Participating in the Alliance Network

To participate in the Alliance network, a provider must sign a Provider Services Agreement and his/her credentials must be approved by the Medical Director or Peer Review and Credentialing Committee (PRCC). The PRCC is comprised of Alliance-contracted network physicians from major disciplines, including primary care and specialty practices. Providers are re-credentialed within 36 months after the initial credentialing date or the last re-credentialing approval date.

Pursuant to Article II of the Provider Services Agreement, all new providers and those eligible for re-credentialing must return a signed California Participating Physician Application (CPPA) to the Alliance, along with all required attachments, including, but not limited to, copies of the following documents:

- Current Medical License or Business License.
- Current Clinical Laboratory Improvement Amendments (CLIA) or Waiver, if applicable.
- Current Drug Enforcement Agency (DEA) License, if applicable.
- Documentation for National Provider Identifier (NPI) and Taxonomy Code.
- Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).
- Signed Taxpayer Identification Form (W-9).
- Signed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form.
- Signed Declaration of Confidentiality form (new providers only).
- Curriculum vitae (with dates in MM/YYYY format)
- Hospital Privileges Status or Admitting Agreement
- Language Verification Form (new providers only).

If a provider is a supervising physician for a non-physician medical practitioner (NPMP), all new NPMPs and those eligible for re-credentialing must return a signed CPPA, along with all required attachments and copies of the following documentation:

- Current completed NPMP/Physician Assistant (PA) Delegation of Services Agreement(s), if applicable.
- Current NPMP staff licenses.

- Current NPMP staff Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).
- Signed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form.

Signed Declaration of Confidentiality form (new providers only)

In addition to the Alliance's credentialing process, providers are required to complete screening and enrollment pursuant to the Department of Health Care Services (DHCS) guidelines. For more information, please see Alliance Policy 300-4025 – Provider Screening and Enrollment Process.

Before the verification process is finalized, a nurse from the Alliance will visit each Medi-Cal PCP site to conduct a site review. After the site review and verification of the credentialing information, the provider's initial credentialing and re-credentialing files are submitted to the Medical Director or the PRCC for review and approval. If a provider's credentials are approved, the Alliance's Chief Executive Officer will countersign the Provider Services Agreement and within 10 business days of approval, new contracted providers will receive and complete new provider orientation training from the Alliance Provider Services Department. For more information, please see Policy 300-6030 – New Provider Training.

For additional information about the Alliance's credentialing policies and procedures, please visit the credentialing policies link on the Alliance provider website.

Notification about Actions Taken Against Provider or Staff

Federal and state laws require that you notify us immediately by phone (with a follow-up in writing) of the following actions taken towards you or any practitioner on your staff:

- Revocation, suspension, restriction, non-renewal of license, certification, or clinical privileges.
- A peer review action, inquiry or formal corrective action.
- A malpractice action or a government action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the state licensing board or similar organization or the National Practitioner Data Bank of adverse credentialing or peer review action.
- Any material change in any of the credentialing information.
- Sanctions under the Medicare or Medicaid programs.
- Placement on the Medi-Cal Suspended and Ineligible Provider list.
- Any incident that may affect any license or certification, or that may materially affect performance of the obligations under the agreement.

Appealing Adverse Decisions by the Peer Review and Credentialing Committee

If the PRCC should make a decision that alters the condition of a provider's participation with the Alliance based on issues related to quality of care, the provider may appeal the adverse decision. For more information on the Alliance fair hearing process for adverse decisions, please seeIf a provider fails to meet the credentialing standards or if his/her license, certification or privileges are revoked, suspended, expired or not renewed, the Alliance must ensure that the provider not provide any services to Alliance members. Additionally, any conduct that could adversely affect the health or welfare of a member will result in written notification instructing the provider not to provide services to Alliance members until the matter is resolved to our satisfaction.

Review Procedure for Decisions Concerning Provider Network Participation

If the Alliance should make a decision that alters the condition of a provider's participation with the Alliance for reasons not related to quality of care, a provider's failure to meet the licensing, certification or authority requirements of the Provider Services Agreement, or a provider being either excluded from participating in, or sanctioned by, the Medicare or Medicaid programs, the provider may be heard through the Alliance review procedure. This review procedure is the provider fair hearing right described in the Provider Services Agreement. For more information on the provider review procedure, please see Policy 300-9010 - Review Procedure for Decisions Concerning Provider Network Participation.

Please note that in no event would a provider have access to both the Fair Hearing Process for Adverse Decisions and the Review Procedure for Decisions Concerning Provider Network Participation with respect to the same decision.

Changes in Ownership

Generally, Alliance provider agreements require that the provider obtain prior written consent from the Alliance when a change of ownership is planned. Additionally, where a change in ownership results in the desire to assign an Alliance agreement to another entity, written approval from the California Department of Health Care Services must be obtained prior to such assignment occurring. Depending upon the circumstances of the change in ownership, it is also possible that a provider's eligibility for incentives may be impacted.

If you anticipate a change in ownership of your organization, please complete the Notice of Change in Ownership document and return it to the Alliance as soon as possible to help ensure that your contract with the Alliance remains in force and accurate.

Debarment, Suspension, Ineligibility or Voluntary Exclusion

In accordance with the Code of Federal Regulations, Title 45, Part 76 (45CFR76), the Alliance receives federal funding and therefore must certify that it has not been debarred or otherwise excluded from receiving these funds. Under this rule, because the Alliance receives this federal funding, the Alliance is considered a "lower tier participant." As subcontractors, our providers, who essentially receive federal funding by nature of their Agreement with the Alliance, are also considered "lower tier participants" and thus

must also attest to the fact that, by signing the form specified below, they have not been debarred or otherwise excluded by the federal government from receiving federal funding.

When providers apply to become part of the Alliance network, they receive a form titled "Certification Regarding Debarment Suspension, Ineligibility and Voluntary Exclusion." This form must be signed by the provider and returned with a completed credentialing application and signed agreement, certifying, as stated above, that the provider is eligible to participate in the Alliance program and receive funds provided by the federal government. Pursuant to this certification and provider agreement with the Alliance, should the provider, or any other subcontracted provider, become suspended or ineligible to receive federal funds, the provider is required to notify the Alliance immediately.

Debarment, Suspension, Ineligibility of Prescribing Providers

In accordance with California Civil Code, Section 51303(k), the Alliance cannot reimburse providers for services ordered, prescribed, or rendered by a provider who is debarred, suspended, or otherwise ineligible from participation in the Medi-Cal program or included on federal debarment and suspension lists. Accordingly, should the Alliance receive a claim for payment, or retrospectively identify payment of a claim, resultant from the order or prescription of a debarred, suspended, or otherwise ineligible provider, such a claim would be unallowable and subject to denial or recoupment, respectively.

For more information, please see Policy 105-3003 – Suspended or Ineligible Providers.

Program Integrity: Anti-Fraud, Waste and Abuse

Alliance anti-fraud, waste and abuse (FWA) efforts encompass two primary activities: FWA *prevention* and *investigation*, collectively known as Program Integrity.

Definitions

Abuse: Activity that is inconsistent with sound fiscal, business, or medical practice standards and results in unnecessary cost or reimbursement. It also includes any act that constitutes abuse under applicable federal law (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Waste: The consumption of resources (products or services) due to mismanagement, inappropriate actions or inadequate oversight. Waste is not typically the result of criminal actions.

Laws and Regulations

False Claims Act (Federal – *31 U.S.C. § 3729-3733;* California – *C.G.C. § 12650-12656)*: The California and Federal False Claim Acts (FCAs) make it illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim. Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil

FCA contains a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States and entitles whistleblowers to a percentage of any recoveries. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines.

For additional anti-FWA laws and regulations that inform the Alliance's Program Integrity efforts, please review Policy 105-3001 - Program Integrity: Fraud Waste and Abuse Prevention Program.

Fraud Waste & Abuse Prevention

Alliance FWA prevention (FWAP) activities are facilitated by the Alliance FWAP Program. The FWAP Program ensures:

- Written policies, procedures and standards for all employees (including management) and any contractor or agent (including providers), that: articulate the Alliance's commitment to comply with all applicable federal and state anti-FWA standards; outline the procedures for preventing, detecting potential/actual FWA; and, provide detailed information about the FCA, administrative remedies for false claims, state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA.
- Employee handbook inclusion of information about the FCA and related laws, the rights of employees to be protected as whistleblowers and Alliance policies and procedures for detecting and preventing FWA.
- The establishment of an anti-FWA program with a central point of contact.
- Provision for internal monitoring and auditing.
- Alliance Compliance Officer and employees receive and complete effective training on FWA prevention, detection and reporting.
- The Alliance does not employ or contract with individuals debarred, proposed for debarment, suspended, declared ineligible or voluntarily excluded by any federal department or agency.
- The Alliance's appropriate use of non-monetary incentives to promote good member health practices.

The FWAP Program promotes:

- Board member, employee and contractor compliance with Alliance FWAP-related policy, and regulatory, contractual and legislative requirements governing the health plan, including the Alliance Code of Conduct and Oath of Confidentiality.
- Member protection in the receipt of health care services through timely detection of potential/actual FWA.
- The protection, security and confidentiality of protected health information.
- Contractor development and maintenance of internal FWAP program and policy.

- Alliance board, contractor/provider and member understanding and awareness of FWA practices through education and information sharing.
- Prompt reporting by Alliance board members, employees and contractors of suspected/actual violations of any FWA-related statute, regulation or guideline applicable to federal and/or state health care programs or Alliance policies.
- Alliance employees maintain awareness and protection of the legal rights of all parties involved in any case of potential/actual FWA.
- A system of internal assessment is organized and maintained to identify and analyze significant opportunities for FWAP program improvement.
- Recognition of Alliance board members, employees, providers, contractors, members, local law enforcement and the state as important partners in this effort.

The Alliance's FWAP program integrates the activities of all Alliance departments in meeting our FWAP objectives. The FWAP program is one of the many ways the Alliance ensures: appropriate service provision to our members; partnerships with reputable contractors; and, proper administration of our health plan, including correct use of public funds. The Alliance takes the position that fraud, waste and abuse at any level are impermissible and intolerable. When a practice is deemed not consistent with Alliance standards and requirements, an investigation may be performed and an action plan developed, as needed.

Fraud Waste & Abuse Investigations

Investigations into suspected/actual FWA are facilitated by the Alliance Special Investigations Unit (SIU). The SIU will only investigate FWA concerns relating/potentially relating to Alliance members, health care providers, non-health care contractors, employees, or Board members. Should the Alliance become aware of potential/actual FWA not related to Alliance entities, the Alliance may facilitate referral to appropriate agencies. The SIU ensures:

- Prompt and complete investigation of suspected/actual FWA. The SIU undertakes research and data analysis, internally and potentially externally, when necessary.
- Reporting of investigative findings to the state and/or law enforcement, as appropriate, when there is reason to believe fraud and/or abuse has occurred by contractors, members, providers, or employees. For the Alliance's Medi-Cal program, potential/actual fraud or abuse concerns will be reported to California Department of Health Care Services (DHCS) within 10 business days; provider-related concerns will also be reported to the California Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse, and/or other applicable law enforcement agencies.
- Development of corrective action plans, including the recoupment of identified overpayments, when indicated by investigative findings.

For additional information, please view Policy 105-3002 – Program Integrity: Special Investigations Unit Operations.

If you have any concerns about practice standards or general questions about Alliance Program Integrity efforts, please contact your Provider Relations Representative.

Medical Records

Each primary care office is responsible for maintaining adequate medical records of patient care. Records must be maintained in accordance with applicable federal and state privacy laws. All medical records must be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for ten years after termination of agreement with the Alliance, including the period required by the Knox-Keene Act and Regulations, and Medicare and Medi-Cal programs.

To ensure compliance with medical record keeping requirements, the Alliance periodically performs audits of network providers for billed services. For additional information about this process, see Policy 105-3004 – Verification of billed Services by Network Providers.

Confidentiality of Information

Providers are responsible for ensuring and maintaining the confidentiality of information about members and their medical records, in accordance with applicable federal and state laws. The names of any member receiving public social services must be kept confidential and protected from unauthorized disclosure. This includes all information, records, and data collected and maintained for the operation of the Agreement including information accessed through the Alliance Provider Portal. Providers may not use any such information for any purpose other than carrying out the terms of their agreement. In compliance with The Health Insurance Portability and Accountability Act (HIPAA), members are entitled to an accounting of any disclosure of information. If an unauthorized disclosure of member information occurs, or is suspected, providers are to notify the Alliance immediately upon discovery by faxing the following information to the Alliance Compliance Department at (831) 430-5680.

- Provider office name, contact person and phone number
- Date the disclosure occurred
- Date the disclosure was discovered
- Number of Alliance members affected
- Identification numbers of affected Alliance members
- How the unauthorized disclosure occurred (fax, email, etc.)
- Who the information was disclosed to
- What information was disclosed (first/last name, identification number, phone number, address, diagnosis/procedure code, etc.)
- How the disclosure was discovered
- Description of what occurred

Medical Record Keeping

The Alliance's provider agreements require medical records be maintained in a manner that is current and demonstrates the Medical Necessity of Covered Services for which a claim for payment is submitted. As a

minimum standard, practitioners billing the Alliance for Covered Services must document the provision of such services in the member's medical record prior to submitting a claim for payment. The Alliance may recoup payments where it identifies that no documentation of the service exists in the member's medical record.

Access to and Copies of Records

Providers are required to have records readily retrievable for all billed services regardless of rendering location. Our Health Services and/or Compliance staff may request records from provider offices for one or more Alliance covered members for several reasons, including:

- Quality improvement studies mandated by the Medi-Cal Managed Care Division.
- Authorization requests.
- Claims' payments issues.
- Assistance with case coordination.
- Determination of "requests for administrative member" status.
- Possible California Children's Services (CCS) referrals.
- Follow-up to a member complaint or quality of care issue.
- Evaluation of potential fraud/abuse concerns.
- Verification that medically necessary goods/services were received by Alliance members.
- Assistance facilitating a medical record review audit.

For complete details on provider responsibilities relative to medical records, please see Policy 401-1510 - Medical Record Review and Requirements.

Accessibility Standards

Providers' requirement to provide timely access to health care will be ensured through a monitoring process using acceptable performance standards. After hours availability standards are described in Policy 404-1202 – After-Hours Availability of Plan and Contract Physician. Additional access standards can be found in Policy 401-1509 - Timely Access to Care and Policy 300-8030 - Monitoring Network Compliance with Accessibility Standards.

Unlawful Harassment

Provider as well as its agents and employees, shall not unlawfully harass or allow harassment against any Alliance Member or their representative. For the purpose of this provision, Harassment means conduct that has the purpose or effect of unreasonably interfering in a substantial manner with an individual's welfare, or creates an intimidating, hostile, offensive, or demeaning environment. Harassment includes, but is not limited to, the following examples of behavior:

- Physical harassment: assault, touching, impeding or blocking movement, grabbing, patting, leering, making express or implied job-related threats in return for submission to physical acts, mimicking, taunting, or any physical interference with normal movement.
- Sexual harassment: may involve the behavior of a person of either sex against a person of the opposite or same sex, and occurs when such behavior constitutes unwelcome sexual advances, unwelcome requests for sexual favors, and other unwelcome verbal, physical, or visual behavior of a sexual nature where:
    - Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's treatment;
    - Submission to or rejection of such conduct by an individual is used as the basis for decisions affecting the individual's welfare; or
    - Such conduct is so severe or pervasive as to alter the environment in a negative or hostile way.
- Verbal harassment, such as epithets (nicknames and slang terms), derogatory or suggestive comments, propositioning, jokes or slurs, intimidation, threats, gestures, flirtations, or graphic verbal commentaries about an individual's body or appearance. Verbal harassment includes patronizing or ridiculing statements that are disparaging and bullying.
- Visual forms of harassment, such as derogatory posters, notices, photographs, bulletins, cartoons, drawings, sexually suggestive objects, or inappropriate electronic communications such as email or texts.