 30 days after initial notification
4. On the first business day following the expiration date , the practitioner's panel will be
5. Closed to new members
6. By the fifth business day following the expiration date AltaMed will terminate the practitioner and move any members pursuant to Member Notification policy
7. Credentialing staff will review the application licensing board prior to termination
8. Member reassignment will be retro-active to the first day of the non-restricted license reinstatement date
9. A provider's non-compliance in providing updated information will be presented to the Credentialing Committee with recommendation to change status to "inactive"
    1. If updated documentation (i.e. DEA, insurance) is not received by expiration date credentialing will terminate effective immediately
    2. If provider is non-compliant of re-credentialing function provider will be presented for termination at Credentialing Committee at

scheduled re-cred cycle month

Note* AltaMed implements procedures to ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in our policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRO,sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment.

Utilization Management:

The Decision Making Process

The Chief Medical Officer and/or designee(s) will regularly monitor and assess the decision-making performance of its Medical Management Team participants, (Chief Medical Officer, Utilization/Quality Committee Members, Case Managers), involved in determining medical necessity, managing care and evaluating the effectiveness of the process and outcomes involved. The assessment is based on the consistent application of specified utilization management criteria (e.g., InterQual CERMe), Milliman & Robertson, Health Care Management Guidelines, HCFA, CMRI).

Consistent Application of Criteria:

The consistent application of utilization management process is enhanced, monitored and evaluated in a number of ways.

1. Member and Provider Appeals: The evaluation of the appeals process provides an opportunity to monitor for consistency. The medical necessity determination is made by the Chief Medical Officer according to established policies and procedures in case review:
    a. Outpatient denied referrals
    b. Concurrent review denials
    c. Tracking overturns of original denials by the appeals process
    d. Authorizations
2. Utilization Management Clinical Criteria
3. The effectiveness of the review process will be evaluated utilizing

participant's follow-up surveys. The results of the evaluation will be reported at least annually to the Quality Management Committee

4. Recommendations for improvement and a written action plan will be developed as appropriate. This may include coaching, training or other measures to assist with achieving compliance goals

The Authorization / Referrals Process:

The Authorization Referral Request Form is an instrument to communicate to a provider the approval, modification or denial of requested medical treatment, services and/or procedure. The Authorization Referral Request Form must be completed and faxed to AltaMed for authorization prior to the practitioner performing any treatment and/or services.

Response Timeframes:

The request will be reviewed, completed accurately and timely:

- Emergent: within twenty-four (24) hours
- Urgent within ICE timeline standards, unless a Health Plan contractual agreement indicated differently
- All others within five (5) business days

Authorization Process:

1. Physicians have telephone access 24 hours a day/7 days a week to request authorization for medical services
2. The authorization, modification or denial determinations will be based on medical necessity and will reflect appropriate application of approved practice guidelines
3. Upon receipt of the Authorization Referral Request Form from the clinic the Data Entry Coordinator will enter the Authorization Request in the system, assign the appropriate CPT/ICD-9 codes and verify benefits through the Health Plan. Eligibility is to be checked by the Clinic prior to providing any service(s)
4. If the patient/ participant/ client has coverage for the service(s), the Authorization Coordinator using the Level of Review Matrix – Level 1 criteria (approved established criteria) would evaluate the request

5. If the requested medical treatment, services and/or procedure are covered by the Health Plan and meets the established criteria, the request will be approved for forty-five (45) days
6. Should the case be questionable, or if additional information is required, the Authorization Coordinator will contract the Primary Care Physician and/or specialist by fax or telephone, requesting specific information as appropriate
7. When the authorization is pended, the authorization form is faxed to the Physician requesting additional information within 24 hours of the decision
8. If the case is pended for additional medical information, requests will be upheld no longer than four (4) working days. There will be notification to practitioners within 24 hours of the decision
9. The Authorization Coordinator will assign the generated authorization number to all approved requests
10. A computer generated authorization request form will be sent via FAX to the requesting practitioner and requested specialist. A computerized approval letter is sent to the patient/participant/client via the U.S. Postal services. The Utilization Management Department will follow up with the patient to provide assistance as appropriate
11. Should the decision be to deny, the rationale for the denial, an alternative treatment, and the Utilization Management Criteria, including information that the Chief Medical Officer and/or designee shall be available by telephone to discuss the case will be included in the letter
12. The letters denying or modifying requested services are sent to the patient/ participant/ client, via registered mail, provider and Health Plan, within two (2) working days of the determination. Only a physician may make an adverse determination

Over and Under Utilization:

The Quality Management Committee on a quarterly basis will review practitioner's report with significant deviations from the standard. The Quality Management Committee will develop any corrective action plans as appropriate.

Thresholds/benchmarks to be developed based on the number of members assigned to each practitioner and practitioner's performances.

Specialty Referral Data:

1. Quarterly, the Primary Care Physician (PCP) monthly rate of referrals by specialty is tabulated. This data is collected by AltaMed to review the data by specific product lines and clinics
2. The PCPs with a significant number of members whose referral patterns differ significantly from the mean will be identified
3. The Utilization Management Committee will review approved and denied referrals of the practitioners identified with significant deviations from the standard
4. Potential over-utilizers will be reviewed for difference in case mix, appropriateness of referrals and evidence of knowledge or skill deficiencies
5. Potential under-utilizers will be reviewed for case mix differences and evidence of strength in a specialty field (i.e. a Primary Care Physician who does all biopsies prior to dermatology referral)
6. A statistical report will be generated for each practitioner indicating referral performance relative to the mean and standard deviation of the group, validating any change from the previous quarter's data

Hospital Admission/Re-Admission:

7. High outliers may be due to intensive treatment for members. Low outliers may be due to underutilization, i.e. barriers to care, case mix or effective preventive health care. Outliers will be identified using M&R guidelines

Emergency Room Visits:

8. High outliers may reflect poor PCP access, management, or case mix. A combination of high emergency room use or low institutional use may raise concern about barriers to primary care and to secondary care
9. Practitioners with statistics higher than the M&R guidelines or industry benchmark will be flagged for possible under-utilization

Feedback And Corrective Action:

10. Practitioners reviewed by the Utilization Management and/or Quality Management Committees will receive specific feedback and/or on-going education
11. Practitioner Corrective Action Plans (CAP) will be developed as appropriate at the recommendations of the Committee

Quality Management:

Program Overview:

The mission of AltaMed Health Services, Corporate Quality Management Program (QMP) is to ensure continuous improvement, providing for the highest quality health care and human services.

This is accomplished through the establishment of a fully integrated multi-disciplinary healthcare network and coordination of all practitioners' participation in performance improvement activities, both clinical and administrative services, under the provision of ArltaMed Health Services Corporate Quality Committee (CQC).

Purpose

- The Corporate Quality Management Program (QMP) is designed to insure that optimal patient care within this health care delivery continuum fulfills the programs' responsibility to patients/participants/clients
- Quality Management is an ongoing integrated program committed to the delivery of optimal care consistent with current medical standards
- The QMP is prepared by Leadership to serve as a resource document, and will be updated as new information is obtained, and as performance improvement activities or external review bodies indicate
- The QMP will be evaluated annually

Scope

- The scope of the program is comprehensive and includes all activities that have a direct or indirect influence on the quality and outcome of clinical care and service delivered to all AltaMed Health Services patients/participants/clients and the services provided to health plans and the AltaMed provider network
- The framework for improving performances includes assessment of clinical performance, patient satisfaction, efficiency and effectiveness of processes, patient/family communication, education, access to, and outcome of care
- Issues, which affect a high volume of patients/participants/clients, occurring frequently, affect specific age groups or identified risk populations, or impact the health and safety of patients/participants/clients will be considered priorities for immediate improvement
- The QMP encompasses all programs, including the Long Term Care Program, Medical Program, HIV Program, PACE, and Teen Program

Goals

The primary goal of the Corporate Quality Management Program is to establish, support, maintain, and document quality improvement in AltaMed Health Services. This is accomplished through:

- Providing quality health care services for all patients/clients/participants through monitoring clinical outcomes and satisfaction
- Coordinating Quality Improvement Activities to ensure the development and implementation of effective health management systems to increase overall healthcare standards of care and services
- Monitoring the Quality Management Program that involves all providers of health care, thereby, ensuring that all levels of care are consistent with professionally recognized Standards of Practice
- Conducting studies of outcome patterns and trends, and communicating, documenting, and trending Quality issues to appropriate person(s)

Authority and Responsibility

Board of Directors

- The AltaMed Health Services Corporation Board of Directors (BOD) is accountable for the quality of care provided at AltaMed. The BOD is responsible for establishing, maintaining and supporting the Quality Management Program. They also have delegated the responsibility for development, review, revision, evaluation, and implementation of the Program to the Corporate Quality Committee (CQC). The Board holds the CEO accountable for the efficient and effective functioning of the AltaMed

Functions / Responsibility

- Develop, review, discuss, evaluate, approve, modify, revise, and implement the QM Program QM Work Plan, and QM Policies and Procedures annually and updates as necessary
- Provide feedback and recommendations to the committees after reviewing summary reports
- Evaluate and assess implementation of quality management activities

Quality Improvement Methodology

- AltaMed Health Services Corporation has adopted the FOCUS-PDCA process as a performance improvement methodology that will be utilized based on needs to address concerns requiring a comprehensive evaluation of the problem and identification of a solution
- The methodology is an ongoing, systematic monitoring and improvement of the measures of quality of care and services. FOCUS-PDCA is an acronym for the steps followed in Continuous Quality Improvement to improve or design a process when identifying opportunities for improvement

Sentinel Events

- Events, which are determined to be “sentinel”, will result in a thorough and credible Root Cause Analysis, implementation of improvement to reduce risk, and monitoring of the effectiveness of the improvements
- Root Cause Analysis: Progresses from “special causes” in clinical

processes to "common causes" in organizational processes. It seeks to identify potential improvements in processes or systems that would tend to decrease the likelihood of such events

- Root Cause Analysis will be used to uncover the cause or causes of performance variations, which may lead to sentinel events

Confict of Interest and Confidentiality

Conflict of Interest

- There is an established AltaMed Health Services policy for Quality Management activities in which there may be a real or potential conflict of interest for the participating practitioners or staff. Where a conflict of interest exists the individual will disqualify him/herself

Confidentiality Statement

- There is an established AltaMed Health Services policy requiring all participants attending any Quality Management Committee to sign a statement of confidentiality. Confidentiality will include information related to the duties and functions of the Committee's action and proceedings
- The Committee members are reminded at each meeting that confidentiality is critical to the effective review process
- There is an established AltaMed Health Services policy requiring practitioners and licensed utilization management staff responsible for utilization decisions to affirm that utilization decisions are based solely on appropriateness of care and services. AltaMed Health Services does not award practitioners or other individuals conducting utilization review decision that result in under-utilization

Medical Decision and Financial Statement

There is an established AltaMed policy requiring practitioners and licensed utilization management staff responsible for utilization decisions to affirm that utilization decisions are based solely on appropriateness of care and services. AltaMed Health Services does not reward practitioners or other individuals

conducting utilization review decisions that result in under-utilization (also stated in our Quality Management Program, refer to Section 5).

Medical Service Denials & Appeals

Members and providers will receive written notification of any denial of medical treatment, service and/or procedure with the appropriate accurate information to allow for a timely appeal.

1. Utilization Management Department will send denial letters to the member, Primary care and specialist providers, and health plan, after the Medical Director or designee has determined the request does not meet medical necessity criteria

2. All denials for service will be handled in a timely manner (see Referral/ Authorization process time frames), and will be entered into the system for tracking purposes

3 Utilization review criteria are applied consistently and the assessment information is clearly documented by the Medical Director or designee. The approval, denial, or deferral/ modification determinations will be based on medical necessity, benefit coverage, approved Utilization Management Criteria and practice guidelines. A psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist reviews any denial of behavioral health care that is based on medical necessity

4. Board-certified physicians from appropriate specialty areas may assist in making denial determinations of medical appropriateness for authorization requests

5. Medical Director or designee will be available to the requesting practitioner to discuss by telephone any determinations based on medical appropriateness

6. All expedited appeals will be processed in accordance with health plans requirements

7. The Utilization Management Department will send denial letters to the member, providers and health plan, in the event that the requests for services are denied by the Utilization Management designated physicians

8. Only physicians may make an adverse determination by using clinical reasons for the decisions regarding medical necessity referencing

description of approved criteria or clinical guidelines

9. These denial letters are used to communicate to the member, provider and health plan that the requests are inappropriate. The rationale for the denial and alternative treatment plan will be documented clearly with a concise explanation of the reasons for the decision

10. The requesting practitioner may at any time contact the AltaMed's Medical Director or designee during normal working hours to discuss determination of medical appropriateness

11. The letters are computer-generated, and are sent to the member within two (2) working days of the determination. It includes an explanation regarding the appeals process for both AltaMed and the member's health plan

12. Denials: Common reason for denial:

    a) The provider is not contracted with AltaMed Health Services
    b) The service does not meet utilization review criteria or benefits
    c) The member is not eligible
    d) The service is not a covered benefit. (This includes "Carve-Out" plans)
    e) The member's benefits for that service have been exhausted
    f) The primary care physician may provide the services
    g) The referring physician is not contracted with AltaMed; and/or Emergency Department services for a non-emergent situation were not authorized prior to treatment

Note: When a denial letter is generated, all information on the referral correlates with the denial letter information. Alternate plans for treatment are explained and required appeal language is included.

Appeals Process

1. If the member or the provider chooses to appeal the determination for a denial of a requested service, or payment by AltaMed, the appropriate medical information is gathered by the Utilization Management Coordinator

for evaluation by the Chief Medical Officer, Physician Leader and/or the Utilization Management Committee

2. If appropriate, the appeal will be reviewed at the next regularly scheduled Utilization Management Committee meeting. The Chief Medical Officer or designee reviews expedited appeals immediately
3. Previous decisions are reconsidered
4. A determination is made regarding a reversal or to uphold the original denial
5. A letter regarding the Utilization Management Committee's decision is sent to the member, provider and appropriate health plan
6. All responses are made within thirty (30) days of appeal
7. All expedited appeal responses are made within seventy-two (72) hours
8. Should the determination be made to modify or reverse the original decision
    A. Reversals of denials for requests for service will be processed within thirty (30) days
    B. Reversals of denials for requests for expedited appeals are processed immediately
9. The Utilization Management Committee reviews all denials and appeal determinations on a regular basis

Transition of Care Requirements

Purpose:
To provide a process for transition of care for patients who are receiving care from a physician whose contract has been discontinued within the last ninety (90) days for reasons other than quality deficiencies (e.g. business reasons or practitioner choice) or to identify members before benefits have been exhausted.

Policy:
In order to provide for the continuity of care during the transition of patients from a terminated practitioner to a contracted practitioner, with minimum disruption to the patients healthcare, [e.g. in an active course of treatment], coverage to continue care with a non-participating practitioner for a transitional period will be provided.

Assembly bill (AB) 1129:
Requires Health Plans to allow members to continue to receive care from a terminated provider, when the member requests such continuity, until a safe transfer to a plan provider may be made, consistent with good professional practice. These continuity of care requirements apply to members who are currently being treated for an acute or serious chronic condition for up to 90 days or for a high–risk pregnancy or a second or third trimester pregnancy until postpartum services related to the delivery are completed by the terminated provider. Additionally the Bill states that a terminated provider is not a provider who voluntarily leaves AltaMed Health Services. It specifically excludes providers terminated or not renewed for a medically disciplinary cause, or other criminal activity.

Procedure:

1. **If the patient requests continuity of care with a terminated physician, AltaMed will review the following information:**

    1.1 Rational for termination, e.g. physician voluntarily terminated his/her contract, terminated for business reasons, disciplinary action, etc

    1.2 Will physician agree to continue present contractual agreement if he/she will continue to provide treatment to members undergoing continuity of care

2. **There is no obligation by AltaMed to continue the provider's services beyond the contract date if:**

    2.1 The terminated provider does not agree to comply or does not comply with the same contractual terms and conditions that were imposed upon the provider prior to termination

    2.2 The terminated provider voluntarily leaves the AltaMed

    2.3 The provider's contract has been terminated for reasons relating to medical disciplinary causes or reasons

3. **Criteria for Continuity of Care:**

    Member must meet one of the following criteria for continuity of care associated with physician termination:

3.1 Acute Condition:

A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention that has a limited duration

3.2 Serious Chronic Condition:

A medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

- Persists without full cure or worsens over an extended period of time
- Requires ongoing treatment to maintain remission or prevent deterioration

3.3 High Risk Pregnancy (as applicable):
A condition identified during the prenatal assessment or during subsequent examinations, which predisposes women to fetal or maternal compromise. High risk conditions may include, but are not limited to the following:

Abruption placenta
Autoimmune related pregnancy loss
Communicable infections in exposure
Gestational diabetes
Group B streptococcus
Hyperemesis gravidarum
Incompetent cervix
Multifetal pregnancy
Oligohydramios
Placenta previa
Polyhydraminos
Pregnancy induced hypertension
Preterm premature rupture of membranes
Previous preterm delivery
Sexually transmitted diseases during pregnancy
Substance use during pregnancy
Urinary tract infection
Uterine fibroids-leimoyomas; and/or Uterine irritability

4. The patient has completed thirty-one (31) weeks of her pregnancy:

i. The patient is in a post-operative or post-traumatic period of

treatment of using defined length of follow-up days

ii. The patient is receiving radiation therapy of chemotherapy for cancer, for a period of time, as determined appropriate

iii. The patient is receiving intravenous therapy such as antibiotics, hyperalimentation/total parenteral nutrition on an outpatient basis for a resolving condition, {e.g. pericarditis, osteomyelitis, acute flare-up of Crohn's disease, pancreatitis as determined appropriate}

iv. The patient is receiving outpatient treatment for mental illness or substance abuse as determined appropriate within benefit limitations until the course of treatment is complete

v. The patient has a life threatening conditions such as implantable defibrillators

Case Management:

Our Case Management Program

The purpose of the Case Management Program is designed to ensure that medically necessary care is delivered in the highest quality and most cost-efficient setting for patients/participants/clients throughout the continuum of care.

- The program focuses on the delivery of cost-effective, appropriate healthcare services for members with complex and chronic care needs. Proactive clinical and administrative processes are implemented to identify, coordinate, and evaluate appropriate high quality services which may be delivered on an ongoing basis
- The case management program is directed at coordinating resources and services, and appropriate cost-effective alternatives for patients/participants/clients that are but not limited to being catastrophically and or chronically ill, or injured. Care coordination is based upon patients/participants/clients individual care plan needs in order to facilitate the achievement of realistic treatment goals

    1. Coordinate cost-effective services
    2. Monitor access and barriers to care related to the patient's/

participant's/client's available benefits

3. Promote early and intensive treatment intervention in the least restrictive setting
4. Provide primary care providers with information regarding patient/participant/client hospital admission(s) and discharge needs
5. Create individualized treatment care plans, and revise it as the patient's/participant's/client's healthcare needs change
6. Utilize multidisciplinary clinical, rehabilitative, and support services
7. Provide coaching to move patients/participants/clients toward self-management of their care
8. Deliver highly personalized case management services
9. Promote healthier living for patients/participants/clients
10. Uphold strict rules of confidentiality
11. Provide ongoing case management analysis and development of the program's effectiveness
12. Encourage collaborative collegial approaches to the case management process
13. Promote the case management program's viability and accountability
14. Protect patient/participant/client rights and encourage responsibility
15. Referrals to case management may be made by AltaMed staff, providers, hospitalist, employers, health plan staff and patients/participants/clients
16. The referral is made to the Case Manager who is a licensed RN or LVN who is educated, trained, and experienced in the Case Management process
17. The Case Manager obtains eligibility information on the patient/participant/client and notifies the referral source of the patient/participant/client's eligibility status for involvement in the Case

Management Program

18. If the patient/participant/client is not eligible, the case manager guides the referral source to an alternate method for managing the patient's/participant's/client's care
19. The Case Manager gathers the appropriate information to complete a case assessment for the patient/participant/client telephonically
20. The case management assessment includes an evaluation of patient/ participant/client clinical, psychosocial, and socio-economic factors
21. The Case Manager develops a plan of care which includes an interdisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and expected outcomes based upon goals set with care team and patient/ participant/client
22. The Case Manager monitors the progress of the implemented plan of care
23. The Case Manager serves as a resource throughout the implementation of the plan, and makes revisions in the plan, as it is appropriate and updates patient/participant/client Primary care provider on progress
24. The Case Manager also coordinates appropriate educational sessions and encourages and coaches the patient/participant/client towards self-management
25. Progress toward the patient/participant/client's achievement of treatment plan goals is monitored in order to determine an appropriate time for the patient/participant/client's discharge from the case management program

Ambulatory Case Management

AltaMed's Ambulatory Case Management focuses on the processes and activities to support high risk and catastrophic patient/participant/clients in the outpatient setting. This program considers the patient/participant/client as a whole

individual taking into consideration of not only his/her medical needs but also the individual in context of cultural values, age disability and self-determination.

Case Management works collaboratively with the health care team to develop and support case management functions which including but are not limited to:

1. Identification and referral of high-risk patient/participant/clients
2. Triage, with time frame
3. Comprehensive assessment processes and formats
4. Care plan development and implementation
5. Carve out patient/participant/client and communication process for case management activity

Criteria for Referral to Case Management

1. The Case Management process is directed at coordination and integrating resources creating cost effective options for catastrophically ill or injured individuals on a case by case basis to facilitate quality treatment goals.
2. Focus will be on patient/participant/clients with the following characteristics:
    a. High recidivism
    b. Medical complexity
    c. Chronically ill
    d. Cost and or length of stay outliers
    e. Catastrophic diagnosis
    f. Inadequate family support
    g. High-risk profiles: the presence of two (2) or more of the following criteria:
        i. Two (2) or more active chronic diagnoses
        ii. Two (2) or more hospitalizations in the past six months
        iii. Two (2) or more emergency room visits in the past six months
    h. Significant impairment in one (1) or more activities of daily living (bathing, dressing, toileting ambulating)

i. Significant impairment in one (1) or more of the instrumental activities of daily living (preparing meals, shopping, housekeeping, transportation, using telephone and managing finances) particularly when there is no support system

j. Developmentally delayed children

k. Evidence of malnutrition

3. Catastrophic Illness: Diagnoses that may qualify a patient/participant/client for case management, which include but are not limited to:
    a. Diabetes out of control
    b. Oncology patient/participant/clients not on hospice
    c. Renal Disease
    d. Multiple high risk diagnoses
    e. Lack of medical compliance
    f. Coronary Disease, complex
    g. Premature infants/congenital anomalies
    h. Self-neglect
4. Cost Outliers: May be an indication for case management.
    a. Patient/participant/clients who are among the top 3% of utilization
    b. Patient/participant/clients who have annual ambulatory cost of $10,000 or more
    c. Patient/participant/clients who have an annual inpatient cost of $20,000 or more
5. Pharmacy Review: Patient/participant/clients who meet any of the following criteria may be assessed for case management follow-up.
    a. Patient/participant/clients taking six or more medications
    b. Patient/participant/clients hospitalized for adverse medication reaction
    c. Cost outliers

Grievances and Appeals:

Corporate Policy (Does not apply to PACE which has its own policy)

Purpose:

To establish an equitable, timely and efficient mechanism to resolve patient/ participant/ client, family/ care giver, provider or AltaMed staff member's complaints, grievances and appeals regarding care and/or services delivered by the AltaMed Health Services Corporation providers.

Policy:

AltaMed shall establish and maintain a complaint and/or grievance process pursuant to which a member or a member's authorized representative may submit complaints or grievances for review and resolution. In relation to this policy and procedure, occurrences of patient dissatisfaction with AltaMed providers, staff, services, benefits, or facilities that have been communicated to AltaMed:

1. Will be considered a "complaint" if the issue was addressed to AltaMed and resolved to the satisfaction of the member within 24 hours
2. Will be considered a "grievance" if the issue was addressed to AltaMed and not resolved to the satisfaction of the member within 24 hours

AltaMed's complaint and grievance process shall address the receipt, handling and disposition of a member's complaint or grievance in accordance with applicable statutory, regulatory, and contractual requirements.

AltaMed shall ensure prompt review and investigation of complaints or grievances. A program may participate in the review and investigation of a complaint or grievance or may manage a complaint or grievance under supervision Office of Quality Management or, if applicable, the member's health plan.

AltaMed shall ensure that there is no discrimination against a member on the grounds that the member filed a complaint or grievance.

AltaMed members will be informed of their right to file a complaint or grievance in compliance with AltaMed's Patient Rights and Responsibility policy and procedure (HS-PRE-001). This includes informing the member about their right to:

1. To appeal a Utilization Management (UM) decision to deny, defer, or modify a request for services based on medical necessity (AltaMed shall process a UM Appeal in accordance with the Appeals section of this

policy and procedure)

2. To request a State Hearing at any time during the Complaint or grievance process

3. To file a Complaint or Grievance with their health plan and/or the Secretary of the United States Department of Health and Human Services regarding violations of his or her privacy rights

4. If a Medi-Cal Managed Care member, the right to request a State Hearing within ninety (90) calendar days after the date of incident that triggers the Complaint or Grievance with the Department of Social Services (DSS) regardless of whether or not a Complaint or Grievance has been submitted to or resolved by AltaMed

    - To request a State Hearing, a member may write to the Department of Social Services State Hearings Division, P.O. Box 944243, Mailstop 19-37, Sacramento, CA 95814, or may call 800-952-5253 (for TDD 800-952-8349)

    - A Member may represent himself or herself at the State Hearing or may be represented by a friend, relative, attorney, or other representative

    - Upon notice from DSS of a Member's request for a State Hearing, AltaMed shall grant the Member Aid Paid Pending, as appropriate, until the State Hearing occurs or a decision is rendered in accordance using the State Fair Hearing Form

5. A member has the right to file a Complaint or Grievance directly with the Joint Commission in writing to the Division of Accreditation Operations, Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Ill 60181, or may call 800-994-6610

6. In addition to any rights set forth in this policy, a Member may request AltaMed to provide an interpreter or auxiliary aide for assistance in the Complaint or grievance process or to provide translation of Complaint or Grievance correspondence

7. AltaMed shall inform a Member of their right to file a complaint or grievance through posting Patient's Rights and Responsibility posters conspicuously in the primary care sites and in every Complaint or

Procedure:

1. **Assistance to Members**

   ii. Members are not required to use any particular form or document to file a complaint in writing; AltaMed's Member Services Department may assist members with processing complaint or grievance statements in writing or the member may submit a written statement directly to AltaMed's member services department or to their health plan

   iii. AltaMed's Member Service Department shall assist Members with questions regarding the procedures for filing Complaint or Grievance

2. **Complaint or grievance process**

   i. The member or a member's authorized representative may file a complaint or grievance with AltaMed via:

      - Any clinic site or location, if in person
      - Telephone: 1 (855) 848-5252 (Members Services Department)
      - Facsimile (323) 597 2466 (Members Services Department)
      - Mail: Members Services Department, 2040 Camfield Ave., Los Angeles, CA 90040

   ii. The related program or service administrator, or designee, shall first be allowed to respond to the complaint or grievance, addressing the members concerns

   iii. If the complaint has been resolved within 24 hours to the patient's satisfaction, it will not be considered a "grievance" and does not require further follow-up or tracking

   iv. If not resolved to the satisfaction of the patient within 24 hours, the grievance must be forwarded to AltaMed's Members Services Department using an "Incident, Complaint, and Unusual Occurrence" report form (refer to LD-RMT-001) by the program or service administrator, or designee

v. If not delegated by respective health plans for complaints and grievances, Member Services will forward the grievance to the respective health plan for assistance. If the complaint or grievance is received directly from a Member that is assigned to AltaMed through a managed care plan that does not delegate the responsibility for handling grievances to AltaMed, such grievance shall be forwarded to the appropriate health plan within 24 business hours of receipt. The review process will be followed as appropriate or guided by the health plan

vi. If delegated by respective health plans for complaints and grievances, AltaMed shall send the member a "Complaint or Grievance Acknowledgment Letter" within five (5) calendar days after receipt of a Complaint or Grievance, indicating:

- Receipt of the Complaint or Grievance and Identifying a Grievance and Appeals Resolution Services staff member whom the Member may contact regarding the Complaint or Grievance
- Said acknowledgement letter is not required for concerns that are not resolved within 24 hours of receipt to the satisfaction of the member

vii. Member Services staff shall investigate the grievance and, as necessary, consult with the AltaMed department or parties responsible for the services or operations that are the subject of the Complaint or Grievance

2.7.1. The Member Services staff shall review the factual findings, proposed resolution, and any other relevant information and shall issue a decision with respect to the Complaint or Grievance in accordance with Exhibit A of this policy. Prior to issuing a decision, Member Services staff will engage the Member's health plan, when applicable and/or as required by delegation status, the Office of Compliance and Risk Management, or the designated nurse or physician reviewer, as necessary

viii. AltaMed shall send to the Member a Complaint or Grievance Resolution Letter within thirty (30) calendar days after receipt of the Complaint or Grievance

2.8.1. The Complaint or Grievance Resolution Letter shall describe the

Complaint or Grievance and provide a clear and concise explanation of the reasons for the decision

2.0.2. For Complaint or Grievances upholding a UM Appeal decision involving the delay, denial, or modification of health care services, the Complaint or Grievance Resolution Letter shall describe the criteria used and clinical reasons for the decision, including all criteria and clinical reasons related to medical necessity

2.0.3. For Complaint or Grievances upholding a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Complaint or Grievance Resolution Letter shall clearly specify the provisions of the contract that exclude that service

2.0.4. AltaMed shall take immediate action to implement the decision in accordance with the Complaint or Grievance Resolution Letter

ix. AltaMed shall immediately review and process all complaint or grievances involving an imminent and serious threat to the health of a member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis

x. Managed care members: Altamed's response and records shall be submitted to the Health Plan within (24) twenty- four hours of the receipt of the request. The Health Plan must make a decision within 72 hours

xi. Non-HMO members: Altamed shall convene an ad hoc Utilization Management meeting with at least (3) three medical providers and make a decision with (72) seventy-two hours

3. Responsible staff

i. AltaMed's Chief Medical Officer (CMO) shall have primary responsibility for maintenance of the complaint or grievance process and utilization of any emerging patterns of Complaint or Grievances in the formulation of policy changes and procedural improvements to AltaMed's administration of the program

ii. AltaMed's AVP, Health Care Services, or designee shall have primary responsibility for the oversight of the complaint or grievance process

4. Notices, Records and Reports

ii. AltaMed shall inform a Member, in writing, of the locations for filing Complaint or Grievances, telephone numbers where Complaint or Grievances may be submitted, and related procedures regarding the Complaint or grievance process upon enrollment and annually thereafter. AltaMed shall provide these notices in Threshold Languages, as required by AltaMed's contract with the Department of Health Services (DHCS)

iii. AltaMed shall maintain written records of each Complaint or Grievance including the date of receipt, Member's name, names of the AltaMed staff who received the Complaint or Grievance and who is designated as the contact person, and all Complaint or Grievance Resolution Letters and Appeal Resolution Letters for a period of five (5) years after the end of the fiscal year in which AltaMed's contract with DHCS terminates

iv. AltaMed shall submit a report of aggregated Complaint or Grievance data, as required, to DHCS on a quarterly basis, forty-five (45) calendar days after the end of each quarter

v. When a written response and/or medical records are required, a copy of the Grievance is faxed to the appropriate party and a written response is requested within (2) working days

vi. 4.5The Grievance is pended in a locked confidential file awaiting response to maintain confidentiality

vii. If no medical decision is required, as determined by the Chief Medical Officer or designee, it will be considered an administrative Grievance and the designated Member Services or Quality Management staff will review the case and make a determination

viii. If the Grievance requires a medical decision, the Grievance is forwarded to the Chief Medical Officer or clinical designee for review and determination

ix. If the Grievance was forwarded by a third party (i.e. DHCS, Ombudsman) that party will also be notified in writing of the resolution

x. Time frames for response will not exceed 30 days as per regulatory and accreditation requirements. Notification to the Member for terminally ill, life threatening or seriously debilitating

conditions must be made within 30 days

5. **Tracking and Reporting**

   i. Verbal complaints received which are not resolved within 24 hours of receipt or written complaints are considered Grievances and will be recorded in the tracking database by the Member Services Department

   ii. The Grievance is entered into the tracking database with documentation including but not limited to:

- Member unique ID
- Program/Site
- Health Plan, if applicable
- Product, if applicable
- Date of original receipt by health plan or program
- Date received by Member Services
- Date Acknowledgement letter is sent
- Complaint/Grievance Code (Exhibit B)
- Medical Record request and received date
- Date of Physician or Nurse Review, if applicable
- Date the Resolution Letter is sent to the Member
- Opened or Closed Status
- The Date Reported to QM Committee
- Severity Level
- Provider ID, if applicable
- Turnaround Time
- Summary of Grievance

   iii. Grievances are presented to the Clinic QM Committee/Peer Review Committee and Corporate Quality Committee at least quarterly or more often if deemed necessary by the Chief Medical Officer or designee

   iv. Prior to submission to the Committees, an adhoc committee composed of Chief Medical Officer or designee, Member Service staff and Quality Management Nursing staff will review and make a recommendation on the severity leveling of the Grievance. Such

recommendations will be presented to the QM Committee

v. Summary level reports and trending analysis shall also be presented to the Committees of appropriate Peer Review or other corrective or appropriate action

vi. Summary reported shall be presented to the Board of Directors at least quarterly

vii. Those situations with a high potential for risk to health, safety, or security or persons or property shall be submitted to the Office of Compliance and Risk Management

viii. Documentation of provider specific issues shall be incorporated into physician credentialing/re-credentialing files, as the situation warrants

6. Appeals

i. Appeals received from the member, family member, Altamed staff members or Health plan shall be forwarded to the Quality Management Department and logged for the current year as follows:

- Member ID
- Health plan
- Line of Business
- Date Health Plan requested/receipt letter
- Date received by Quality Management Department
- Clinic/ site location
- Medical Record request/received date
- To/From Physician Reviewer- when applicable
- Response to Recipient/ Health plan date
- Open/ closed dates
- Turn-around time
- Summary of appeal

ii. The designated QM staff will determine if the information from the appealing party is complete. If necessary, the QM staff will contact the appealing party and/or practitioner to provide any missing information, including but not limited to medical records.

Additional information may also be obtained from Claims and/or Utilization Management

A monthly review to identify trends will be conducted in conjunction with the AVP of Managed Care Operations

7. **Resolution**
   - The Provider Relations shall review the factual findings, all other relevant information, and the proposed resolution
   - Within thirty (30) calendar days after the Provider Relations receipt of the Complaint, the Provider Relations Staff shall send to the Provider a Complaint Resolution Letter or a Pending Status Letter if AltaMed is unable to issue a decision within the thirty (30) day period following receipt of the Complaint
   - The Complaint Resolution Letter shall describe the Complaint, provide a clear and concise explanation of the reasons for the decision, and describe the Provider's appeal rights

8. **Implementation of Resolution**

   AltaMed shall take immediate action to implement the decision set forth in the Complaint Resolution Letter

Grievances and Appeals:

Corporate Policy (Does not apply to PACE which has its own policy)

Purpose:
To define the process in which AltaMed addresses and resolves Provider Complaints in accordance with applicable statutory, regulatory, and contractual requirements.

Policy:
AltaMed shall establish and maintain a Grievance Process pursuant to which Providers may submit Complaints for review and resolution.

The Grievance Process shall address the receipt, handling, and disposition of Provider Complaints in accordance with applicable statutory, regulatory, and

contractual requirements.

AltaMed shall ensure that Complaints are promptly reviewed and investigated by management or dedicated staff responsible for resolving Complaints and, as appropriate, shall consult with providers, health plans, or staff responsible for the services or operations that are the subject of the Complaint.

AltaMed shall ensure that Complaints are resolved within the timeliness requirements as set forth in this policy.

Providers who seek to contest any decision made by AltaMed pursuant to this policy are required to comply with the arbitration terms of their agreement or Joint Commission, if applicable.

Procedure: Filing a Complaint
A Provider that has furnished Covered Services to an AltaMed Member and is dissatisfied with any aspect of the AltaMed's program shall file a written Complaint to AltaMed's Provider Relations Representative after participating in the following processes, as applicable:

- AltaMed's UM Appeal Process
- AltaMed's Claims Resubmission Process

A Provider may submit any such Complaint no later than three-hundred and-sixty-five (365) calendar days after the occurrence that precipitated the dissatisfaction, e.g., an adverse action or decision that directly affects the Provider.

AltaMed has implemented the following methods for a Provider to submit Complaints either via email, mail or phone:

AltaMed Health Services Corporation
2040 Camfield Ave
Los Angeles, CA 90040
Attn: Provider Services
Phone: 1 (855) 848-5252

AltaMed Complaint Process

- Acknowledgment of Complaint
  - Within five (5) calendar days (for complaints received by mail or phone), or (2) business days (for complaints received electronically)

following the receipt of a complaint, AltaMed shall send the provider a Complaint Acknowledgement letter

- The Provider Relations staff shall immediately log and record the Complaint in an electronic and hard copy Complaint file

- Investigation
  - Within five (5) calendar days (for complaints received by mail or phone), or (2) business days (for complaints received electronically) following the receipt of a complaint, AltaMed shall send the provider a Complaint Acknowledgement letter
  - The Provider Relations staff shall immediately log and record the Complaint in an electronic and hard copy Complaint file
  - Provider Relations shall use the Incident, Complaint, and Unusual Occurrence Report form (attached) or a similar form to communicate and document findings and proposed resolutions
- Resolution
  - The Provider Relations shall review the factual findings, all other relevant information, and the proposed resolution
  - Within thirty (30) calendar days after the Provider Relations receipt of the Complaint, the Provider Relations Staff shall send to the Provider a Complaint Resolution Letter or a Pending Status Letter if AltaMed is unable to issue a decision within the thirty (30) day period following receipt of the Complaint
  - The Complaint Resolution Letter shall describe the Complaint, provide a clear and concise explanation of the reasons for the decision, and describe the Provider's appeal rights
- Implementation of Resolution
  - AltaMed shall take immediate action to implement the decision set forth in the Complaint Resolution Letter

Credentialing:

Policy: AltaMed Health Services is committed to providing quality care to its members. Consequently, AltaMed uses a rigorous process to evaluate providers.

This process thoroughly evaluates a provider's experience, licensing and sanction activity, and quality of care.

Procedure:

1. **Review process:**

   The Credentialing Committee is responsible for making decisions regarding provider credentialing. The Credentialing Coordinator reviews each initial application with all supporting verifications and documentation prior to submission to the Credentialing Committee. The Credentialing Committee is described in the credentialing policy MS-CRD-001

2. **Initial Application**

   AltaMed Health Services uses the approved California Participating Physician Application. This application will require the provider to provide information on:

   - Reasons for inability to perform the essential functions as a provider, with or without accommodation
   - Lack of present illegal drug use
   - History of loss of license and felony convictions
   - History of loss or limitations of privileges or disciplinary activities
   - Attestation by the applicant of the correctness and completeness of the application

3. **Completed Application**

   Each applicant will be required to complete an application.
   In addition, the applicant will provide:

   - A Curriculum Vitae (CV)
   - A copy of current State Medical or Dental License(s) (pocket license)
   - A copy of a valid DEA certificate (if applicable)
   - Face Sheet of Professional Liability Policy or Certification for past and present coverage, in the minimum amounts of $1 million per occurrence and $3 million aggregate
   - Board Certification Certificates (if applicable)

- Certificates of Degree Completion (i.e. medical or dental school)
- Internships and Residency certificates of completion
- A copy of ECFMG (if applicable, Educational Commission for Foreign Medical Graduates)

4. **Incomplete Application**

The Credentialing Department will send two follow-up requests for missing information (e.g. any application which is incomplete, is not accompanied by all supporting documentation, does not include a signed Physician Provider Agreement or is dated more than 180 days prior to receipt). If the requested information is not received within 10 business days, the credentialing process will be discontinued

5. **Primary source verification:**

Upon receipt of a completed application, AltaMed will obtain and verify information from the sources listed in Appendix A. The Credentialing Department will obtain, through the most effective methods, additional information or clarification, as needed, to provide the CMO and/or Credentialing Committee adequate information to make an informed decision regarding the applicant's qualifications

6. **Provider's rights (Due Process)**

Providers have the right to:

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

7. **Re-applying**

   Providers denied by the Board of Directors will not be eligible to reapply for membership for a period of at least one (1) year

8. **Practitioners will be credentialed for an initial period of two years or three years in accordance to credentialing policy MS-CRD-001**

9. **Errors and Omissions:**

   The Practitioner will be immediately notified in writing of any occurrence. A copy of the official report (if applicable) will be sent to the practitioner along with a letter of explanation

10. **All documents received will be date stamped and initialed**

Application Verification

Refer to Appendix A after this section for method for verification and associated time frames.

Re-credentialing:

Review Process: The Credentialing Committee is responsible for making decisions regarding recredentialing. The Credentialing Coordinator reviews each application with all supporting verifications and documentation prior to submission to the Credentialing Committee. The Credentialing Committee is described in the credentialing policy MS-CRD-001.

Re-credentialing Application:

AltaMed Health Services uses the approved California Participating Physician Reapplication. This application will require the provider to provide information on:

- Reasons for inability to perform the essential functions as a provider, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitations of privileges or disciplinary activities
- Attestation by the applicant of the correctness and completeness of the application

Completed Re-credentialing Application:

Each applicant will be required to complete a re-credentialing application every two years or three years in accordance to credentialing policy MS-CRD-001.

An initial request and one (1) follow-up request will be sent to the provider via US mail/e-mail.

The second request will be sent thirty (30) days after the initial request if the application has not been received and telephone follow-ups.

The third request will be sent by certified mail/e-mail and last telephone follow-up will be conducted. If the application is not returned within thirty (30) days of the third request it will be considered a voluntary resignation and Non-Compliant credentialing termination notice will be forward to provider and will be presented to the Credentialing Committee for Non-Compliant of re-credentialing function & will be terminated.

In addition, the applicant will provide:

- A copy of current State Medical or Dental License(s) (pocket license)
- A copy of a valid DEA certificate (if applicable)
- Face Sheet of Professional Liability Policy or Certification for past and present coverage, in the minimum amounts of $1 million per occurrence and $3 million aggregate
- Board Certification Certificates (if updated since last appointment)
- Residency/Internship/Fellowship certificates of completion (if updated since last appointment)
- Addendum A
- Addendum B
- Provider Rights
- Completed Privileging form (as applicable)
- Delegation of Service Agreements (mid-levels) (as applicable)

Incomplete Application

The Credentialing Department will send three follow-up requests for missing information (e.g.: any application which is incomplete, is not accompanied by all supporting documentation or is dated more than 180 days prior to receipt). If the requested information is not received within 10 business days of initial request, the physician's name will be taken to the Credentialing Committee for Non-Compliant of re-credentialing function & will be terminated.

Primary Source verification:
Upon receipt of a completed re-credentialing application, AltaMed will obtain and verify information from the sources listed in Appendix A. The Credentialing Department will obtain, through the most effective methods, additional information or clarification, as needed, to provide the Chief Medical Officer and Credentialing Committee adequate information to make an informed decision regarding the applicant's qualifications.

Office site reviews:
Facility Site Review is required for all primary care physicians, obstetricians, gynecologists and high volume specialists prior to submission to the Credentialing Committee upon re-credentialing. The Facility Site Review should be conducted within the re-credentialing cycle.

Performance Monitoring:
Appendix A

Initial Application Verification:
The following describes the credentialing elements verified, the methods of verification and the normal timeframes for completion.

Item/Method of Verification/Timeframes:

1. California License
    - On-line query of Medical Board of California through Department of Consumer Affairs or Applicable source
    - On-line query of Dental Board of California through Department of Consumer Affairs for DMD & DDS
    - Online verification is immediate
2. DEA Certificate/CDC*(180-day time limit)
    - Copy of current DEA/CDC certificate, NTIS verification or DEA Office of Diversion Control website
    - NTIS & DEA Office of Diversion Control on-line verification is immediate
3. Board Certification*(180-day time limit)
    - Verified through CertiFacts website for ABMS verification or primary source verification of specialty boards for specialists not certified by ABMS
    - Online verification is immediate

4. *Internship /Residency/Fellowship Training* (180-day time limit)
    - For M.D.,D.O, or P.A.: AMA profile to verify internship/ Residency/Fellowship training or verified through primary source as applicable
    - For D.D.S. or D.M.D.: Verify from dental school. For D.P.M.: Verify with medical school
    - AMA takes 1 business day. Written queries take up to 45 days
5. Malpractice Insurance (180-day time limit)

AltaMed incorporates as a requirement Element-A. All of the following quality indicators are applicable in the re-credentialing decision-making process:

- Member Grievances/Complaints
- PCP/Staff Complaints
- Access Studies
- Member Satisfaction (PCP's only)
- Utilization Management

Provider rights (Due Process):

Providers shall have the right to:

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

Re-applying:

Providers denied by the Board of Directors will not be eligible to reapply for membership for a period of at least one year.

Length of appointment:

Providers will be appointed every two years or three years in accordance to credentialing policy MS-CRD-001.

Errors and Omissions:

The Practitioner will be immediately notified in writing of any occurrence. A copy of the official report (if applicable) will be sent to the practitioner along with a letter of explanation.

All documents received will be date stamped and initialed.

Re-credentialing Application Verifications:

Refer to Appendix A after this section for method for verification and associated time frames.

- Copy of current insurance certificate that shows dates of coverage, including expiration date, and amounts of coverage (minimum of $1 million per occurrence/$3 million aggregate)
- History of 5 year malpractice insurance on provider application required
- Primary source verification is required
- A copy of certificate (s) is acceptable

Professional Liability Claims History (180-day time limit)

- Verified through NPDB and primary source verification from malpractice carriers
- NPDB takes 1 business day
- Written queries take up to 10-15 days

Hospital Affiliations (At Facilities) (180-day time limit)

- Primary source verification of membership and clinical privileges in good standing via letter to all AltaMed contracted facilities, to include status, date of appointment, specialty, restrictions and recommendations/ actions. If a provider has no hospital clinical privileges, he or she must provide proof of coverage by an appropriately licensed physician within AltaMed Network
- Written verifications may take up to 14 days

Work History (180-day time limit)

- Work history activities since completion of postgraduate training listed on provider's application in mm/yy format. Curriculum vitae (CV) is not sufficient

NPDB (180-day time limit)

- On-line query of National Practitioner Data Bank (NPDB).
  Up to 1 business day

Sanctions on Medical License (180-day time limit)

- On-line query of Medical Board of California or written query to other state boards with letter to request information on any sanctions, accusations or 805 or 805.01 reports
- MBC verification is immediate. Other states may take up to 14 days. Sanction reports may take up to 14 business days

Medicare/Medicaid Sanctions (180-day time limit)

- NPDB
- AltaMed prohibits employment or contracting with individuals that are excluded form participation under Medicare and Medi-Cal; employment or contracting with individuals who "opt out" of Medicare; practitioners, who are excluded, sanctioned, or "opt out" of Medicare may not receive CMS funds for care rendered to Medicare beneficiaries
- NPDB takes up to 1 business day

Peer References

- Three (3) Peer References to be obtained
- Written verifications may take up to 10-15 business days

Ongoing Credentialing Update

- Licenses, DEAs/CDCs, malpractice insurance certificates, and board certification status are tracked on a continuous basis
- Providers are notified within 60 calendar days of credentials expiration
- Second notifications are sent after 30 days after initial notification
- On the first business day following the expiration date, the practitioner's panel will be closed to new members

- By the fifth business day following the expiration date AltaMed will terminate the practitioner and move any members pursuant to Member Notification policy
- Credentialing staff will review the application licensing board prior to termination
- Member reassignment will be retro-active to the first day of the non-restricted license reinstatement date
- A provider's non-compliance in providing updated information will be presented to the Credentialing Committee with recommendation to change status to "inactive"

Note* AltaMed implements procedures to ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in our policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment.

Temporary/Provisional Status

Purpose:
To institute an effective and efficient process for granting temporary/provisional status to qualified practitioners for the purpose of providing coverage and/or to meet important patient/participant/client (P/P/C) care needs and/or new applicants.

Policy:
A practitioner may be granted "Temporary/Provisional" status if he/she meets the established criteria set forth below as a way of demonstrating adequate qualifications (licensure, relevant education, training and experience), and current competence.

The process for granting temporary privileges must be complete prior to the provision of care to any AltaMed P/P/C

"Temporary/Provisional" status may be granted, as determined by the Chief Medical Officer or his/her Designee, to individuals permitted by law and AltaMed to practice independently.

Credentialing:

"Temporary/Provisional" Status (Used for "Covering Practitioners" and/or new applicants to meet important P/P/C needs:

- Criteria for "Temporary/Provisional" Status:

To be considered for temporary/provisional status the applicant must submit the following documents and must meet the criteria indicated in number 2 below:

- A complete California Participating Physician Application (includes attestation)
- Addendum A
- Addendum B (as applicable)
- Provider Rights;
- Completed Privileging form;
- Delegation of Service Agreements (mid-levels)
- Curriculum Vitae
- State Medical or Dental License(s) (pocket license)
- DEA Certificate (if applicable)
- Face Sheet of Professional Liability Policy or Certification for past and present coverage
- Board Certification Certificates (if applicable)
- Certificates of Degree Completion (i.e. medical or dental school)
- Internships and Residency certificates of completion
- ECFMG (if applicable, Educational Commission for Foreign Medical Graduates)
- National Provider Identifier

Procedures:

- Criteria for Clean Primary Source Verification: Upon receipt of the required documents, the Credentialing Coordinator will initiate primary source verification as summarized below:
  - Application: A complete California Participating Provider Application, including all attestations and required attachments
  - Ability to Perform Functions: No stated reason for inability to perform the essential functions as provider with our without accommodation
  - Attestation: Provider confirmation of the following:
    (i) Lack of illegal drug use
    (ii) No history of license and felony convictions
    (iii) No history of loss or limitations of privileges or disciplinary

activities; and (iv) the correctness and completeness of the application

- Education & Training: Verification of the highest level of credentials
- Hospital Privileges: Not been subject to involuntary limitation, reduction, denial, or loss of privileges
- Work Experience: Summary of at least five (5) years of relevant work experience, to be provided by the practitioner though the CPPA or curriculum vitae, with no gaps in excess of six (6) months
- Current California License: Must be valid and current, with no restrictions or on limitations scope of practice and no current or previously successful challenge to license or registration
- Current DEA: A current and valid DEA or CDS, if applicable
- Malpractice Claims History: No history of malpractice claims
- Insurance: Proof of current malpractice insurance with the required limits and practitioner's assurance that he/she shall provide for not less than Thirty (30) days advance written notice to AltaMed of any cancellation, reduction, or other material change in the amount or scope of coverage;
- OIG/NPDB Sanctions: No history of Medicare, Medicaid or state sanctions/restrictions; Not been subject to involuntary termination of professional or medical staff membership at another organization, when applicable to the discipline
- Obtained and evaluated peers recommendations;
- Verify identity by viewing and copying a valid picture ID
- Obtained and evaluated Site Visit/Medical Record keeping Review results

  To ensure no findings of critical elements were found deficient;
- No significant variances in information provided through the credentialing process from the information provided by the applicant
- Quality Data Assessment (Re-credentialing Only)
- No member grievances/complaints with a level II (potential adverse effects)or higher
- No PCP/Staff Complaints with a level 3 ("considerable" problem) or higher

- No Access study score(s) of less than 100% or less for which a CAP has not been submitted and accepted
- Unsatisfactory member satisfaction score(s) for which a CAP has not been submitted and accepted
- Unsatisfactory Utilization Management for which a CAP has not been submitted and accepted

1. Verification Time Limits:

   Adherence to all primary source verification standards and verification time limits

2. Provider Notification:

   The Credentialing Coordinator shall notify all practitioners being considered for temporary/provisional status of the credentialing decision within ten (10) working days of the approval/non-approval

3. Length of Appointment:

   May not exceed 120 days

4. Non-Approval:

   In the event the verifications are not deemed "clean" or if Chief Medical Officer, or his/her Designee, does not approve the request for temporary/provisional status, the practitioner will be offered the opportunity to have his/her request re-reviewed by the full Credentialing Committee at its next scheduled meeting. Such notice shall be sent to the practitioner by certified mail, return receipt requested

5. Committee Notification:

   Practitioners granted Temporary/Provision status will be reviewed by the Credentialing Committee and subsequently forwarded to the Board Quality Committee for the final determination

Claims Management:

Eligibility and Benefits Verification:

To the best of its ability, AltaMed will provide Patient/Participants/Clients ("P/P/Cs") and providers with accurate benefit and eligibility information when rendering, authorizing, or referring provider services. Verification will be reviewed upon each requested encounter. Staff will communicate to P/P/Cs their benefits

and status of coverage based on the assessment of assigned medical insurance coverage for requested services. Each provider must confirm information and accuracy of eligibility status. Approval and referral for services do not guarantee payments.

Procedure:

1. Provider must request or confirm status and coverage through the P/P/C's current health plan assignment. However, eligibility of coverage is not a guarantee for assignment, risk, coverage of services or out of pocket expense

    1.1 Eligibility & Benefits verification:

    The provider and AltaMed will utilize all appropriate resources to identify P/P/C's eligibility and benefits related to the requested services. The resources may include the following:

    a) Electronic data interchange of eligibility information from the health plans
    b) Point of Service verification system
    c) EZ-CAP eligibility system file
    d) Direct contact with the Health Plan
    e) Health Plan monthly hard copy eligibility list

    1.2 P/P/C coverage type and frequency of verification:

    a) Each P/P/C is assigned a benefit or group code by their respective health plan. These codes identify the type of coverage provided and any limitations to the scope of coverage and/or amounts payable by their plan. This coverage may be for an extended period of time, or on a month-to-month basis
    b) Each P/P/C referral or visit must have these benefits reviewed in order to determine any cost to the P/P/C and/or the assigned payor risk responsibility
    c) Coverage of services is based on current eligibility under the assigned plan, subject to the benefits and financial responsibility included under the approved plan type

1.3 To determine appropriate coverage and assignment of benefits:

a) As part of the registration of each new P/P/C, AltaMed must include verification of eligibility and benefit limitations obtained directly from the P/P/C's respective health plan. This information shall be documented in writing and become part of the medical record

b) Each P/P/C registration or request for referral must be accompanied by a photocopy of the P/P/C's valid insurance card

c) Each P/P/C and/or the financially responsible party must sign the insurance verification form as proof of testament to the information provided and to understanding the explained coverage of benefits provided by their respective insurance policy. AltaMed's intake staff must sign the insurance verification form as a confirmation of their having reviewed with the P/P/C the benefits and coverage information obtained from the insurance carrier

d) Managed care HMO members assigned to AltaMed but not previously seen in one of our facilities prior to receiving specialty referral care must have their eligibility verified with the health plan prior to paying any provider claims

External/Contracted Providers (Per Diem and Fee-For-Service)

All claims must be completed based on CMS 1500 and/or UB92 or UB04 standards with appropriate medical information and authorization documentation. All claims must be submitted timely within the scope of provider's contractual agreement

Procedure:

Each claim and/or document must be mailed to the appropriate AltaMed department based on health plan type.

1. Document mailing guide:
    a. All claims must be submitted to the address listed below. AltaMed

Health Services Corporation Claims Department:

PO Box 7280

Los Angeles, CA 90022

b. Appropriate Forms

Based on the type of service rendered, providers must submit the claim on the appropriate form and with necessary supporting documentation

Professional & Ancillary Services -
CMS 1500 Facility Services - UB-92 / UB-04

2. Claim submission requirements:

a) Each claim must identify all appropriate client and provider demographics for proper identification and processing

b) Each non-emergent claim must be accompanied by an authorization of services specific to the member, the dates of service and the services provided. Authorizations must be obtained at the time of or prior to providing services

c) Claims without specific authorization must include appropriate medical documentation and records to expedite review and determination of medical necessity for services rendered

d) Claims must identify referring provider, rendering provider, and rendering facility if applicable

e) All claims must identify a valid Employer Tax ID Number and provider's license and NPI numbers. These standards are developed and mandated by CMS in the National Standard Formatting of Claims. Failure to comply with the procedures requested may delay payment, due to information required for AltaMed to process and approve claims

Incomplete Forms:

Claims received without proper or complete information will be processed and suspended. The provider will be notified in writing of the status of any missing required information and will be requested to provide the required information in order to complete the approval process for payment. Failure to timely provide requested information will result in the claim being contested.

Claims must be received for processing in a timely manner or they may

be contested. For contracted providers, claims must be submitted within the time frame specified in the contractual agreement. All others are subject to the time limitations imposed by the insuring health plan and/or governmental agency – within twelve (12) months of the date of service for Medi-Cal and eighteen (18) months for Medicare.

Reimbursement of Services Rendered By Specialty Providers:

All claims received by AltaMed that are submitted by a provider or medical facility rendering specialty referral services to our assigned HMO population will be entered into our Managed Care Claims Processing system for adjudication. Services will be processed for payment, adjustment or denial based on contractual agreements and obligations between the provider of service, AltaMed and the insuring health plan. Claims will be adjudicated within the time frames established by contract and/or State or Federal regulations.

Procedure:
All claim documents for assigned HMO members are dated stamped upon receipt, batched, scanned into I-Max / Macess and entered into the EZ-Cap Claims Processing system. Claims are entered with all available information provided, which in turn determines whether the claim status is “clean” or “un-clean”.

Clean Claims

By definition, a “clean claim” is “one which can be paid as soon as it is received, because it is complete in all aspects, including complete coding, itemization, dates of service and billed amounts”. A claim is considered “clean” even if additional information must be obtained from within the plan such as eligibility or utilization review information.

Emergency services or out-of-area urgently needed services:

Do not require prior authorization to be considered “clean”. However, if additional information is required from outside the plan to determine payment, such as an ER report or medical records, the claim is NOT “clean”. Any claim which does not meet the criteria of “clean” shall be considered “un-clean” and will be contested.

Non-AltaMed Claims

Claims that do not belong to members assigned to AltaMed will not be entered into our system. These original claims must be forwarded immediately to the proper responsible party or returned to the sender with a letter of explanation.

Medical Management Review

All documents that meet the criteria of an “Un-Clean Claim” will be entered into

EZ-Cap and a letter of request sent to the Provider and/or the UM Department for resolution within the set time frames of the Provider Contract and/or health plan compliance standards.

AltaMed Health Services Corporation Downstream Provider Notice

Claims Settlement Practices & Dispute Resolution Mechanism

As required by Assembly Bill 1455, the California Department of Managed Health Care ("DMHC") has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the DMHC. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products where AltaMed Health Services Corporation ("AltaMed") is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

AltaMed Claim Submission Instructions:

a) For services provided to members assigned to AltaMed, please mail claims to:

AltaMed – Claims Department
P.O. Box 7280
Los Angeles, CA 90022

To file claims via phone or to inquire about the claims status, call **(855) 848-5252**: The prompts are as follows:

For Providers:
Option 1 (Provider),
then Option 1 (Claims)

b) **For Electronic Claims:**

1. Office Ally: (866) 575-4120; Payer ID # ALTAM
2. Change Healthcare/Emdeon: (877) 363-3666; Payer ID # 95712

Claim Submission Requirements

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by AltaMed:

i. Claims submitted for reimbursement bust be "complete".
As defined in 1300.71

A "complete claim means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information and information necessary to determine payer liability

a. "Reasonably relevant information" is further defined to be "the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements." (1300.71 (10))

b. "Information necessary to determine payer liability" means "the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements." (1300.71 (11))

ii. To satisfy these requirements, based on the type of service rendered and category of provider, claims must be submitted to AltaMed on the appropriate paper form and with all necessary supporting documentation:

a. For Physicians, other Professional Providers and Ancillary Service Providers: CMS Form 1500 is to be used. Services must be identified using appropriate Current Procedural Terminology (CPT) coding, and associated diagnoses should be identified with International Classification of Diseases (ICD-9-CM) codes at the highest available level of specificity. In addition, any entries

required by federal statute and regulations, and any state-designated data requirements included in statutes or regulations must be satisfied

b. For Institutional Providers and Facility Services: Form UB-92 or UB-04 and the completed data set are to be used. In addition, any entries required by federal statute and regulations, and any state-designated data requirements included in statutes or regulations must be satisfied

c. Each claim must identify all appropriate client and provider demographics for proper identification and processing

d. Each non-emergent claim must be accompanied by an authorization of services specific to the member, the dates of service and the services provided. Authorizations must be obtained at the time of or prior to providing services

e. Claims without specific authorization must include appropriate medical documentation and records to expedite review and determination of medical necessity for services rendered

f. Claims must identify referring provider, rendering provider, and rendering facility if applicable

g. All claims must identify a valid Tax ID (either the Social Security or TIN) Number and provider's license and NPI numbers. These standards are developed and mandated by CMS in the National Standard Formatting of Claims. Failure to comply with the procedures requested may delay payment, due to information required for AltaMed to process and approve claims

iii. Claims must be received for processing in a timely manner or they may be contested

(a) For contracted providers, claims must be submitted within the time frame specified in the contractual agreement

(b) All others are subject to the time limitations imposed by the insuring health plan and/or governmental agency, but never beyond twelve (12) months from the month of the date of service for Medi-Cal and Commercial claims, or after December of the year following the year when the service was rendered for Medicare claims

iv. All completed claims submitted to AltaMed in a timely fashion shall be

paid by AltaMed within the shorter of sixty (60) calendar days or the time periods required by regulation

v. Notwithstanding the above, AltaMed shall have the right to contest particular billed items(s) in dispute up to forty-five (45) working days from the date received, provided, further, that in any case involving possible fraud and abuse or other improper billing practice AltaMed will retain the right to contest the bill or item for a period of one (1) year after the discovery of the impropriety

h. Claim Receipt Verification

For verification of claim receipt by AltaMed, use any one or combination of the following:

Phone Inquires: 1 (855) 848-5252

Dispute Resolution Process for Contracted Providers

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

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

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

iii. If the contracted provider dispute involves an enrollee or group of

enrollees: the name and identification number(s) of the enrollee or enrollees; (b) clear explanation of the disputed item, including the Date of Service; (c) the provider's position on the dispute; and (d) an enrollee's written authorization for provider to represent said enrollees

iv. Sending a Contracted Provider Dispute to AltaMed. Contracted provider disputes submitted to AltaMed must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent in writing to the following address:

Via Mail: AltaMed – Claims Department
PO Box 7280
Los Angeles, CA 90022
Via Email: claims@altamed.org

B. Time Period for Submission of Provider Disputes.

i. Contracted provider disputes must be received by AltaMed within 365 days from AltaMed's action that led to the dispute (or the most recent action if there are multiple actions that led to the dispute)

ii. In the case of AltaMed's inaction, contracted provider disputes must be received by AltaMed within 365 days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired

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

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

D. Contact AltaMed Regarding Contracted Provider Disputes. All telephone inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to AltaMed's Claims Department at: 1 (855) 848-5252

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

   i. Sort provider disputes by similar issue

   ii. Provide cover sheet for each batch, include copy of original claim and identify original claim number

   iii. Number each cover sheet

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

F. Time Period for Resolution and Written Determination of Contracted Provider Dispute

   AltaMed will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute

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

Dispute Resolution Process for Non-Contracted Providers

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

   i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from AltaMed to provider the following must be provided: (a) clear identification of the disputed item; (b) the Date of Service; (c) and a clear explanation of the basis upon which the provider believes the payment amount, request for

additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect

ii. If the non-contracted provider dispute involves an enrollee or group of enrollees: (a) the name and identification number(s) of the enrollee or enrollees; (b) a clear explanation of the disputed item, including the Date of Service; (c) the provider's position on the dispute; and (d) an enrollee's written authorization for provider to represent said enrollees

A. Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in sections above

Claim Overpayments

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

B. Contested Notice. If the provider contests AltaMed's notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to AltaMed stating the basis upon which the provider believes that the claim was not overpaid. AltaMed will process the contested notice in accordance with AltaMed's contracted provider dispute resolution process described in Section above

C. No Contest. If the provider does not contest AltaMed's notice of overpayment, provider shall refund to AltaMed the amount of the overpayment within 30 days of the date of receipt of the notice of the overpayment

D. Offsets to Payments. AltaMed may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse AltaMed within the timeframe set forth in Section IV.C., above, and (ii) AltaMed's contract with the provider specifically authorizes AltaMed to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, AltaMed will provide the provider

with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims

AltaMed's Compliance Program:

Our Commitment to Compliance

The true foundation of AltaMed has always been its commitment to provide quality care to our patients. As part of this, we strive to ensure an ethical and compassionate approach to healthcare delivery and management. We demonstrate consistently that we act with absolute integrity in the way we do our work.

AltaMed's Compliance Program:

AltaMed Health Services Corporation's Compliance program is designed to prevent, detect, and collaboratively resolve non-compliance with business ethical standards, contractual requirements, applicable federal and state statutes and regulations, and/or AltaMed policy. As outlined through supporting policies and procedures, AltaMed's compliance program is a continual integral process that strives to:

1. Demonstrate to employees and the community the organization's commitment to excellent corporate conduct
2. Identify and prevent criminal and unethical conduct
3. Improve the quality of Patient/Participant/Client care
4. Create centralized source of information of healthcare regulations
5. Develop procedures that allow the prompt, thorough investigation of alleged misconduct
6. Reduce AltaMed's exposure to civil damages and penalties, or criminal sanctions
7. This document will describe AltaMed's organizational compliance structure; identify roles and responsibilities; and describe AltaMed's approach to developing and managing a comprehensive compliance program

Compliance Program Components

Designation of a Compliance Officer

The Board of Directors and the President & CEO have designated the Director of

Compliance & Risk Management as AltaMed's "Compliance Officer." As such, the OCRM Director maintains personal responsibility for successful implementation, coordination, and oversight of compliance program activities for the organization. Responsibility includes implementation of the compliance program, including appropriate response to known or suspected non-compliance.

Contact information for the Compliance Officer:

Isaac R. Garcia, Director Compliance & Risk Management
AltaMed Health Services Corporation
2040 Camfield Avenue
Los Angeles, CA 90040

Office 323-725-8751 | Confidential Fax: 323-889-7803

Business Code of Conduct:

As we work together to provide the highest quality care without exception, we must likewise exercise the highest standards of ethics and professional behavior. AltaMed's Business Code of Conduct ("the Code") sets forth the operational procedures for ethical conduct (including, but not limited to, disclosure and management / mitigation of conflicts of interest, reporting of concerns, and disciplinary actions for non-compliance with the Code). It applies to all employees, physicians, health care professionals, trainees, agents, board members, volunteers, representatives, contractors, vendors and other persons or companies working with AltaMed to provide products or services to or on behalf of AltaMed. It requires each of us to follow all applicable laws, regulations, and internal policies related the work we do for AltaMed. This includes:

- Shared Responsibilities for reporting and responding to concerns, including anti-retaliation.
- Maintaining a Supportive Work Environment that is safe, alcohol/drug free, and compliant with labor laws.
- Financial Integrity through accurate, secure records and appropriate payments and refunds.
- Doing the Right Thing through ethical decision-making, honest government dealings, and preventing fraud, waste, and abuse.
- Conflicts of Interests: understanding what they are and how to disclose and manage them.

- Safeguarding Information and Resources, such as confidential patient and business information and company resources.
- Healthcare Advocacy guidelines and prohibited political activities.

Contact AltaMed's Chief Compliance Officer at AltaMed's Corporate Headquarters to address situations where requirements differ from the standards outlined in this Code or for questions about applicable laws, regulations, or policies.

Report known or suspected regulatory violations via AltaMed's Compliance Hotline at 1-888-418-1398 or online at www.MyComplianceReport.com (Access ID: ALTA)

AltaMed's Business Code of Conduct is publicly accessible through in the Regulatory Notices section of AltaMed's website (https://www.altamed.org/regulatory-notices).

Internal Monitoring:

The purpose of an internal monitoring and auditing functions of the Compliance Program is to proactively:

- Identify individuals who may have knowingly or inadvertently violated applicable Federal or State laws, including the laws, regulations and standards of the Medicare and Medicaid programs, and/or other AltaMed requirements or guidelines that pose risk to AtlaMed's funding or reputation
- Facilitate the correction of any non-compliance
- Implement procedures necessary to ensure future compliance
- Protect AltaMed in the event of civil or criminal enforcement actions
- Preserve and protect AltaMed's Assets

As part of its efforts to implement an effective compliance program, AltaMed will periodically conduct routine audits of its operations, including its coding and billing practices, compliance with contractual expectations, and compliance with written standards and policies and procedures in an effort to ascertain problems and weaknesses in its operations and to measure the effectiveness of its Compliance Program.

External Monitoring Activities (Audits):

In order to manage and coordinate external compliance reviews among AltaMed Health Services Corporation, the Director of Compliance and Risk Management, under the direction of AltaMed's President & CEO, will work with the appropriate AltaMed Leadership and Management to develop and coordinate strategies for prioritizing and preparing for the external compliance reviews, as needed.

As necessary, contracted providers and vendors may be required to provide documents and/or information to support compliance with federal, state, or local laws, regulations, or guidelines. These efforts will be coordinated through the AltaMed's Office of Compliance & Risk Management (OCRM) or designee.

Training and Education:

1. All board members, officers, employees, volunteers and agents who act on AltaMed's behalf will receive initial and annual training and education on:
    i. AltaMed's Compliance Program, policies, and procedures
    ii. AltaMed's Business Code of Conduct
    iii. Requirement to report Fraud, Waste, and Abuse
    iv. Possible consequences, including disciplinary measures, for fraudulent behavior
    v. Anti-Kickback Statutes & Stark-Law Prohibitions
    vi. Affirmative Duty to Report policy
    vii. Whistleblower Protections policy
2. Contracted providers may participate in AltaMed's training programs or may elect to provide training that substantially meets AltaMed compliance training requirements; training must be evidenced by training materials and participation logs

Responding Appropriately to Detected Non-Compliance:

1. In the event that internal or external monitoring activities identify non-compliance, employee misconduct, and/or suspected criminal activity, AltaMed will ensure that, as quickly as possible, the offending practice is ceased by the involved parties
2. If the conduct involves improper submission of claims for payment,

AltaMed will immediately cease all billing potentially affected by the offending practice. Appropriate actions will take place to address the misconduct or suspected criminal activity

3. When an area of non-compliance is noted, the Compliance Department will require the development of a Corrective Action Plans (CAP), which must be reviewed and approved by the Compliance Department and other designated functions; CAPs must outline immediate corrective actions (if possible), preventive corrective actions, and monitoring processes to ensure the effectiveness of the corrective actions
4. The Compliance Department will monitor CAPs through collection of evidence and/or compliance probes to validate improvement, if necessary
5. If an investigation uncovers what appears to be criminal conduct on the part of an employee, appropriate disciplinary action against the employee or employees who authorized, engaged in or otherwise participated in the offending practice will include, at a minimum, the removal of the person from any position of oversight and may also include, written reprimand, suspension, demotion and termination

Open Communication:

1. AltaMed has established mechanisms by which anyone can report known or suspected concerns, issues or suspected non-compliance which could threaten the funding or reputation of AltaMed without fear of retaliation
2. Affirmative Duty to Report. An individual who is aware of or suspects a violation of law or of the AltaMed's policies and procedures, including the Business Code of Conduct, is required to report this information without regard to the identity or position of the suspected offender
3. AltaMed has implemented the following methods for reporting known or suspected non-compliance:

    - Notifying the Provider's Relation Department;
        - Submitting a completed "Report of Violation of Governmental Regulations" to the Office of Compliance & Risk Management in an envelope marked, "CONFIDENTIAL;"
        - Mail: AltaMed Health Services Corporation,

          Attention: Director of Compliance & Risk Management,

2040 Camfield Avenue, Los Angeles, CA 90047

- Confidential Fax: 323-889-7803

- Notifying the Director of Compliance & Risk Management by phone at AltaMed's Corporate Headquarters
- Contacting the toll-free Compliance Hotline (800-955-7813)

4. On a periodic basis, AltaMed will update employees on relevant compliance issues through such mechanisms as an article in the newsletter, compliance bulletins, conspicuous notices, and training
5. Whistleblower Protections. Anti-Retaliation. No retaliatory action will be taken against any individual who, in "good faith", reports suspected or known instances of non-compliance
   - It is the policy of AltaMed to refrain from intimidation, threat, coercion, discrimination or retaliatory acts against individuals for having refused an illegal order, or who believe, in good faith, that AltaMed, its employees, or agents have engaged in improper governmental activity or activities that violate privacy, professional or clinical standards, or that care, services or conditions provided by AltaMed potentially endangers one or more patients, workers or the public and discloses information to the proper agency or authority
   - Retaliation concerns must be reported to the Director of Compliance & Risk Management (see above contact information)

Evaluation:

1. A compliance program is never final. Its growth and development will be constant
2. AltaMed will work to expand the program to fit the needs of the organization. The compliance program will always take into account the "big picture" and expand or focus the program accordingly
3. Consistent with the three (3) effectiveness measures identified by the Health Care Compliance Association, structure, process and outcome, AltaMed will measure the program effectiveness annually by:
   a. Comparing issues year to year
   b. Tracking and trending complaints
   c. Tracking corrective actions

d. Audit results
e. Educational sessions pre- and post-test
f. Tracking "bill denials"
g. Organizational survey results
h. Compliance topics on department/organization agenda

Appendices:

AltaMed Service Matrix

AltaMed provides community-based health services from thirty-one community sites radiating out from, and around East Los Angeles, the historic cultural and geographic center of the Latino community in Los Angeles, and Orange County. These sites include Medical and Dental Groups, Adult Day Health Centers, PACE centers, and Community Care Health Centers.

The following illustrates the location of sites and distribution of programs and services among them:

AltaMed Medical & Dental Groups	Special Services
AltaMed Medical Group – Commerce **5427 Whittier Blvd.** **Los Angeles, CA 90022**	• **Women's Health** • **HIV Services** • **Urgent Care** • **Diabetes Prevention & Management** • **Behavioral Health**
AltaMed Medical and Dental Group – Boyle Heights **3945 Whittier Blvd.** **Los Angeles, CA, 90023**	• **Women's Health** • **Dental** • **Diabetes Prevention & Management** • **Behavioral Health**
AltaMed Medical Group – East Los Angeles, 1st Street **2219 E. 1st St.** **Los Angeles, CA 90033**	• **Diabetes Prevention & Management** • **Behavioral Health**

AltaMed Medical Group – Pico Rivera, Slauson **9436 E. Slauson Ave.** **Pico Rivera, CA 90660**	• **Women's Health** • **HIV Services** • **Diabetes Prevention & Management** • **Behavioral Health** • **Urgent Care**
AltaMed General Pediatrics at Children's Hospital – Los Angeles **4650 W. Sunset Blvd., MS 76** **Los Angeles, CA 90027**	• **Pediatric** • **Urgent Care**
AltaMed Medical & Dental Groups	**Special Services**
AltaMed Medical and Dental Group – El Monte **10418 Valley Blvd.** **El Monte, CA 91731**	• **Dental** • **HIV Services** • **Urgent Care** • **Diabetes Prevention & Management**
AltaMed Medical Group – Garden Grove **12751 Harbor Blvd.** **Garden Grove, CA 92840**	• **Urgent Care** • **Diabetes Prevention & Management** • **Behavioral Health**
AltaMed Medical and Dental Group – Santa Ana, Main **1400 N. Main St.** **Santa Ana, CA 92701**	• **Dental** • **Diabetes Prevention & Management** • **Behavioral Health**
AltaMed Medical and Dental Group – Anaheim, Lincoln **1814 W. Lincoln Ave., Ste A & B** **Anaheim, CA 92801**	• **Dental** • **Diabetes Prevention & Management**
AltaMed Medical Group – Anaheim, Lincoln – West **1820 W. Lincoln Ave.** **Anaheim, CA 92801**	• **Urgent Care** • **Diabetes Prevention & Management**
AltaMed Medical Group – Ramona Gardens **1424 Crusado Ln., Ste. 168** **Los Angeles, CA 90033**	

AltaMed Medical & Dental Groups	Special Services
AltaMed Medical Group – Estrada Courts **1305 S. Concord St., Ste. 18** **Los Angeles, CA 90023**	
AltaMed Medical Group – William Mead **268 E. Bloom St., Ste. 322** **Los Angeles, CA 90012**	
AltaMed Youth and Senior Care Management – Indiana **512 S. Indiana St.** **Los Angeles, CA 90063**	• **Youth Services** • **HIV Services**
Community Care Health Centers	**Special Services**
AltaMed Medical Group – Huntington Beach **8041 Newman Ave.** **Huntington Beach, CA 92647**	• **Dental** • **Urgent Care** • **Behavioral Health**
AltaMed Medical Group – Santa Ana, Bristol **2720 S. Bristol St., Ste. 110** **Santa Ana, CA 92704**	• **Urgent Care** • **Behavioral Health** • **Diabetes Prevention and Management**
AltaMed Medical Group – Orange **4010 E. Chapman Ave.** **Orange, CA 92869**	
AltaMed's PACE	**Special Services**
AltaMed PACE – East Los Angeles **5425 E. Pomona Blvd.** **Los Angeles, CA 90022**	• **Senior Services**
AltaMed ADHC – Grand Plaza **701 W. Cesar E. Chavez Ave., Suite 201** **Los Angeles, CA 90012**	• **Senior Services**

AltaMed PACE – Lynwood **3820 Martin Luther King Jr. Blvd.** **Lynwood, CA 90262**	• **Senior Services**
AltaMed PACE – Downey **12130 Paramount Blvd.** **Downey, CA 90242**	• **Senior Services**
AltaMed PACE – Covina **535 S. Second Ave.** **Covina, CA 91723**	• **Senior Services**
AltaMed PACE – El Monte **10418 Valley Blvd., Suite B** **El Monte, CA 91731**	• **Senior Services**
AltaMed PACE – Huntington Park **1900 E. Slauson Ave., Ste. B** **Huntington Park, CA 90255**	• **Senior Services**
AltaMed PACE – South Los Angeles **1776 E. Century Blvd.** **Los Angeles, CA 90002**	• **Senior Services**

Community Medical Clinics:

Medical Services Division

AltaMed operates twenty one community clinics throughout Los Angeles and Orange Counties. The services they provide are the following:

1. Family Planning
2. Family Practice, Pediatrics
3. Geriatrics
4. HIV outpatient medical care
5. Immunizations
6. Internal Medicine
7. Women's Health

Board-certified family physicians and mid-level practitioners are part of the permanent, full-time staff providing services at the clinics. Specialty care is provided through specialists contracted by AltaMed to provide services at

the clinics. They include obstetricians, pediatricians, cardiology, urology, orthopedic, and clinical psychologists.

Contracts are also maintained with a laboratory and with several pharmacies to provide their respective services. The main clinics East Los Angeles, Pico Rivera, El Monte, Anaheim, Santa Ana and Garden Grove are staffed with certified x-ray technicians. Specialized radiology services are provided through a contracted radiology groups.

Through a mobile medical unit that AltaMed operates, residents in the service areas receive immunization services, on-site physicals and health examinations, and family planning services, provided by mid-level practitioners.

AltaMed Medical & Dental Groups
AltaMed Medical and Dental Group – Commerce **5427 Whittier Blvd.** **Los Angeles, CA 90022**
AltaMed Medical and Dental Group – Boyle Heights **3945 Whittier Blvd.** **Los Angeles, CA, 90023**
AltaMed Medical Group – East Los Angeles, 1st Street **2219 East 1st. St.** **Los Angeles, CA 90033**
AltaMed Medical Group – Pico Rivera, Slauson **9436 East Slauson Ave.** **Pico Rivera, CA 90660**
AltaMed General Pediatrics at Children's Hospital **4650 W. Sunset Blvd., MS 76** **Los Angeles, CA 90027**
AltaMed Medical, Dental, El Monte **10418 Valley Blvd.** **El Monte, CA 91731**
AltaMed Medical Group – Commerce **5427 Whittier Blvd.** **Los Angeles, CA 90022**

AltaMed Medical Group at Hollywood Presbyterian Medical Center **1300 N. Vermont Ave.,** **Patient Tower, First Floor** **Los Angeles, CA, 90027**
AltaMed Medical Group – Huntington Park **1900 E. Slauson Ave.** **Huntington Park, CA 90255**
AltaMed Medical & Dental Groups
AltaMed Medical & Dental Group – Anaheim, Lincoln **1814 W. Lincoln Ave.** **Anaheim, CA 92801**
AltaMed Medical Group – Anaheim, Lincoln- West **1820 W. Lincoln Ave., Ste. A & B** **Anaheim, CA 92801**
AltaMed Medical Group – Ramona Gardens **1424 Crusado Ln., Ste. 168** **Los Angeles, CA 90033**
AltaMed Medical Group – Estrada Courts **1303 S. Concord St., Ste. 18** **Los Angeles, CA 90023**
AltaMed Medical Group – William Mead **268 E. Bloom St., Ste. 322** **Los Angeles, CA 90012**
AltaMed Medical Group – Pico Rivera, Passons **6336 Passons Blvd.** **Pico Rivera, CA 90660**
AltaMed Medical and Dental Group – South Gate **8627 Atlantic Ave.** **South Gate, CA 90280**

AltaMed Medical and Dental Group – West Covina **1300 S. Sunset Ave.** **West Covina, CA 91790**
AltaMed General Pediatrics and Dental Group – Westlake, 3rd Street **2100 W. 3rd Street, Ste. 200 & 220** **Los Angeles, CA 90057**
AltaMed Medical Group – Santa Ana, Broadway **1515 Broadway St.** **Santa Ana, CA 92707**

AltaMed Orange County
AltaMed Medical and Dental Group – Huntington Beach Community Clinic **8041 Newman Ave.** **Huntington Beach, CA 92647**
AltaMed Medical Group – Orange **4010 E. Chapman Ave.** **Orange, CA 92869**

HIV Services:

AltaMed's HIV Services program is one of the leading comprehensive providers of HIV medical care and HIV prevention services in the Greater Los Angeles community.

- Medical care and Psychosocial services are housed within the same HIV medical sites promoting access and follow-through with treatment, care and referrals
- Pharmacy services by AltaMed pharmacists are offered to patients with delivery services that help HIV patient have easy access to medications
- HIV prevention activities are available at both HIV medical clinics in additional to several satellite offices
- Free anonymous/confidential HIV testing and counseling is offered at all primary care clinics and at all HIV Prevention locations

AltaMed HIV Services (323) 869-5448 (Appointments)	
AltaMed Medical Group – Commerce **5427 Whittier Blvd.** **Los Angeles, CA 90022**	**Pico Rivera HIV Clinic** **6336 Passons Blvd.** **Pico Rivera, CA 90060**
AltaMed Medical and Dental Group – El Monte **10418 Valley Blvd., Ste. B** **El Monte, CA 91731**	**AltaMed Medical Group – Santa Ana Bristol** **2720 S. Bristol St., Ste. 110** **Santa Ana, CA 92704**

HIV Medical Outpatient & Primary Care

(Program Capacity 840 Annually)

- Almost all patients are recipients of the Ryan White Care Act and the AIDS Drug Assistance Program (ADAP) which provides access to medical care and prescriptions at no cost to the patient
- Our goals are to slow the progress of HIV in patients, to strengthen compromised immune systems, and to enhance the quality of life for patients living with HIV/AIDS
- Expert HIV medical care is provided by a professional, multi-disciplinary and dedicated team
- The clinics provide on-site infusion services, state-of-the-art laboratory testing, complete primary care services, access to specialty medical care through Community HIV/AIDS Intervention Network (CHAIN), and radiology
- The Clinical Trials component offers access to new and emerging pharmaceutical studies to patients who are resistant to all current and available marketed drugs, to patients who would benefit from medications that are not yet approved by the FDA, or to patients who cannot access medications through public/private resources

Individual and Family Support Case Management Services

(Program Capacity: 300 Annually)

- The Case Management programs assist HIV infected individuals by facilitating referrals to psychosocial services which may positively affect their HIV care and health
- Psychosocial services include intake, assessment, care planning, follow-up, referrals, and other resources depending on need and Symptomatic HIV diagnosis
- Though services are provided on-site to complement HIV medical primary care, not all case management clients are medical patients of AltaMed. Home Health RN Case Managers provide case management services at the patient's home to clients who cannot access services at the clinic due to physical limitations related to HIV/AIDS

Treatment Education and Advocacy / Self-Help Programs

(Program Capacity: 300 Annually)

- AltaMed's HIV patients have access to these programs, either through staff or self-referral, that are designed to support medication compliance, enhance patient participation in their treatment programs, and to enable patients to make more informed decisions about their care
- Treatment Advocates provide individual and group education to patients within the clinic to increase levels of HIV knowledge, enhance the understanding of treatment options, and develop patient communication skills with care providers
- Weekly self-help support groups allow individuals to share their personal experiences with HIV and to develop a support system among "peers". Activities for these programs vary depending on the needs of the patient

HIV Prevention and Education Programs

(PCM Program Capacity: 380 Annually)

- HIV prevention and education programs and HIV counseling and testing

services target populations at high-risk of HIV infection such as men-who-have-sex-with- men (MSM's), disproportionately impacted minority populations, sexual partners of HIV-infected individuals, women at sexual risk, injection-drug users, etc.

- Over 4,600 persons are tested annually with the goal of reducing the incidence of HIV infection/re-exposure and to identify HIV-positive persons. Identified persons are then linked to appropriate medical interventions and other needed services
- Peer HIV Health Educators conduct off-site education to target population members, provide individual prevention case management (PCM), support groups and educational workshops, as well as HIV counseling and testing
- AltaMed HIV prevention drop-in centers are community resources that provide risk-reduction education, health education materials and referral information. AltaMed's HIV Mobile Testing Unit (MTU) visits community agencies serving substance users, sex workers, homeless persons, and others at risk of infection. The MTU provides on-site HIV educational workshops and HIV testing

Mental Health

(Program Capacity: 300 Annually)

- AltaMed HIV Programs may refer patients/clients to the HIV Mental Health Program. These patients/clients have been identified as having an emotional/ mental condition severe enough that it could affect their HIV condition and medical treatment
- A masters-level Mental Health Clinician conducts an Intake and Assessment of the patient/client's current condition
- Mental health treatment could begin immediately in the form of individual psychotherapy, couples psychotherapy, group psychotherapy or psycho-educational groups
- Patients/ clients receive services from California Board of Behavioral Science licensed clinicians or license-eligible clinicians supervised by a licensed clinician (LMFT, LCSW, Ph.D.). Patients could receive psychiatric services in conjunction with the psychotherapy sessions

Youth Services:

Medical Services Division

AltaMed's youth services consist of several individual case management programs Cal-Learn, Adolescent Family Life Program (AFLP), and Positive Youth Development (PYD) which promote personal responsibility, encourage completion of a high school level education, and empower young adults to lead self-sufficient lives.

YOUTH SERVICES Locations & Hours	
AltaMed Youth & Senior Care Management – Indiana **512 S. Indiana St.** **Los Angeles, CA 90063**	**AltaMed Youth Services – Long Beach** **711 E. Wardlow Rd., Ste. 203** **Long Beach, CA 90807**

(Program Capacity: 475)

The majority of clientele are pregnant and/or parenting teens ('parenting teens' include fathers), and/or where high school drop-out has occurred or is being considered.

Case managers facilitate individual and group level interventions to help adolescents set goals and, as needed, to refer clients to community resources such as mental health services and counseling, medical care, public benefits, and continuing education centers.

Cal-Learn and AFLP/PYD Case Managers work with pregnant or parenting teens to prevent a subsequent pregnancy, graduate high school, and teach parenting skills (through certified parenting classes) aimed at preventing the incidents of reported child abuse and or neglect, while promoting the overall stability and wellbeing of the entire family.

Health Education and Wellness:

Our Health Education and Wellness Department has short-term and long-term programs that provide patients with the knowledge and skills to make healthy behavior modifications.

Clinical Programs:

Wellness programs and services include single-session and multi-session programs around healthy lifestyle changes at AltaMed's clinic sites and PACE locations. Patients have the ability of receiving health coaching in a one-on-one session and/or group education. Patients are also connected to local community resources as needed.

	One-on-One Sessions	Group Sessions
Short-term (less than or equal to 3 months)	• Arthritis management • Asthma • Breast health • Diabetes • Healthy heart (hypertension and cholesterol) • Nutrition • Stress management	• Arthritis management • Asthma • Breast health • Diabetes • Healthy heart (hypertension and cholesterol) • Nutrition • Stress management
		Diabetes Group Visits
		Ritmo y Salud
Long-term (> 3 months)	• Programa Esperanza (study)	STOMP
		Diabetes Prevention Program
		Unidas Por Vida (study)

Diabetes Prevention Program (DPP)

Adult Weight Management Program – lasts a full year. The first 16 weeks or 4 months require weekly medical visits. Target participants: patients with pre-diabetes.

Unidas Por la Vida Program

This five-year research study and project with UC Irvine targets Latina mothers and daughters who are interested in losing weight. In order to qualify for study, mother must have diabetes and the adult daughter must be overweight or obese.

The intervention is based on the diabetes prevention program and includes home visits. Mother and daughter must both be eligible to participate.

Diabetes Group Visits

Small groups of patients meet to learn from their Provider and each other what the best way of managing their diabetes.

Ritmo y Salud

This is a five session program, where participants review healthy eating and also includes a 60 minutes Zumba workout.

Solutions and Treatment for Obesity Management Program

Pediatric Weight Management - lasts a full year. The first 12 weeks or 3 months require weekly medical visits and the last 3 months are maintenance.

Programa Esperanza (PACE ONLY)

Eligible patients complete 12 weekly sessions of problem solving treatment to manage and cope symptoms of depression.

Community-Based Programs:

These programs operate in the community including schools, churches, and within target zip codes:

On the Move

Afterschool program for school-age children and their parents where they learn how to make healthy nutritional choices, increase physical activity, eliminate sugary drink consumption and reduce screen time.

Choose Health LA Kids

Offers food demonstrations, grocery store tours, and 6-week nutrition and parenting workshops for parents and caregivers of children ages 5 and under. Participants must live in the following communities: Bell, Commerce, East Los Angeles, Maywood, Montebello, Pico Rivera, West Whittier - Los Nietos.

YMCA Diabetes Prevention Program

CDC-recognized DPP - also lasts a full year. First 16 weeks require weekly visits with a trained lifestyle coach. AltaMed patients can now be referred by their provider, and enrollment in the program includes YMCA membership.

Additional Resources:

The Health Education and Wellness Department can provide you with materials on:

- Arthritis
- Asthma
- Breastfeeding
- Breast cancer
- Cancer prevention
- Cholesterol
- Dental care
- Diabetes
- High blood pressure
- Immunizations
- Nutrition
- Smoking cessation
- Stress Management
- Weight management
- And more

Some services are available to patients and community members at no cost, in the Los Angeles and Orange Counties.

Provider Education on Health Education Services

The Health Education and Wellness Department undergoes extensive efforts to educate providers on health education requirements set forth by the Department of Health Care Services (DHCS) and various health plans. The Department also provides education on available health education resources. Examples of our educational strategies include:

- presenting during provider meetings
- making on-site visits
- presenting during new-provider orientation
- including health education services in the provider manual
- website postings

All new providers are provided with an onboarding guidebook that is available on the corporate intranet. Once providers are inside intranet they go to SharePoint and then click on the Physicians Tab. They then go to Shared Documents and select Onboarding Guide which is approximately 157 pages and the information

relevant to Health Education is located between pages 109-111. New and current providers can access this guidebook at any time to orient themselves about health education and obesity prevention services including health education topics, program descriptions, patient education materials and more.

Providers may also access health education information for their P/P/Cs using the AltaMed Health Education and Wellness Website:

http://www.altamed.org/programs_and_services/health_education OR the Document Library found on EHR (see policy HS-PED-003: Educational Resources and Materials).

Education Assessment, Referral and Evaluation

P/P/C Assessment

During the P/P/C assessment, appropriate education will be provided and documented in the electronic health record. (See PolicyHS-PED-005: Health Ed Referral & Tracking Through EHR).

P/P/C Referral

The Health Education and Wellness Department receives electronic referrals via NextGen, the electronic health records system adopted by AltaMed. This referral system is designed to provide a consistent and timely mechanism for the referral, tracking, and follow-up of patients referred to the department for services. Referrals are generated by the Medical Division. The referral links P/P/C's to health education programs, classes, one-on-one sessions, health education materials and community resources.

AltaMed Sites that Offer Health Education Services:

The clinic sites listed below provide individual and group sessions on nutrition, weight management, prenatal care, family planning, and chronic conditions such diabetes, high cholesterol, hypertension and stress/depression.

Los Angeles County	Orange County
AltaMed Medical and Dental Group – Boyle Heights **3945 Whittier Blvd.** **Los Angeles, CA 90023**	**AltaMed Medical and Dental Group – Anaheim, Lincoln** **1814 W. Lincoln Ave., Ste. A & B** **Anaheim, CA 92801**

**AltaMed Medical Group – Commerce 5427 Whittier Blvd. Los Angeles, CA 90022	AltaMed Medical Group – Anaheim, Lincoln – West 1820 W. Lincoln Ave. Anaheim, CA 92801
**AltaMed Medical and Dental Group – El Monte 10418 Valley Blvd., Suite B El Monte, CA 91731	AltaMed Medical Group – Garden Grove 12751 Harbor Blvd. Garden Grove, CA 92840
**AltaMed Medical Group – Pico Rivera 9436 East Slauson Ave., Pico Rivera, CA 90660	AltaMed Medical and Dental Group – Huntington Beach 8041 Newman Ave. Huntington Beach, CA 92647
AltaMed Medical Group – West Covina 1300 S. Sunset Ave. West Covina, CA 91790	AltaMed Medical Group – Orange 4010 E. Chapman Ave. Orange, CA 92869
*AltaMed PACE – Huntington Park 1900 E. Slauson Ave., Ste. B Huntington Park, CA 90255 Phone (323) 277-7678 Fax (323) 277-7686	AltaMed Medical Group – Santa Ana, Broadway 1515 Broadway St. Santa Ana, CA 92707
*AltaMed PACE – Lynwood 3820 Martin Luther King Jr. Blvd. Lynwood, CA 90262	**AltaMed Medical Group – Santa Ana, Central 1155 W. Central Ave., Ste. 104–107 Santa Ana, CA 92707
Los Angeles County	**Orange County**
*AltaMed PACE – Downey 12130 Paramount Blvd. Downey, CA 90242 Phone (562) 923-9414 Fax (562) 923-9451	AltaMed Medical and Dental Group – Santa Ana, Main 1400 N. Main St. Santa Ana, CA 92701
*AltaMed PACE – East Los Angeles 5425 E. Pomona Blvd. Los Angeles, CA 90022 Phone (323) 728-0411 Fax (323) 728-1535	AltaMed Medical Group – Santa Ana, Bristol 2720 S. Bristol St., Ste. 110 Santa Ana, CA 92704

***AltaMed PACE – El Monte** **10418 Valley Blvd., Ste. B** **El Monte, CA 91731** **Phone (626) 258-1600 Fax (626) 258-1609**	
***AltaMed PACE – Grand Plaza** **701 W. Cesar E. Chavez Ave., Suite 201,** **Los Angeles, CA 90012** **Phone (213) 217-5300 Fax (213) 217-5396**	

*PACE sites which cater to a geriatric population offer more senior-focused health education topics such as arthritis, tai chi exercise, congestive heart failure, chronic obstructive pulmonary disease, fall prevention, Alzheimer's Disease and more.

Furthermore, several of AltaMed's clinic sites offer HIV specialty care (as noted by **).
At these sites, health education topics are centered on HIV/STD prevention, treatment and care.

All classes are provided in English or Spanish unless patient requests another language in which case counselor or instructor would request an interpreter.

For more information, call the Health Education and Wellness Resource Line (323) 558-7606.

Making it through the day

If you have a chronic condition, you may feel a number of things, like fatigue, discomfort, stress, frustration or depression. Through these workshops you will learn how to cope with conditions such as diabetes, cholesterol, hypertension and asthma so that you can live a happier, healthier life.

Eating well and feeling great

Have fun while learning how to eat healthy and exercise. Classes and workshops are focused on helping you learn and identify your specific needs. AltaMed even offers classes for families. The following is a small sample of the wide range of classes available:

- Adult Nutrition
- Family Nutrition
- Salsa Sabor y Salud
- Stress Management
- Weight Management
- What To Do When Your Child Gets Sick?
- Raising Emotionally Healthy Children

Call AltaMed to receive a complete class list.

Taking control of your health
Maintaining a healthy lifestyle can be challenging. AltaMed offers programs that help you learn how to take control of your health and manage your health related conditions. Programs include:

- Healthier Living
- Arthritis Foundation Exercise Program
- El Poder Sin Ver

Ageless health
AltaMed offers a number prevention and management classes for seniors such as:

- Arthritis
- Congestive Heart Failure
- Fall Prevention
- Tai Chi

One on one
Individual counseling is available for the following:

- Diabetes
- Cholesterol
- Hypertension
- Nutrition
- Stress Management
- Weight Management
- Asthma

Benefits of health education
Results you may enjoy by joining one of AltaMed's free health education programs, classes, and workshops include:

- How to communicate effectively with your doctor
- Better understanding, skills and confidence in managing your condition
- Improved results in health exams
- Increased energy level

AltaMed has been guiding individuals and their families in preventitive health care for over 40 years.

Sign up for a class today!
Call us at:
1-323-558-7606
AltaMed.org/healthedclasses

Cultural and Linguistic Services

In order to ensure compliance with regulatory requirements contracted providers must provide culturally and linguistic appropriate services to all Limited English

Proficient (LEP) and hearing impaired patients by enabling the following:

1. Free 24/7 language interpreting services whenever the patient or legal representative is unable to communicate with the practitioner because of language or communication barriers. Interpreter services include but is not limited to:
    a) face-to-face / in-person
    b) over the phone
    c) in-person sign language (ASL)
    d) internal interpreting staff (fully bilingual and properly trained)
2. The Contracted Provider's staff will inquire on the need of interpreter services and will advise patients of their right to free interpreter services
3. If the patient declines such service then the Contracted Provider:
    a) will document the request/refusal in the health record
    b) will not require nor encourage the use of minors as interpreters
4. Signs informing patients of the availability of interpreting services will be posted in the Contracted Provider's waiting and examining rooms*
5. If requested by the patient, Contracted Provider will provide written translation of vital documents in the appropriate language
6. Contracted provider may include a disclaimer informing patient about how to obtain vital documents translated in their language*

*If the LEP patient is an HMO beneficiary, he/she may receive translation asistance from their Health Plan.Provider must contact the member services department of the appropriate Health Plan to request translation services.

JCAHO Network Standards

#	Joint Commission Standards
Environment of Care	

EC.01.01.01	The organization plans activities to minimize risks in the environment of care. Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.
EC.02.01.01	The organization manages safety and security risks.
EC.02.01.03	The organization prohibits smoking.
EC.02.02.01	The organization manages risks related to hazardous materials and waste.
EC.02.03.01	The organization manages fire risks.
EC.02.03.03	The organization conducts fire drills.
EC.02.03.05	The organization maintains fire safety equipment and fire safety building features. Note: This standard does not require organizations to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.
EC.02.04.01	The organization manages medical equipment risks.
EC.02.04.03	The organization inspects, tests, and maintains medical equipment.
EC.02.05.01	The organization manages risks associated with its utility systems.
EC.02.05.03	The organization has a reliable emergency electrical power source.
EC.02.05.05	The organization inspects, tests, and maintains utility systems. Note: At times, maintenance is performed by an external service. In these cases, organizations are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.
EC.02.05.07	The organization inspects, tests, and maintains emergency power systems. Note: This standard does not require organizations to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.
#	**Joint Commission Standards**
Emergency Management	

EC.02.05.09	The organization inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require organizations to have the medical gas and vacuum systems discussed below. However, if an organization has these types of systems, then the following inspection, testing, and maintenance requirements apply.
EC.02.06.01	The organization establishes and maintains a safe, functional environment.
EC.02.06.05	The organization manages its space during demolition, renovation, or new construction. Note: These elements of performance are applicable to all occupancy types.
EC.03.01.01	Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.
EC.04.01.01	The organization collects information to monitor conditions in the environment.
EC.04.01.03	The organization analyzes identified environment of care issues.
EC.04.01.05	The organization improves its environment of care.
EM.01.01.01	The organization engages in planning activities prior to developing its Emergency Management Plan. Note: An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.
Emergency Management	
EM.02.01.01	The organization has an Emergency Management Plan. Note: The organization's Emergency Management Plan is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the Plan's response procedures address the prioritized emergencies, but are also adaptable to other emergencies that the organization may experience.

EM.02.02.03	As part of its Emergency Management Plan, the organization prepares for how it will manage resources and assets during emergencies. Note: All organizations are required to respond to a patient's immediate care and safety needs if an emergency occurs with patients on site.
EM.02.02.05	As part of its Emergency Management Plan, the organization prepares for how it will manage security and safety during an emergency.
EM.02.02.07	As part of its Emergency Management Plan, the organization prepares for how it will manage staff during an emergency.
EM.02.02.09	As part of its Emergency Management Plan, the organization prepares for how it will manage utilities during an emergency.
EM.02.02.11	As part of its Emergency Management Plan, the organization prepares for how it will manage patients during emergencies.
EM.02.02.13	During disasters, the organization may grant disaster privileges to volunteer licensed independent practitioners. Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.
EM.02.02.15	During disasters, the organization may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration. Note: While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster.
EM.03.01.03	The organization evaluates the effectiveness of its Emergency Management Plan.

#	Joint Commission Standards
LD.04.03.01	The organization provides services that meet patient needs.
LD.04.03.07	Patients with comparable needs receive the same standard of care, treatment, or services throughout the organization.
LD.04.03.09	Care, treatment, or services provided through contractual agreement are provided safely and effectively.
LD.04.04.01	Leaders establish priorities for performance improvement. (See also the "Performance Improvement" (PI) chapter.)
LD.04.04.03	New or modified services or processes are well-designed.

LS.01.01.01	The organization designs and manages the physical environment to comply with the Life Safety Code. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in the event of an emergency in the organization. Note 2: This standard applies to all Ambulatory Surgical Centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.

LD.04.04.05	The organization has an organization-wide, integrated patient safety program.
LD.04.04.09	The organization uses clinical practice guidelines to design or to improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.
Life Safety	
LS.01.02.01	The organization protects occupants during periods when the Life Safety Code is not met or during periods of construction. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in the event of an emergency in the organization. Note 2: This standard applies to all Ambulatory Surgical Centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.
Life Safety	
LS.03.01.10	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support.

LS.03.01.20	The organization maintains the integrity of the means of egress. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).
LS.03.01.30	The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space(for example, fire alarm system, automatic sprinkler system).
Life Safety	
	The organization provides and maintains fire alarm systems. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

	The organization provides and maintains equipment for extinguishing fires. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).
	The organization provides and maintains special features to protect individuals from the hazards of fire and smoke. Note: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

#	Joint Commission Standards
LS.03.01.50	The organization provides and maintains building services to protect individuals from the hazards of fire and smoke. Note 1: This standard applies to sites of carewhere four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

LS.03.01.70	The organization provides and maintains operating features that conform to fire and smoke prevention requirements. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).
Medication Management	
MM.01.01.01	The organization plans its medication management processes.
MM.01.01.03	The organization safely manages high-alert and hazardous medications.
MM.02.01.01	The organization selects and procures medications.
MM.03.01.01	The organization safely stores medications.
MM.03.01.03	The organization safely manages any emergency medications.
Medication Management	
MM.03.01.05	The organization safely controls medications brought into the organization by patients, their families, or licensed independent practitioners.
MM.04.01.01	Medication orders are clear and accurate.
MM.05.01.01	The organization reviews the appropriateness of all medication orders for medications to be dispensed in the organization.
MM.05.01.07	The organization safely prepares medications. Note: This standard is applicable to all organizations that prepare medications for administration.
MM.05.01.09	Medications are labeled. Note: This standard is applicable to all organizations that prepare and administer medications.
MM.05.01.11	The organization safely dispenses medications.
MM.05.01.15	The organization safely obtains medications when it does not operate a pharmacy.

MM.05.01.17	The organization follows a process to retrieve recalled or discontinued medications. Note: This standard is applicable to all organizations that dispense medications, including sample medications
MM.05.01.19	The organization safely manages returned medications.
MM.06.01.01	The organization safely administers medications.
MM.06.01.05	The organization safely manages investigational medications.
MM.07.01.01	The organization monitors patients to determine the effects of their medication(s).
MM.07.01.03	The organization responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.
MM.08.01.01	The organization evaluates the effectiveness of its medication management system.
National Patient Safety Goals	
NPSG.01.01.01	Use at least two patient identifiers when providing care, treatment, or services.
NPSG.02.01.01	For verbal or telephone orders or for telephone reporting of critical test results, the individual giving the order or test result verifies the complete order or test result by having the person receiving the information record and “read back” the complete order or test result.
NPSG.02.02.01	There is a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.
National Patient Safety Goals	
NPSG.02.03.01	The organization measures, assesses, and, if needed, takes action to improve the timeliness of reporting and the timeliness of receipt of critical tests and critical results and values by the responsible licensed caregiver.
NPSG.02.05.01	The organization implements a standardized approach to hand-off communications, including an opportunity to ask and respond to questions.
NPSG.03.03.01	The organization identifies and, at a minimum, annually reviews a list of look- alike/sound-alike medications used by the organization and takes action to prevent errors involving the interchange of these medications.
NPSG.03.04.01	Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

NPSG.03.05.01	Reduce the likelihood of patient harm associated with the use of anticoagulant therapy. Note: This requirement applies only to organizations that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.
NPSG.07.01.01	Comply with current World Health Organization (WHO) hand hygiene guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
NPSG.07.02.01	Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function related to a health care–associated infection.
NPSG.08.01.01	A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the organization
NPSG.08.02.01	When a patient is referred to or transferred from one organization to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a patient leaves the organization's care to go directly to his or her home, the complete and reconciled list of medications is provided to the patient's known primary care provider, the original referring provider, or a known next provider of service. Note: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the patient and, as needed, the family list of reconciled medications is sufficient.

#	Joint Commission Standards
NPSG.08.03.01	When a patient leaves the organization's care, a complete and reconciled list of the patient's medications is provided directly to the patient and, as needed, the family, and the list is explained to the patient and/or family.
NPSG.08.04.01	In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed. Note: This requirement does not apply to organizations that do not administer medications. It may be important for health care organizations to know which types of medications their patients are taking because these medications could affect the care, treatment, or services provided.
NPSG.13.01.01	Identify the ways in which the patient and his or her family can report concerns about safety and encourage them to do so.

UP.01.01.01	Conduct a pre-procedure verification process.
Provision of Care, Treatment, Services	
PC.01.01.01	The organization accepts the patient for care, treatment, or services based on its ability to meet the patient's needs.
PC.01.02.01	The organization assesses and reassesses its patients.
PC.01.02.03	The organization assesses and reassesses the patient and his or her condition according to defined time frames.
PC.01.02.07	The organization assesses and manages the patient's pain.
PC.01.02.09	The organization assesses the patient who may be a victim of possible abuse and neglect.
PC.01.02.15	The organization provides for diagnostic testing.
PC.01.03.01	The organization plans the patient's care.
PC.02.01.01	The organization provides care, treatment, or services for each patient.
PC.02.01.03	For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.
PC.02.01.05	The organization provides interdisciplinary, collaborative care, treatment, or services.
PC.02.01.07	The organization safely administers blood and blood component(s).
Provision of Care, Treatment, Services	
PC.02.01.09	The organization plans for and responds to life-threatening emergencies.
PC.02.02.01	The organization coordinates the patient's care, treatment, or services based on the patient's needs.
PC.02.02.03	The organization makes food and nutrition products available to its patients.
PC.02.03.01	The organization provides patient education and training based on each patient's needs and abilities.
PC.03.01.01	The organization plans operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.
PC.03.01.03	The organization provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of deep sedation or anesthesia.

#	Joint Commission Standards
PC.03.01.05	The organization monitors the patient during operative or other high-risk procedures and/or during the administration of moderate or deep sedation or anesthesia.
PC.03.01.07	The organization provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.
PC.03.02.03	Written policies and procedures guide the organization's safe use of restraint.
PC.03.02.07	The organization monitors patients who are restrained.
PC.04.01.01	The organization has a process that addresses the patient's need for continuing care, treatment, or services after discharge or transfer.
PC.04.01.03	The organization discharges or transfers the patient based on his or her assessed needs and the organization's ability to meet those needs.
PC.04.01.05	Before the organization discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, or services.
PC.04.02.01	When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.
Performance Improvement	
PI.01.01.01	The organization collects data to monitor its performance.
PI.02.01.01	The organization compiles and analyzes data.
PI.03.01.01	The organization improves performance.
Record of Care Treatment Services	
RC.01.01.01	The organization maintains complete and accurate clinical records.
RC.01.02.01	Entries in the clinical record are authenticated.
RC.01.03.01	Documentation in the clinical record is entered in a timely manner.
RC.01.04.01	The organization audits its clinical records.
RC.01.05.01	The organization retains its clinical records.
RC.02.01.01	The clinical record contains information that reflects the patient's care, treatment, or services.

RC.02.01.03	The patient's clinical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.
RC.02.01.05	The clinical record contains documentation of the use of restraint.
RC.02.01.07	The clinical record contains a summary list for each patient who receives continuing ambulatory care services.
RC.02.03.07	Qualified staff receive and record verbal orders.

#	Joint Commission Standards
Rights and Responsibilities of the Individual	
RI.01.01.01	The organization respects patient rights.
RI.01.01.03	The organization respects the patient's right to receive information in a manner he or she understands.
RI.01.02.01	The organization respects the patient's right to participate in decisions about his orher care, treatment, or services.
RI.01.03.01	The organization honors the patient's right to give or withhold informed consent.
RI.01.03.03	The organization honors the patient's right to give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his or her care.
Rights and Responsibilities of the Individual	
RI.01.03.05	The organization protects the patient and respects his or her rights duringresearch, investigation, and clinical trials.
RI.01.04.01	The organization respects the patient's right to receive information about the individual(s) responsible for his or her care, treatment, or services.
RI.01.05.01	The organization addresses patient decisions about care, treatment, or services received at the end of life.
RI.01.06.03	The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.
RI.01.07.01	The patient and his or her family have the right to have complaints reviewed by the organization.
RI.02.01.01	The organization informs the patient about his or her responsibilities related to his or her care, treatment, or services.
Waived Testing	

WT.01.01.01	Policies and procedures for waived tests are established, current, approved, and readily available.
WT.02.01.01	The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate identifies the staff responsible for performing and supervising waived testing. Note 1: Responsible staff may be employees of the organization, contracted staff, or employees of a contracted service. Note 2: Responsible staff may be identified within job descriptions or by listing job titles or individual names.
WT.03.01.01	Staff and licensed independent practitioners performing waived tests are competent.
WT.04.01.01	The organization performs quality control checks for waived testing on each procedure. Note: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.
WT.05.01.01	The organization maintains records for waived testing.

Definitions

Managed Care:
Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Two plan Model:
Under the Managed Care Two-Plan Model, the Department of Health Care Services (DHCS) contracts with two managed care plans to provide medical services to most Medi-Cal recipients in each of the 14 participating counties. The 14 Two-Plan Model counties are Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin,

Santa Clara, Stanislaus and Tulare. Each county offers a local initiative plan and a commercial plan.

Local initiative plans, which are initiated by a county board of supervisors, are operated by a locally developed comprehensive managed care organization. Commercial plans are operated by non-governmental managed health care organizations. Medi-Cal recipients may enroll in either plan.

Medicaid:
A joint federal and state program that helps low-income individuals or families pay for the costs associated with long-term medical and custodial care provided they qualify. Although largely funded by the federal government, Medicaid is run by the state where coverage may vary.

Medi-Cal:
The Medicaid program in California, provides health coverage to people with low-income and asset levels who meet certain eligibility requirements.

Medicare:
Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

The different parts of Medicare help cover specific services:

- **Medicare Part A** (Hospital Insurance)
  Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care
- M**edicare Part B** (Medical Insurance)
  Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services
- **Medicare Part C** (Medicare Advantage Plans)

  Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans

Cal MediConnect:
Is a program to serve people that are eligible for both Medicare and Medi-Cal. Cal MediConnect is an all-in-one health plan that covers medical, prescription drugs (medicines) and long-term services and supports.

The Cal MediConnect program aims to improve care coordination for dual eligible beneficiaries and drive high quality care that helps people stay healthy and in their homes for as long as possible. Additionally, shifting services out of institutional settings and into the home and community helps create a person-centered health care system that is also sustainable.

Seniors and Persons with Disabilities (SPD):
A federal waiver granted under Section 1115(a) of the Social Security Act permits mandatory enrollment of Medi-Cal only Seniors and Persons with Disabilities into Medi-Cal managed care. The Waiver allows the Department of Health Care Services to achieve care coordination, better manage chronic conditions, and improve health outcomes. Mandatory enrollment began June 2011.

Medical Marketing Guidelines:

Please refer to Exhibit IV; DHCS Plan letter # 13-015

Appendix A – PACE Program Provider Manual

AltaMed
WORK BOLDLY. LIVE BRILLIANTLY.

2040 Camfield Avenue, Los Angeles, CA 90040
(323) 725-8751 | AltaMed.org