American Choice Healthcare
Compliance Policy and Procedure Manual

April 16th, 2024

American Choice Healthcare

Contents

Accounting of Disclosures of Protected Health Information

Effective Date: June 2023

Policy

It is the policy of American Choice Health Care (ACH) to provide individuals with an accounting of all disclosures of their Protected Health Information (PHI) made by ACH or by a Business Associate of ACH during the six years prior to the date of the individual's request (hereinafter referred to as "Accountable Disclosures").

Applicability

This policy and procedure applies to all ACH Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Individuals Who May Request Accounting
   1. The individual who is the subject of the PHI or his or her personal representative may request an accounting in accordance with this Policy.
   2. Any individual who would like to obtain an accounting of their PHI must submit a request in writing.
   3. Any requests for an accounting must include, at a minimum, the following information for the individual who is the subject of the PHI:
      - Full legal name;
      - Unique personal identification number (e.g., HICN, SSN);
      - Address and phone number;
      - Date of birth;
      - Signature (of the individual or authorized representative); and,
      - Date range of records requested.
   4. The request may be submitted, by an authorized individual to the Provider for processing.

B. Types of Disclosures that are Accountable:
   1. General Rule
      - Upon receipt of a written request for an accounting from an individual, Providers shall provide the individual an accounting of all disclosures of PHI

made by them or by a Business Associate during the six years prior to the date of the individual's request, or during any lesser period that the individual expressly requests (hereinafter referred to as the "Accounting Period").

2. Permissible Exceptions

   ACH is not required to provide individuals an accounting of disclosures of PHI that were made:

   - To carry out treatment, payment, and Health Care Operations;
   - To the individual of PHO about them;
   - Incident to a use or disclosure otherwise permitted or required by the Privacy Rule;
   - Pursuant to an authorization;
   - For the facility's director or to other persons involved in the individual's care or other notification purposes
   - For national security or intelligence purposes in accordance with the providers Notice of Privacy Practices;
   - To correctional institutions or law enforcement officials in accordance with the Provider's Notice of Privacy Practices;
   - As part of a limited data set; or,
   - That occurred prior to February 24th, 2020.

3. Providers temporarily suspend an individual's right to receive an accounting of disclosures that were made to the health oversight agency or law enforcement official (in accordance with § 164.512) or, respectively, for the time specified by such agency or official, if such agency health oversight agency or law enforcement official providers the provider with a written statement that such an accounting to the individual would be reasonably likely to impede such agencies or official's activities and specifying the time for which such a suspension is required. The terms and length of such suspension will be as follows:

   - <u>Oral Request</u>
     i. If ACH receives an oral request, it must document the occurrence of the request, including the identity of the agency or official making the request.
     ii. Temporarily suspend the individual's right to an accounting of disclosures subject to the statement; and

iii. Limit the temporary suspension to no longer than 30 days from the date of the oral statement unless a written statement is submitted during that time.

4. An individual may request an accounting of disclosures for a period of time less than six years from the date of the request.

C. Content of the Accounting

1. General Rule

- Providers must provide the individual a written accounting that includes all the following, with respect to each Accountable Disclosure that was made by the Provider or any of its Business Associates during the Accounting Period:
  - i. The date of the disclosure;
  - ii. The name of the entity or person who received the Protected Health Information and, if known, the address of such entity or person;
  - iii. A brief description of the Protected Health Information disclosed; and,
  - iv. A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure;
- If during the period covered by the accounting, the provider has made multiple disclosures of PHI to the same person or entity for a single purpose under § 164.502(a)(2)(ii) or § 164.512, the accounting may, with respect to such multiple disclosures, provide:
  - i. The information required by section C 1. i-v above for the first disclosure during the accounting period;
  - ii. The frequency, periodicity, or number of the disclosures made during the accounting period; and
  - iii. The date of the last such disclosure during the accounting period.

2. Multiple Disclosures exception

- If during the Accounting period, the provider has made multiple disclosures of PHI to the same person or entity for a single purpose pursuant to the individual's written authorization, a Secretary's Request, the written accounting may, with respect to such multiple disclosures, contain the following:
  - i. The frequency, periodicity, or number of the disclosures made during the Accounting Period; and,
  - ii. The date of the last such disclosure during the accounting period.

3. Timing of response to Individuals Request of Accounting

- Providers must act on the individuals request for an accounting, no later than 60 days after receipt of such a request, as follows:
    i. A written accounting; or
    ii. If unable to provide the written accounting within 60 days of receipt of the individual's written request, a written statement of the reasons for the delay and the date by which ACH will provide the accounting (which may not be later than 90 days from the date of ACH's receipt of the individual's initial written request).

4. Retention of Accounting
    - Providers shall retain each written accounting that it creates in accordance with this Policy and each written response it provides to an individual in connection therewith for a period of 6 years from the date that the written accounting or other written response, as applicable, is created. In addition, Providers shall retain each written request for an accounting it receives and any documentation it creates of this Policy from the date such written request is received, or such documentation is created, as applicable. All requests shall be kept in the patients' Medical Records.

Reporting

A. N/A

Adding & Removing Participant & Preferred Providers

Effective Date: April 2024

Policy

It is the policy of the American Choice Healthcare (ACH) to ensure Compliance with the ACO Reach Model requirements regarding changes to Participant and Preferred Providers List.

Applicability

This policy and procedure applies to all ACH Participant Providers, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedures

A. ACH may only add Participant Provider TINs during the Annual Certification Process which occurs prior to each Performance Year in accordance with CMS's PY2023 Participant and Preferred Provider Management Guide (e*xhibit A) and* ARTICLE IV of ACO REACH Model Agreement. There are CMS allowed exceptions outlined in the above, this guide and the ACO REACH Model Agreement may be updated by CMS at their discretion.

B. Prior to each Performance Year, ACH shall submit to CMS its proposed lists of Preferred and Participant Providers that are expected to participate in the ACO Reach Model
The list must:
   1. Identify each individual or entity by name, NPI, TIN, Legacy TIN (if applicable) and CCN (if applicable);
   2. Identify the individuals and entities, if any, that have agreed to a Fee Reduction; and
   3. Identify the Benefit Enhancements, if any, in which a Provider has agreed to participate.

C. <u>Additions of Preferred Providers During the Performance Year:</u>
ACH may add an individual or entity to the Preferred Provider List during a Performance Year per e*xhibit A* and the ACO REACH Model Agreement. If ACH wishes to add a Preferred Provider during the Performance Year:
   1. The Contracting Department notifies the ACH Credentialing Committee that a provider wishes to participate in the program. If approved by the committee, Contracting will submit information to the Population Health team to submit into 4i.
      - If CMS approves the Provider into the program, the Provider will be active as of the date assigned by CMS and will be placed as active.
      - If the Provider is not approved, due to a PECOS error the error must be corrected and resubmitted in the next ad hoc window.

D. Removal of an ACH Participant or Preferred Provider:

1. A Provider who wishes to be terminated from the program must submit their request in writing, on Letter Head and be signed by an authorized signer. Upon receipt, the letter is submitted to the Credentialing Committee for review and approval.
2. For Providers requesting termination the following process will be followed:
    - The Credentialing Committee will flag the Provider as a potential termination.
    - If the termination is approved, the Provider shall be removed from 4i by the Population Health Department.
    - The website is to be updated monthly.
    - Termination of the individual or entity will be effective on the date when the individual or entity's;
        - Agreement with ACH to participate in the Model is terminated and has been accepted by CMS, or
        - If the provider discontinues billing for items and services to beneficiaries under a Medicare plan.
    - In Contract Logix, the Contracting department shall upload the Termination Letter, add the termination date, and change the status of the Provider to "Terminated".
3. For Participant or Preferred Providers that become ineligible to receive payment from Medicare, the following process will be followed:
    - ACH shall notify CMS within 15 days of receiving notice of such ineligibility Steps c – f of the process above will then be followed.

E. Providers dropped by CMS

1. Provider Success Team is notified of the providers that have been dropped as per CMS
2. The Providers/practice are contacted and informed why they were dropped.
    - If provider wishes to be added back to the list, the credentialing committee will address feasibility of the request. If approved, the provider will be added into 4i by the Population Health team for the following performance year.
3. Once the Provider/Practice has been informed, it is documented and stored .

F. ACO REACH Provider list on the Public Reporting Website

1. Contracting Department will communicate changes made to the list of ACO REACH Providers on a monthly basis.
2. Updates to the website are to be done within 30 calendar days

G. ACH Notice to NPI's and TINS:

Please see Notices to Proposed Providers and TINs Policy.

H. ACH Certification of Lists:

1. ACH shall review the preliminary lists of approved Participating and Preferred Providers and:

- Make any necessary corrections to it, including the removal of any individuals or entities that have not agreed to participate in the Model pursuant to a signed agreement or that are otherwise ineligible to participate, and
- Complete the survey/attestation to CMS as required by the established deadline, confirming accuracy and completeness of the Provider lists.

I. Any changes to enrollment information for ACH Participant and Preferred Providers, including changes to reassignment of the right to receive Medicare payment, are reported to CMS consistent with 42 C.F.R Section 424.516.

Reporting

A. Quarterly audits of the ACO REACH Provider list will be performed to ensure that information is accurate as per the requirements in this policy.

Exhibit A

2024 Participant
and Preferred Provid

Beneficiary Discharges and Dismissals

Effective Date: February 2023

Policy

It is the policy of American Choice Health Care (ACH) to treat every Beneficiary with fairness and dignity and without discrimination.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. **Termination of Doctor-Patient Relationship**

1. Beneficiaries may initiate the end of a doctor-patient relationship by providing oral or written notification.
2. A provider (including, but not limited to, physicians and nurse practitioners) may determine that they cannot treat a Beneficiary due to extenuating circumstances (examples provided below) and dismiss the Beneficiary from their practice.
3. When a provider determines that they can no longer care for a Beneficiary, a reasonable effort will be made to transfer the Beneficiary from one provider to another, when appropriate.

B. **Beneficiary Discharge of Provider**

1. Beneficiaries may discharge a provider for a variety of reasons including, but not limited to, the Beneficiary's:
    a. Moving to a new location;
    b. Inability to pay the provider fees; and,
    c. Dissatisfaction with their care or treatment plan.
2. If the Beneficiary requests to change providers related to medical care, the provider should attempt to resolve the Beneficiary's concern and/or refer the Beneficiary to another provider within the practice or a provider of the Beneficiary's choice. If the provider is concerned about the possibility of a malpractice claim, then they should seek legal counsel.

If Beneficiaries are leaving due to office practices (such as waiting too long for an appointment or waiting too long in reception), then the provider office should review practice workflows.

3. The individual that is informed of the termination by the Beneficiary will document the conversation or notification in the Beneficiary record. This documentation should include the Beneficiary's reason for termination.
4. The ACH provider should send the Beneficiary a letter acknowledging the Beneficiary's choice to terminate the relationship and maintain a copy in the Beneficiary's record. An investigation should be completed by the provider to determine the reason for termination and further action will be taken, as appropriate.

C. **Provider Discharge of a Beneficiary**

1. Providers may terminate doctor-patient relationships for non-discriminatory reasons, provided that they give the Beneficiary proper notice and do not withdraw in the middle of a medical crisis. The provider is the only person who should determine to end a doctor- patient relationship, not other individuals in the practice or ACH. For some providers (e.g., home health providers, nurse practitioners, etc.), the medical director should be involved in the decision.
2. A provider may not terminate a Beneficiary relationship for any discriminatory reason, such as race, color, religion, ethnicity, national origin, sexual identity, gender identity, or any other nationally recognized basis for discrimination.
3. A provider may not terminate a Beneficiary based on an assessment that the individual is high risk, as defined by CMS, or because the Beneficiary is unwilling or unable to cooperate with ACO REACH activities. This includes, but is not limited to a decision to decline sharing of PHI;
4. A provider may not reasonably terminate a relationship where "continuity of care" is disrupted. If the Beneficiary is in the midst of a "course of treatment," such as chemotherapy or radiation, or hospitalized for a medical condition, the provider must continue the relationship to a point of stabilized care.
5. Reasons for termination that are legally justifiable may include, but are not limited to:
    a. The provider practice closing – may be due to moving, death, retirement, or a decision to close.
    b. Failure of the Beneficiary to pay fees due to the provider by the Beneficiary. This does not include failure of the Beneficiary's insurance company to provide payment
    c. The Beneficiary is disruptive, rude, or obnoxious, uses improper language, exhibits violent behavior, makes unwanted sexual advances, or threatens the safety of the provider, the provider's staff, or other individuals in the office.
    d. The Beneficiary requires more highly specialized services than the practitioner can provide to them.

e. There is a conflict of interest between the Beneficiary and the provider (such as religious beliefs by the provider) that preclude offering treatment options, or the provider has a personal or financial interest in the treatment option.

f. The Beneficiary did not provide an honest history which compromises the treatment plan (e.g., drug seekers, prior surgery).

g. The Beneficiary develops a personal interest in the practitioner or vice versa. Behaviors may include making excessive appointments, acting in a manner inappropriate to colleagues, or becoming unreasonable if one party is unavailable.

h. Beneficiary death – a notation will be made in the Beneficiary's medical record if notified that the Beneficiary is deceased.

6. Process for Beneficiary discharge may include:

a. Beneficiaries are to receive a letter in writing, sent certified mail, confirming the termination of the relationship.

b. The patient should be offered 30 days to be seen in an urgent basis.

c. No medical records shall be released to a new PCP without a written request by the Beneficiary to do so.

d. Document the reasons for termination, process, and outcome in the medical record in detail along with Beneficiary discussions.

Reporting

A. N/A

Beneficiary Education & Self-Management

Effective Date: February 2023

Policy

It is the policy of American Choice Health Care (ACH) to provide Beneficiary education and strive toward self-management on an ongoing basis to enable Beneficiaries to be independent and have a plan for their involvement in the care process. This policy is applicable to communications that do not directly or indirectly reference the ACO REACH model and/or are educational information on specific medical condition. If the beneficiary education & self-management materials/outreach directly or indirectly references the ACO REACH model, the ACH Marketing Guidelines would also need to be followed.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. ACH will provide guidance to all American Choice Healthcare (ACH) Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities to identified needs and any materials available to the entire population.

B. The Provider Success Team will assist ACH Participating, ACH Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities by providing appropriate educational materials and self- management tools. The educational materials and self-management tools may relate to wellness and prevention, procedure recovery, disease management, medications, end- of-life care, or other resources specific to the Beneficiary's needs. Educational materials provided to Beneficiaries and their caregivers will be appropriate for their cultural and linguistic needs, and consideration will be given to their reading level. Referral to education and training programs may be used to enhance the self-management capabilities of the Beneficiary.

C. Educational materials, including individual Beneficiary materials and group presentations, should be screened for commercial messages regarding services or

supplies and scrutinized for quality, appropriateness, and any conflicts of interest by the ACH Providers.

D. ACH Participating, ACH Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH 's activities should determine as an inter-disciplinary team, what type of education is best for each situation. Some Beneficiaries may benefit from group learning while others may require individual attention.

E. ACH Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities should document in the Beneficiary's medical record each time educational materials, self-management support, or referrals are provided to increase Beneficiary knowledge and self-management.

Reporting

A. N/A

Beneficiary Engagement & Communication

Effective Date: February 15, 2023

Policy

It is the policy of American Choice Healthcare (ACH) to promote Beneficiary engagement with a focus on patient- centeredness and a commitment to quality improvement in the care and health of Beneficiaries, especially those identified as having the greatest health needs.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Participating Providers, ACH Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. ACH Participating, ACH Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities will evaluate the unique health needs of Beneficiaries, considering demographics, language preference, literacy, and socioeconomic status and cultural diversity. Through tools such as Annual Wellness Visits (AWVs), Beneficiary Engagement Incentives (BEIs) and/or In-Kind Renumeration, ACH will promote beneficiary engagement by utilizing the information gained from the visit to tailor health plans for and communication to Beneficiaries and increase accessibility to all aspects of care. ACH Participating Providers and Preferred providers should focus on effectively communicating with Beneficiaries in a manner that they can understand and enabling Beneficiaries to play an active role in their healthcare.

B. ACH Participating, ACH Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities will review information and data to identify Beneficiaries who may benefit from participating in care coordination and shared decision-making regarding their health needs. This information may include:

    1. Utilization data and CMS reports based on claims history;
    2. Assessments such as Personal Health Assessment (PHA) results;
    3. Physician referrals and/or referrals from other healthcare professionals/specialists;

4. Inpatient clinical documentation;
5. Care coordination assessments;
6. Care coordination staff recommendations;
7. Beneficiary/caregiver requests; and,
8. Record reviews and clinical information.

C. ACH Participant Providers and Preferred Providers should contact Beneficiaries identified as having the potential for improved care health through care coordination to discuss the care process. Contact with Beneficiaries may be performed telephonically or by face-to-face interaction. Assessments are performed to identify factors which may affect the Beneficiary's learning and comprehension of the material to be shared. These initial and ongoing assessments will account for variances based upon, but not limited to:
    1. Reading ability;
    2. Language barriers;
    3. Cultural differences; and,
    4. Home environment/socio-economic factors.

D. ACH Participant Providers and ACH Preferred Providers may provide Beneficiaries with additional information involved with their care coordination regarding topics such as:
    1. Understanding their medical condition;
    2. Care planning and proposed treatment options using evidence-based medicine to facilitate Beneficiary engagement for informed decision-making;
    3. Treatment benefits and risks;
    4. Consequences of non-adherence or refusal of treatment;
    5. Available community resources; and,
    6. Beneficiary access to personal medical records according to federal and state law.

E. ACH Participating, Preferred Providers, Professionals, and care coordinators should collaborate with the Beneficiary about care recommendations and requests while involving the Beneficiary in the communication and decision-making process. Each Beneficiary identified for care coordination will be assessed to determine the most appropriate method to use for disseminating the information to the Beneficiary in a comprehensible way. If the information references the ACO REACH program specifically it will be subject to the CMS approved Marketing Plan. These methods may include, but are not limited to:
    1. One-on-one/face-to-face interactions;

2. Telephonic contact;
3. Audio/visual videos;
4. Brochures;
5. Group sessions;
6. Newsletters; and,
7. Web-based instructional modules.

F. The Beneficiary, ACH Participating, ACH Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities will come to a mutual agreement (may be verbal) about ongoing treatment, and a care plan will be developed. Decisions may be affected by the Beneficiary's needs, preferences, values, and priorities. The care plan will include a mutually agreed upon date/time whereby the Beneficiary and care coordination designee will discuss the treatment plan, including Beneficiary adherence and effectiveness of treatment.

G. Annual Wellness Visits (AWVs) are a useful tool for promoting beneficiary engagement through the provision of an individualized care plan with a focus on patient-centeredness. These visits may be completed by an ACH Provider. AWVs facilitate the collection of vital baseline data for individuals, while allowing the ACH Participant to gather information about the beneficiary such as language barriers. Further, they provide valuable face-to-face interaction time between the provider and beneficiary to discuss the beneficiary's care plan and options.

H. Beneficiary Engagement Incentives (BEIs) are a tool ACH may deploy to improve beneficiary engagement with care plan participation/compliance. These BEIs include but are not limited to Chronic Disease Management Reward and Part B Cost-Sharing Support. BEIs will be further outlined in a separate Policy and Procedure.

I. In-Kind Renumeration is a tool ACH may deploy to improve beneficiary engagement with care plan participation/compliance for beneficiaries meeting specific criteria outlined by CMS.

J. If barriers are identified, the ACH Participating, Preferred Providers, ACH Professionals, or other individuals or entities performing functions or services related to ACH's activities will work to amend the treatment plan, if necessary, to address gaps or Beneficiary issues.

K. Ongoing evaluation will be performed to determine if the Beneficiary is able to understand the information that is shared. This may include, but is not limited to:
1. "Teach-back";
2. Return demonstration; and,

3. Written self-assessment tools.

L. Information obtained from all sources will be documented in the appropriate documentation system.

Reporting

A. Oversight of Marketing Materials Policy.

Beneficiary Financial Incentives for Gifts, Promotions or Rewards

Effective Date: November 2022

Policy

It is the policy of American Choice Healthcare (ACH) to ensure compliance with state and federal regulations prohibiting the ACH Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACO REACH Model activities from providing any remuneration to Beneficiaries as inducements for receiving, or continuing to receive, items or services from ACH Participants, or Preferred Providers, or to induce them to continue to receive items or services from the ACH Participants or Preferred Providers.

Applicability

This policy and procedure applies to all ACH Participants, Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Consistent with the requirements of the ACO REACH Model and all other applicable laws and regulations, ACH shall not provide gifts or other remuneration to Beneficiaries as inducements for: The individual who is the subject of the PHI or their personal representative may request an accounting in accordance with this Policy.
    1. Receiving, or continuing to receive, items or services from ACH or its Participant or Preferred Providers,
    2. Influencing a Beneficiary's decision to complete or not complete a Voluntary Alignment Form, or
    3. Receiving rewards to influence a Beneficiary's decision

B. ACH Participant or Preferred Providers may provide in-kind items or services to beneficiaries only if:
    1. There is a reasonable connection between the items and services and the medical care of the Beneficiary; and,
    2. The items or services are preventive care items or services or advance a clinical goal for the Beneficiary, including adherence to a treatment regime, adherence

to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition.

3. The in-kind item or service is not a Medicare-covered item or service for the Beneficiary on the date the in-kind item or service is furnished to that Beneficiary. For purposes of this exception, an item or service that could be covered pursuant to a Benefit Enhancement is considered a Medicare-covered item or service, regardless of whether the ACH Participant or Preferred Provider has selected to participate in such Benefit Enhancement for the Performance Year.
4. The in-kind item or service is not furnished in whole or in part to reward the Beneficiary for designating, or agreeing to designate, an ACH Participant or Preferred Provider as his or her primary clinician, main doctor, main provider, or the main place where the Beneficiary receives care through Voluntary Alignment.

C. For each in-kind item or service provided by the ACH Participant or Preferred Provider under this Policy, they shall maintain records of the following:
    1. The nature of the in-kind item or service;
    2. The identity of each Beneficiary that received the in-kind item or service;
    3. The identity of the individual or entity that furnished the in-kind item or service; and
    4. The date the in-kind item or service was furnished
D. The applicability and scope of new or proposed activities involving Beneficiary Incentives must be shared with the Compliance Department.
E. The Compliance Officer will determine whether the activity/initiative is appropriate and can be conducted compliantly.
    1. If approved, the drafted proposal shall be presented to the Compliance Committee for approval.
        a. The Governing Body may approve a Proposal during the normal course of business at a general meeting or during a special meeting
    2. Once approved by the Compliance Committee, the Proposal must be submitted to CMS for approval.
F. The prosed activity may be carried out ONLY with CMS approval.

Reporting

A. A file with the proposed, approved, and rejected proposals shall be kept by ACH.

Beneficiary Notifications and Marketing/Data Sharing Preferences

Effective Date: November 2022

Policy

A. It is the policy of American Choice Healthcare (ACH) to provide initial notification to Beneficiaries of their alignment to the ACH Participant or Preferred Provider for the Performance Year and ensure that beneficiaries are aware of their marketing and data sharing preferences.

B. American Choice Healthcare (ACH) Participants, Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities to comply with the beneficiary notification, marketing, and data sharing preferences and all related provisions in the ACO REACH Participation Agreement between ACH and CMS.

Applicability

A. This policy and procedure applies to all American Choice Healthcare (ACH) Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. **Beneficiary Notification Mailings**: The Operations department shall be responsible for providing Beneficiaries notice in writing that they have been aligned to the ACH Participant or Preferred Provider for the Performance year on or before the deadline given by CMS.

   1. CMS shall provide ACH with a template letter indicating letter content that shall not change and places in which ACH may insert its own original content.
      a. Pursuant to the Participation Agreement and the ACH's Policy: Oversight of Marketing Materials and Activities, the final notification letter content must be approved by Compliance and CMS prior to sending letters to Beneficiaries.
   2. In the case that a beneficiary notification is returned to ACH, it must follow up with the attributed provider and obtain a current address for the beneficiary. Once that current address is obtained, the letter will be sent to the ACH beneficiary.

a. If the second attempt of delivery is unsuccessful, ACH will document events and mark this patient as a missed opportunity. Documentation will be saved on the shared drive.

B. **Beneficiary Rights to Opt-Out of Unsolicited Marketing:** ACH's Marketing Department shall be responsible for providing the beneficiaries with a way to opt out of all unsolicited marketing. The beneficiaries can opt out by calling the ACH phone number provided on the marketing material. This process is clearly stated on all marketing material.

1. Once the beneficiary calls and requests to opt out, the Support Services Associate will communicate this to our Business Intelligence (BI) team.
2. BI will then flag the patient as opted out in our analytics platform
    a. Beneficiary preferences are always reviewed before any communication is sent.

C. **Posters**

Posters may be provided by ACH to hang in provider's offices that inform Beneficiaries that those providers are participating in the ACO REACH Model only if these posters are CMS approved. The offices may display the posters in prominent places such as waiting areas.

D. **Beneficiary Rights to Opt Out of Data Sharing:** ACH shall provide Beneficiaries who inquire about and wish to modify their data sharing preferences information about how to modify their sharing preferences via 1-800-MEDICARE.

1. Beneficiaries are allowed to reverse a data sharing preference at any time. They can accomplish this by calling 1-800-MEDICARE.
2. Participating providers will also develop an appropriate method to track that the information has been provided to the assigned Beneficiaries.
3. If a beneficiary inquiries about data sharing, program structure and data sharing will be discussed with the Beneficiary and/or Beneficiary representative as an educational and decision-making opportunity. The following information will be provided:
    a. The benefits of an ACH Participant or Preferred Provider created by a focus on patient-centered care;
    b. The rights of the Beneficiary to decline having Medicare share his/her health information at any point; and,
    c. Notice that Beneficiaries may change their data sharing preferences at any time. If the Beneficiary requests to change his/her status after the initial notification, then the Beneficiary will need to call Medicare at 1/800-MEDICARE.
4. ACH may contact a Beneficiary who has elected to decline data sharing once in a given Performance Year to provide information regarding data sharing.

E. **Beneficiary Substance Abuse Data Opt-In:** Regulations allow that a Beneficiary may opt into substance abuse data sharing only by submitting a CMS-approved substance abuse opt in form to ACH however, ACH neither requests nor receives substance abuse claims data from CMS.

F. ACH may contact a Beneficiary who has elected to decline data sharing once in a given Performance Year to provide information regarding data sharing. This includes, but is not limited to: mailings, phone calls, electronic communications or other methods of communicating with Beneficiaries outside of a clinical setting.

1. Any communications used to contact Beneficiaries for this purpose must be approved by Compliance and CMS.

Reporting

A. N/A

Beneficiary Voluntary Alignment Activities

Effective Date: February 2023

Policy

It is the policy of American Choice Healthcare (ACH) to comply with ACO REACH Model Participation Agreement requirements governing Beneficiary Voluntary Alignment activities when electing to participate in Voluntary Alignment for a given Performance Year.

Applicability

This policy and procedure applies to all ACH Participating Providers, ACH Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Influencing or Attempting to Influence the Beneficiary

- ACH shall not, and shall require its Participating Providers or Preferred Providers performing functions or services related to ACH's activities to not, directly, or indirectly, commit any act omission, nor adopt any policy that coerces or otherwise influences a Beneficiary's decision to complete a Signed Attestation-based Voluntary Alignment Form (SVA) or a MyMedicare.gov, Medicare.gov or any successor site designation, including but not limited to the following:
    - Signing or dating the SVA on behalf of the beneficiary.
    - Designating a primary clinician on MyMedicare.gov, Medicare.gov, or any successor site on behalf of the Beneficiary
    - Including the Voluntary Alignment Form and instructions with any other materials or forms, including but not limited to materials requiring the signature of the Beneficiary
    - Withholding or threatening to withhold medical services or limiting or threatening to limit access to care.
- ACH Participating Providers or ACH Preferred Providers may answer questions from Beneficiaries regarding Voluntary Alignment but are prohibited from completing a Voluntary Alignment Form or Designating a clinician on MyMedicare.gov, Medicare.gov (or any successor site) on behalf of the Beneficiary.

B. Form Requests

- ACH shall permit any Beneficiary who receives care from a Participating Provider to receive a Voluntary Alignment Form, upon request. ACH shall permit the Beneficiary to request a Voluntary Alignment Form in person at the office of the Participating Provider or by calling ACH.

- ACH shall permit any Beneficiary who has received a Voluntary Alignment Form to request another Voluntary Alignment Form that identifies a different Participating Provider as the Beneficiary's main doctor, main provider, and/or main place the Beneficiary receives care; or that identifies a physician or other individual or entity that is not a Participating Provider as the Beneficiary's main doctor, main provider, or main place the Beneficiary receives care; or otherwise reverses the Beneficiary's SVA. ACH shall permit such requests to be made by calling the ACH.
- ACH shall permit the appointed representative of a Beneficiary who has received a Voluntary Alignment Form to complete and sign the Voluntary Alignment Form on behalf of the Beneficiary. ACH Participating Providers and Preferred Providers shall instruct Beneficiaries to call ACH at 1-877-285-1185 for questions about how to make changes to a Voluntary Alignment Form or how to designate a primary clinician on MyMedicare.gov, Medicare.gov (or any successor site). Voluntary Alignment Forms may not be sent or distributed outside the service area. Forms are only to be provided at the point of care in the offices of the ACH Participating Providers. ACH shall notify CMS by a date specified by CMS if ACH elects to provide the Voluntary Alignment Form at the point of care.

C. Voluntary Alignment Outreach
   - ACH will conduct Voluntary Alignment outreach for all Original Medicare Beneficiaries within the ACH Service Area who have been seen by an ACH Participating in the past 24 months. The list of identified Beneficiaries will be provided to ACH's Print and Mailing Vendor who will be responsible for conducting and tracking ACH's Voluntary Alignment outreach.

D. Communication Methods
   - <u>Regular Mail</u>
     - A Voluntary Alignment Form is mailed out to the Beneficiary who must fill out and sign the form and mail it to the return address. Please see *exhibit A* for form. ACH Providers shall make no changes to the template Voluntary Alignment Form provided by CMS, with the exception of changes made solely for the insertion of the following information where indicated:
       i. The name of the Participating Provider that the ACO believes may be the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary receives care
       ii. The logo of ACH or Participant Provider; and
       iii. Instructions for how the Beneficiary can submit the Voluntary Alignment Form to ACH.
     - If ACH includes a cover letter, no changes to the template Letter where CMS has indicated content that ACH cannot amend or remove. ACH may otherwise make changes, subject to ACH obtaining CMS approval of the final Letter content including:
       i. Formatting for electronic distribution

ii. Inserting the name of the Participating Provider that the ACO believes may be the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary received care
iii. Inserting the logo of ACH or Participating Provider;
iv. The addition of instructions for how the Beneficiary can submit the Voluntary Alignment Form to ACH
v. The insertion of information about unique care coordination and preventative services offered by ACH
vi. Inserting ACH's contact information for answering Beneficiaries' questions.

- Kiosk
  - Beneficiaries may fill out SVA form through Kiosks located at the medical centers of Participating Providers
  - Kiosks will house a tablet where patients can electronically access the SVA form through a HIPAA compliant e-signing platform. A copy of the entre form to include all pages of the SVA form is e-mailed to the beneficiary.
    i. If beneficiary does not have an email, all pages of the SVA form will be printed and handed to them in the office.
  - Please see *exhibit B* for form.
- E-mail
  - Email will include a link to an online form where Beneficiaries may fill and sign the SVA form electronically.
  - Beneficiaries may choose to opt out of receiving e-mail communications via a link provided on all e-mail communications sent.
  - Please see *exhibit C* for form.
- Third Party Vendor
  - ACH may utilize a vendor that specializes in voluntary alignment campaigns, they may contact beneficiaries via regular mail, e-mail, and in-person using a QR code link.
    i. Please see *exhibit D* for forms
- If a provider decides on using their EMR to collect SVA forms, they may do so if all sections of the policy are followed.

E. Maintenance of Record

ACH shall maintain and shall provide to the government upon request a list of all Beneficiaries to whom ACH has sent the Voluntary Alignment Form and Letter, copies of all Voluntary Alignment Forms sent or otherwise furnished to Beneficiaries (including copies of the Letter sent with such forms), and, as applicable, original executed Voluntary Alignment Forms, envelopes in which Voluntary Alignment Forms were returned to the ACO, written documentation of any oral communications with a Beneficiary or his or her appointed representative regarding the potential or actual reversal of a Voluntary Alignment Form, all electronic data and files associated with the distribution and submission of Voluntary Alignment Forms, and all other documents and records regarding ACH's participation in SVA, including documents and records pertaining to Beneficiary communications.

F. ACH shall submit to CMS a list that contains the following by the required deadline:

- The name, Medicare Beneficiary Identifier (MBI), and, to the extent required by CMS, any other identifying information of each Beneficiary who returned a valid Voluntary Alignment Form to ACH identifying a Participating Provider or a physician or other individual or entity that is not a Participating Provider as the Beneficiary's main doctor, main provider, or main place the Beneficiary receives care. The ACO must include on the SVA List all Beneficiaries who have submitted a valid Voluntary Alignment Form to ACH. A Voluntary Alignment Form is valid only if it has been signed and dated by the Beneficiary or his or her appointed representative and was returned to ACH on or before the date on which ACH submits its SVA List to CMS. If a Beneficiary returns more than one valid Voluntary Alignment Form to ACH, THIS should include only the information from the latest submitted valid Voluntary Alignment Form. A Voluntary Alignment Form submitted to a Participating Provider is considered to have been returned to ACH.
- For each Beneficiary identified pursuant to Section III.A.1 of the agreement, the date on which the Beneficiary executed the Voluntary Alignment Form and the identity of the Participating Provider or physician or other individual or entity that is not a Participating Provider that the Beneficiary has identified as his or her main doctor, main provider, and/or main place the Beneficiary receives care, and, if the Beneficiary identified a Participating Provider that is not an ACO Professional, the identity of an ACH Professional associated with that Participating Provider
- A certification by an executive of ACH made in accordance with Section 15.05 of the Agreement that, to the best of his or her knowledge, information, and belief, the information contained on the SVA List is true, accurate, and complete and identifies only those Beneficiaries who have submitted a valid Voluntary Alignment Form to ACH.

Reporting

A. Quarterly audits of randomly chosen SVA forms will be performed by the Compliance Department to ensure SVA form compliance.

Exhibit A

<Practice Name>
<Address>
<City, State, Zip>

<Patient Name>
<Address>
<City, State, Zip>

<CMS Logo>
<ACO Logo>
<Practice Logo>

Dear Medicare Beneficiary:

Please complete this form to confirm our practice is the main place you go for routine care.

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in an Accountable Care Organization (ACO), to work together with Medicare to give you more coordinated care and services.

Our practice is voluntarily taking part in this new initiative by joining **<ACO Name>** because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by <ACO Name>.

You can use this form to confirm that our practice is the main doctor or other health care professional you see **or** the main place you go for routine care, to help determine if <ACO Name> should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension.

Please return your completed form as soon as possible

MSVAV5-0

(Over)

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether <ACO Name> should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call <ACO Name> at <ACO Phone>, or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about ACOs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through Medicare.gov is your choice AND you can change your mind. If you choose to complete this form or select a doctor or other health care professional through Medicare.gov you should do so yourself. No one else should complete this for you.

No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through Medicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please call <ACO Phone> or update your online selection if you change your mind later about whether you consider our practice to be the main doctor or other health care professional you see or the main place you go for routine care.

Sincerely,
<Practice Name>

Get more information about ACOs.

CMS Website:
https://innovation.cms.gov/innovation-models/aco-reach

ACO Website:
<ACO URL>

MSVAV5-0

<CMS Logo> <ACO logo> < Practice Logo>

Confirmation of Main Doctor or Other Healthcare Professional Form

1. CONFIRM

By signing below I am confirming that my main doctor or other healthcare professional – or the main place I go to for routine medical care – is:

Or scan QR code to submit this form online:
<QR Code>
<e-Sign Form URL>

Provider Name and/or Medical Group <Practice Name>

Beneficiary Name <Patient Name>

Signature **Date (Required)**

Print Name

<Patient MBI>
Medicare Number

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, or to opt-out of future notices, please call <ACO Name> at <ACO Phone>.

2. RETURN

Return this form to our practice or mail to:

<ACO Address>

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits. This form is not valid unless it includes both a signature and date.

Exhibit B

Please complete this form to confirm our practice is the main place you go for routine care.

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in an Accountable Care Organization (ACO), to work together with Medicare to give you more coordinated care and services.

Our practice is voluntarily taking part in this new initiative by joining **American Choice Healthcare** because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by American Choice Healthcare.

You can use this form to confirm that our practice is the main doctor or other health care professional you see **or** the main place you go for routine care, to help determine if American Choice Healthcare should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension.

Please return your completed form as soon as possible.

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether American Choice Healthcare should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call American Choice Healthcare at 877-285-1185, or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about ACOs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through Medicare.gov is your choice AND you can change your mind. If you choose to complete this form or select a doctor or

other health care professional through Medicare.gov you should do so yourself. No one else should complete this for you.

No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through Medicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please call 877-285-1185 or update your online selection if you change your mind later about whether you consider our practice to be the main doctor or other health care professional you see or the main place you go for routine care.

Sincerely,

American Choice Healthcare

Get more information about ACOs.

CMS Website:

https://innovation.cms.gov/innovation-models/aco-reach

ACO Website:

https://americanchoicehealthcare.com/

CONFIRMATION OF MAIN DOCTOR OR OTHER HEALTHCARE PROFESSIONAL FORM

1. CONFIRM ✓

By signing below, I am confirming that my main doctor or other healthcare professional

is _____ and the main place I go to for

routine medical care is _____

_____	_____	_____
Signature	**Print Name**	**DOB**

_____	_____
Date	**Medicare Beneficiary Identifier (MBI)**

Note: Completing this form is voluntary. It won't affect your Medicare benefits.
If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, please call American Choice Healthcare at 877-285-1185 to request a new form.

Exhibit C

EMAIL:

Subject: Action requested: Please sign this Medicare form
Pre-header text: Please sign this form to tell Medicare that we are your main healthcare provider

CMS | <DCE Logo>

a<Provider Logo>

Dear Medicare Beneficiary:

Please complete this form to tell Medicare that <Practice Name> is the main place you go for routine care.

<SIGN THE FORM>

Commented [SG1]: This button links to the webform that can be signed electronically. The webform includes the templated content of the letter and form previously supplied by CMS.

See the last 3 pages of this submission for the webform.

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in a Direct Contracting Entity (DCE), to work together with Medicare to give you more coordinated care and services.

Our practice is voluntarily taking part in this new initiative by joining <DCE Name> because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by <DCE Name>.

You can use this form to confirm that our practice is the main doctor or other health care professional you see or the main place you go for routine care, to help determine if <DCE Name> should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension.

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether <DCE Name> should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call <DCE Name> at <DCE Phone>, or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about DCEs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through Medicare.gov is your choice AND you can change your mind. If you choose to complete this form or select a doctor or other health care professional through Medicare.gov you should do so yourself. No one else should complete this for you.

No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through Medicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please call <DCE Phone> or update your online selection if you change your mind later about whether you consider our practice to be the main doctor or other health care professional you see or the main place you go for routine care.

Sincerely,
<Practice Name>

<SIGN THE FORM>

Commented [SG2]: This button links to the webform that can be signed electronically. The webform includes the templated content of the letter and form previously supplied by CMS.

See the last 3 pages of this submission for the webform.

Get more information about DCEs.

CMS Website:
https://innovation.cms.gov/innovation-models/gpdc-model

DCE Website:
<DCE website>

<internal code>

<one-click unsubscribe link>

Commented [SG3]: Patients can opt out of future emails.

English (US)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Confirmation of Main Doctor or Other Healthcare Professional Form

Voluntary Alignment Cover Letter

Dear Medicare Beneficiary:

Please complete this form to confirm our practice is the main place you go for routine care.

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in a Direct Contracting Entity (DCE), to work together with Medicare to give you more coordinated care and services.

Our practice is voluntarily taking part in this new initiative by joining because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by .

You can use this form to confirm that our practice is the main doctor or other health care professional you see or the main place you go for routine care, to help determine if should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension.

Please return your completed form as soon as possible.

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call at , or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about DCEs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through Medicare.gov is your choice AND you can change your mind. If you choose to complete this form or select a doctor or other health care professional through Medicare.gov you should do so yourself. No one else should complete this for you.

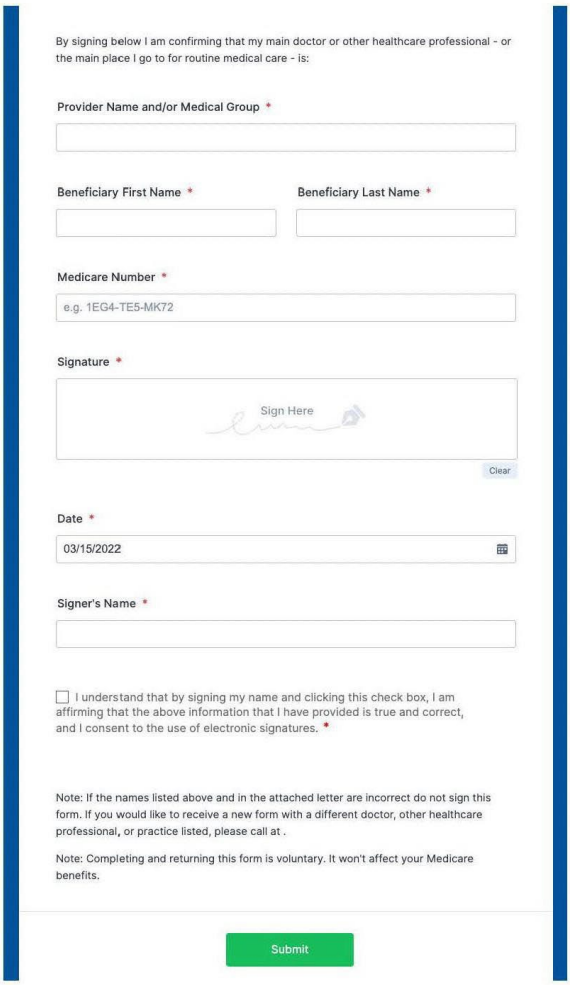
No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through Medicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please call or update your online selection if you change your mind later about whether you consider our practice to be the main doctor or other health care professional you see or the main place you go for routine care.

Get more information about DCEs:

CMS Website: https://innovation.cms.gov/innovation-models/gpdc-model

DCE Website: (DCEwebsite.com)



By signing below I am confirming that my main doctor or other healthcare professional - or the main place I go to for routine medical care - is:

Provider Name and/or Medical Group *

Beneficiary First Name * Beneficiary Last Name *

Medicare Number *

e.g. 1EG4-TE5-MK72

Signature *

Sign Here

Clear

Date *

03/15/2022

Signer's Name *

I understand that by signing my name and clicking this check box, I am affirming that the above information that I have provided is true and correct, and I consent to the use of electronic signatures. *

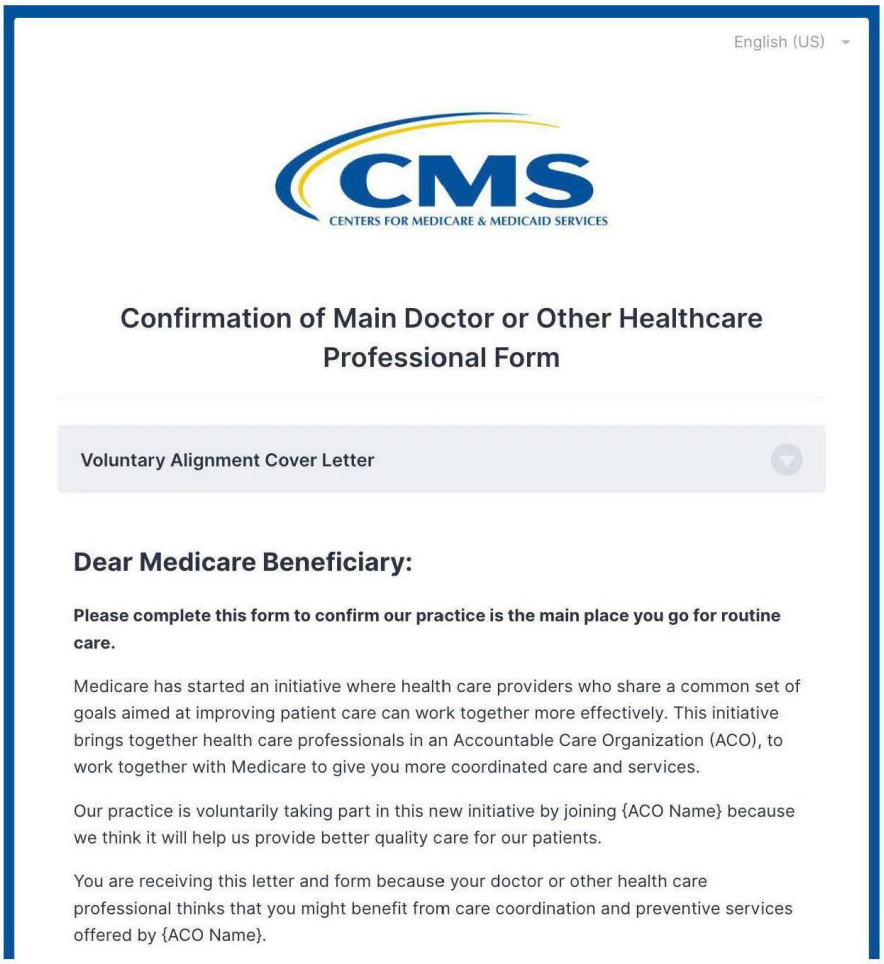
Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, please call at .

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits.

Submit

<control number>

Exhibit D



English (US)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Confirmation of Main Doctor or Other Healthcare Professional Form

Voluntary Alignment Cover Letter

Dear Medicare Beneficiary:

Please complete this form to confirm our practice is the main place you go for routine care.

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in an Accountable Care Organization (ACO), to work together with Medicare to give you more coordinated care and services.

Our practice is voluntarily taking part in this new initiative by joining {ACO Name} because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by {ACO Name}.

You can use this form to confirm that our practice is the main doctor or other health care professional you see or the main place you go for routine care, to help determine if {ACE Name} should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension.

Please return your completed form as soon as possible.

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether {ACO Name} should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call {ACO Name} at {ACO Phone}, or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about ACOs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through Medicare.gov is your choice AND you can change your mind. If you choose to complete this form or select a doctor or other health care professional through Medicare.gov you should do so yourself. No one else should complete this for you.

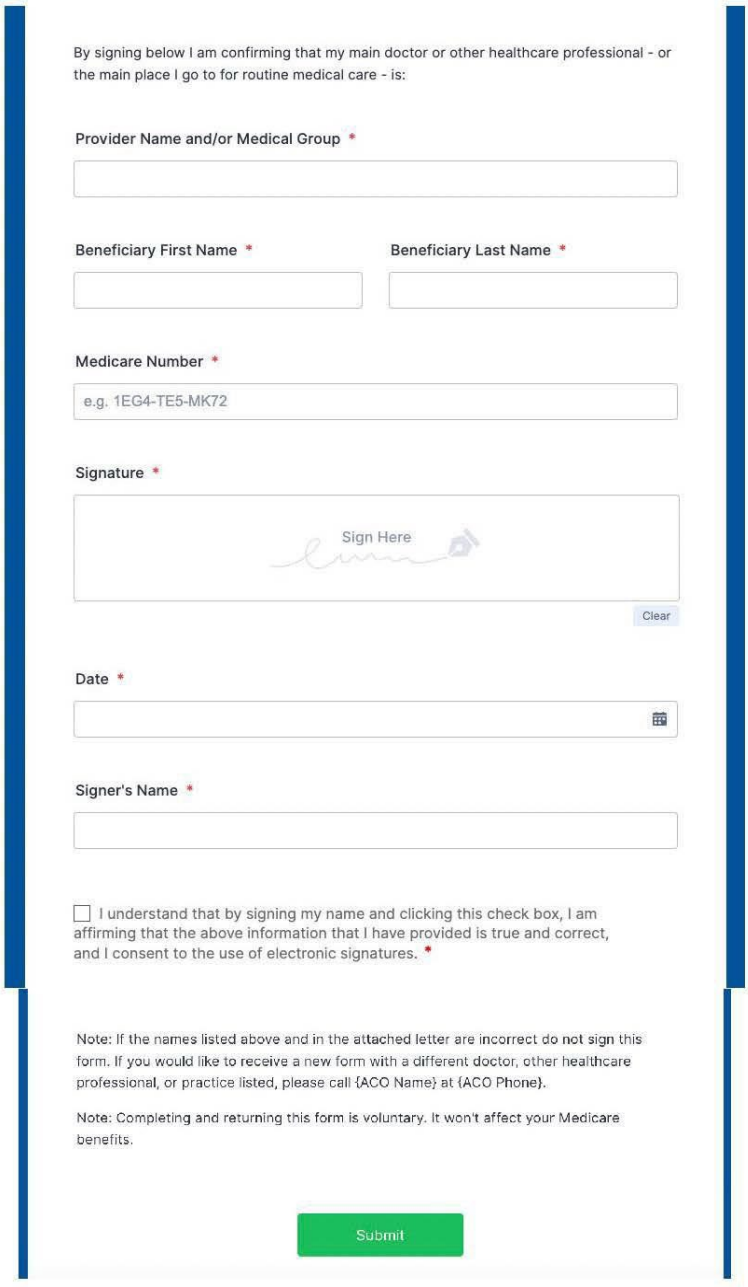
No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through Medicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please call {ACO Phone} or update your online selection if you change your mind later about whether you consider our practice to be the main doctor or other health care professional you see or the main place you go for routine care.

Get more information about ACOs:

CMS Website: https://innovation.cms.gov/innovation-models/gpdc-model

ACO Website: {ACO URL}



<control number>

American Choice Healthcare

<Practice Name>
<Address>
<City, State, Zip>

<Patient Name>
<Address>
<City, State, Zip>

<CMS Logo>
<ACO Logo>
<Practice Logo>

Dear Medicare Beneficiary:

Please complete this form to confirm our practice is the main place you go for routine care.

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in an Accountable Care Organization (ACO), to work together with Medicare to give you more coordinated care and services.

Our practice is voluntarily taking part in this new initiative by joining **<ACO Name>** because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by <ACO Name>.

You can use this form to confirm that our practice is the main doctor or other health care professional you see **or** the main place you go for routine care, to help determine if <ACO Name> should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension.

Please return your completed form as soon as possible

MSVAV5-0

(Over)

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether <ACO Name> should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call <ACO Name> at <ACO Phone>, or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about ACOs. TTY users should call 1-877-486-2048.

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Please call <ACO Phone> or update your online selection if you change your mind later about whether you consider our practice to be the main doctor or other health care professional you see or the main place you go for routine care.

Sincerely,
<Practice Name>

Get more information about ACOs.

CMS Website:
https://innovation.cms.gov/innovation-models/aco-reach

ACO Website:
<ACO URL>

MSVAV5-0

<CMS Logo> <ACO logo> < Practice Logo>

Confirmation of Main Doctor or Other Healthcare Professional Form

1. CONFIRM

By signing below I am confirming that my main doctor or other healthcare professional – or the main place I go to for routine medical care – is:

Or scan QR code to submit this form online:
<QR Code>
<e-Sign Form URL>

Provider Name and/or Medical Group <Practice Name>

Beneficiary Name <Patient Name>

Signature **Date (Required)**

Print Name

<Patient MBI>
Medicare Number

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, or to opt-out of future notices, please call <ACO Name> at <ACO Phone>.

2. RETURN

Return this form to our practice or mail to:

<ACO Address>

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits. This form is not valid unless it includes both a signature and date.

MSVAV5-0 <Unique Letter ID>

EMAIL:

Subject: Action requested: Please sign this Medicare form
Pre-header text: Please sign this form to tell Medicare that we are your main healthcare provider

 | <ACO Logo>

<Provider Logo>

Dear Medicare Beneficiary:

Please complete this form to tell Medicare that <Practice Name> is the main place you go for routine care.

<SIGN THE FORM>

Commented [SG1]: This button links to the webform that can be signed electronically. The webform includes the templated content of the letter and form previously supplied by CMS.

See the last 3 pages of this submission for the webform.

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in an Accountable Care Organization (ACO), to work together with Medicare to give you more coordinated care and services.

Our practice is voluntarily taking part in this new initiative by joining <ACO Name> because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by <ACO Name>.

You can use this form to confirm that our practice is the main doctor or other health care professional you see or the main place you go for routine care, to help determine if <ACO Name> should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension.

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether <ACO Name> should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call <ACO Name> at <ACO Phone>, or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about ACOs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through Medicare.gov is your choice AND you can change your mind. If you choose to complete this form or select a doctor or other health care professional through Medicare.gov you should do so yourself. No one else should complete this for you.

No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through Medicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please call <ACO Phone> or update your online selection if you change your mind later about whether you consider our practice to be the main doctor or other health care professional you see or the main place you go for routine care.

Sincerely,
<Practice Name>

<SIGN THE FORM>

Commented [SG2]: This button links to the webform that can be signed electronically. The webform includes the templated content of the letter and form previously supplied by CMS.

See the last 3 pages of this submission for the webform.

Get more information about ACOs.

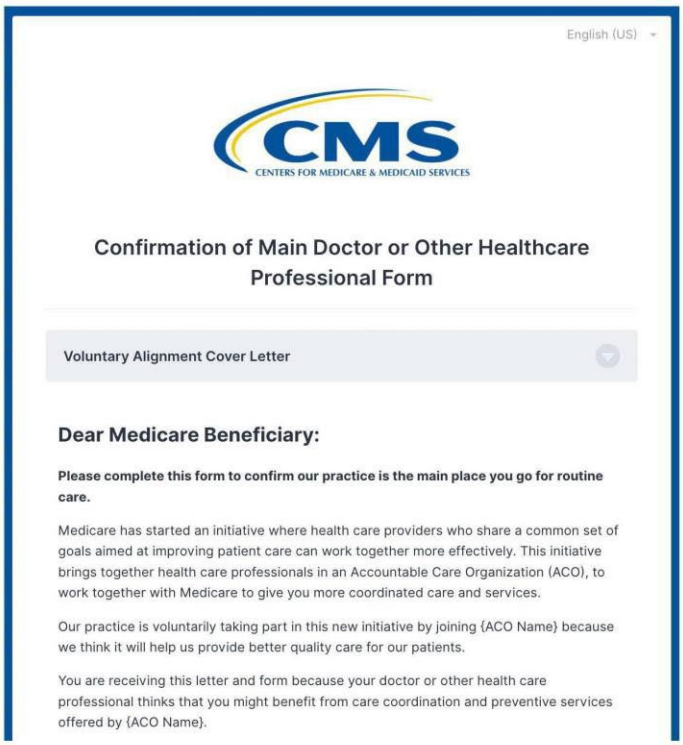
CMS Website:
https://innovation.cms.gov/innovation-models/aco-reach

ACO Website:
<ACO website>

<internal code>

<one-click unsubscribe link>

Commented [SG3]: Patients can opt out of future emails.



English (US)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Confirmation of Main Doctor or Other Healthcare Professional Form

Voluntary Alignment Cover Letter

Dear Medicare Beneficiary:

Please complete this form to confirm our practice is the main place you go for routine care.

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in an Accountable Care Organization (ACO), to work together with Medicare to give you more coordinated care and services.

Our practice is voluntarily taking part in this new initiative by joining {ACO Name} because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by {ACO Name}.

You can use this form to confirm that our practice is the main doctor or other health care professional you see or the main place you go for routine care, to help determine if {ACE Name} should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension.

Please return your completed form as soon as possible.

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional in order to determine whether {ACO Name} should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call {ACO Name} at {ACO Phone}, or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about ACOs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through Medicare.gov is your choice AND you can change your mind. If you choose to complete this form or select a doctor or other health care professional through Medicare.gov you should do so yourself. No one else should complete this for you.

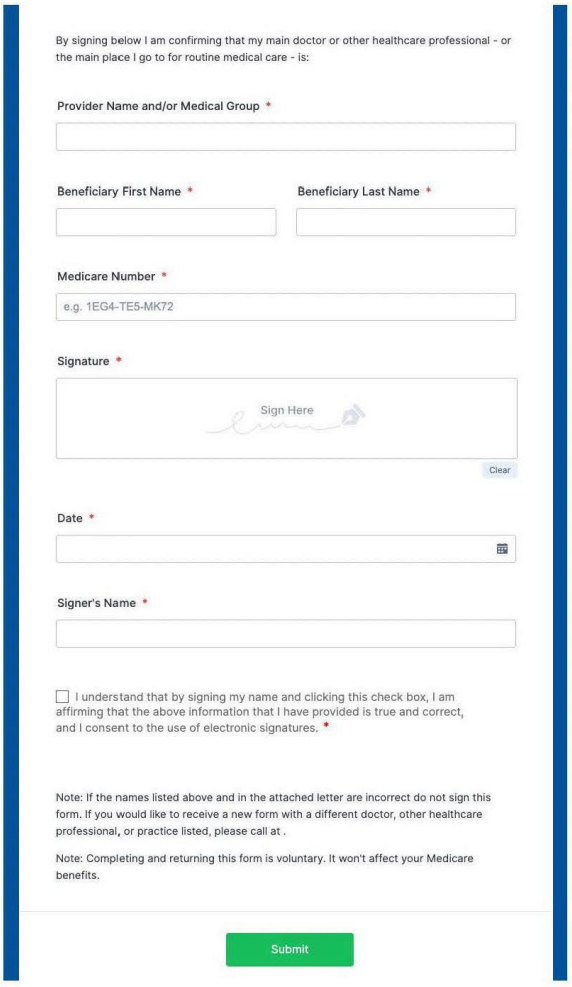
No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through Medicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please call {ACO Phone} or update your online selection if you change your mind later about whether you consider our practice to be the main doctor or other health care professional you see or the main place you go for routine care.

Get more information about ACOs:

CMS Website: https://innovation.cms.gov/innovation-models/gpdc-model

ACO Website: {ACO URL}



By signing below I am confirming that my main doctor or other healthcare professional - or the main place I go to for routine medical care - is:

Provider Name and/or Medical Group *

Beneficiary First Name * Beneficiary Last Name *

Medicare Number *

e.g. 1EG4-TE5-MK72

Signature *

Sign Here

Clear

Date *

Signer's Name *

I understand that by signing my name and clicking this check box, I am affirming that the above information that I have provided is true and correct, and I consent to the use of electronic signatures. *

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, please call at .

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits.

Submit

<control number>

Centers for Medicare & Medicaid Services (CMS) Audit & Monitoring

Effective Date: January 2023

Policy

It is the policy of American Choice Healthcare (ACH) Participating, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACO REACH model will cooperate with CMS Right to Audit which includes all items outlined in the ACH Record Retention Requirements Policy and includes audits, inspections, investigations, monitoring, oversight or evaluation of any books, contracts records, medical records, documents and other evidence requested.

Applicability

This policy and procedure applies to all ACH Participant Providers and ACH Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to the ACO's activities.

Procedure

A. The Federal Government, including CMS, HHS, and the Comptroller General or their designees, has the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents, and other evidence of ACH, and its Participant and Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities or Marketing Activities that pertain to the following:

- The ACO's compliance with the terms of the Agreement, including provisions that require ACH to impose duties or requirements on Participating Providers or Preferred Providers
- Whether Participant Providers and Preferred Providers complied with the duties and requirements imposed on them by ACH pursuant to the terms of the Agreement
- The quality of services performed under the Agreement
- ACH's compliance with applicable laws, regulations and Medicare Program requirements

- Any activity by ACH, Participant Provider or Preferred Provider that may pose a potential risk of harm to Beneficiaries or a vulnerability to the integrity of the model test
- ACH's right to, and distribution of, Shared Savings
- The ability of ACH to bear the risk of potential losses and the obligation and ability of ACH to repay any Shared Losses or Other Monies Owed to CMS.

B. Cooperation in an independent evaluation activity conducted by CMS and/or its designees aimed at assessing the impact of the Model on the goals for better health, better health care, and lower Medicare per capita costs for Beneficiaries is required.
    - ACH shall ensure it has written agreements and/or legal relationships with individuals and entities performing functions and services related to ACO Activities to ensure compliance with a CMS independent evaluation activity.

C. ACH Providers are encouraged in CMS sponsored learning activities that are designed to strengthen results and share learning that emerges from participation in the ACO REACH Model. This may include periodic conference calls, site visits and virtual or in-person meetings where they can actively share resources, tools and ideas as recommended by CMS.

D. Handling an onsite Visit:
    - Establish the identity of the government representative(s).
        a. Request to see the photo identification, business card(s) or other credentials of the investigator(s) and make copies of the identification provided.
        b. Be polite and let them know that the appropriate administrative personnel will arrive shortly to respond to their inquiry.
    - If asked, staff should kindly advise the government investigators that staff does not have the authority to disclose documents or consent to a search and then direct the government investigators to ACH's President.
    - If notice is provided prior to the site visit, ACH shall ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available. If no notice is provided, ACH will make a reasonable effort to ensure these individuals are available.
    - Document the activity.
        a. If possible, document exactly what the investigator(s) review, request copies of, or take with them.

b. The investigator(s) is to be accompanied as they execute the audit.
c. The Investigator(s) must provide a written receipt for any property taken when they leave the premises.
d. A record of all interactions between the government representative(s) and staff, and all documents exchanged shall be maintained.
    i. This includes Beneficiary records or claims information that government representative(s) may view, even if they do not take the copies.
        a. The government representative(s) may not take original documents. If they wish to take documents, copies of the originals will be provided.
    ii. A copy of the legal document authorizing the release of Beneficiary Protected Health Information (PHI) must be obtained.
    iii. A record of all PHI that was used or disclosed must be obtained.

- Do not obstruct the investigation.
    a. It is a crime to destroy or alter documents, falsely deny knowledge of requested information, or attempt to influence the testimony of staff.
    b. Staff must respond to questions about the location of documents but are not required to answer other questions without the benefit of legal counsel.
    c. Accordingly, if the government investigator(s) have properly identified themselves, presented written authorization, and assert that their audit must be immediate, do not attempt to block the search.
- Comply with laws
    a. The government representative(s) must comply with applicable laws and regulations (e.g., the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) unless an exception applies.
    b. If staff is unclear whether an exception applies, politely ask the government representative(s) to produce evidence of an exception to applicable law. Inform the government representative(s) the desire to cooperate with the investigation, but also has a legal obligation to protect its Beneficiaries' PHI and must comply with applicable laws and regulations.
- Preserve documents; do not destroy or alter documents that are the subject of a government investigation.

a. Take affirmative steps, if necessary, to ensure the preservation of documents (including electronic data) that are the subject of a government inquiry.
b. Immediately halt any planned or routine destruction of relevant information.
c. Under certain circumstances CMS may determine there is a special need to retain a particular record or group of records for a longer period. In these cases, CMS will notify ACH at least 30 days before the normal disposition date. If there has been a termination, dispute, or allegation of fraud or similar fault against the ACH, its Participating or Preferred Providers, or other individuals or entities performing functions or services related to its activities, ACH will retain records for an additional six (6) years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

- Staff may not communicate any matter related to a government investigation without written authorization from an ACH leadership and/or legal counsel.
    a. Inquiries from the media should be directed to ACH's President and/or the Communications department.
    b. Staff is prohibited from providing any comments to the press.
- During the government investigation, all correspondence related to the investigation should be directed through ACH's legal counsel and the Compliance Officer.

E. ACH has ultimate responsibility for adhering to and complying with the terms and conditions of its agreement with CMS, notwithstanding any arrangements between or among ACH Participant or Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACHs activities.

Reporting

A. The Compliance Designee shall be tasked with storing a copy of any logs, authorizations, audit requests or copies in electronic format related to visits, inquiries, or request for information by CMS or other government agencies.

Code of Conduct

Effective Date: February 2023

Policy

It is the policy of American Choice Healthcare (ACH) to commit to ethical standards. This policy provides guidance in carrying out the activities of ACH with honesty, ethical and legal standards.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Compliance

- ACH Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities are required to comply with all applicable laws and regulations.

B. Ethical Conduct

As part of ACH's commitment to unimpeachable standards of business ethics and integrity, all ACH Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities will accurately and honestly represent ACH and will not engage in any activity or arrangement intended to defraud anyone of money, property, or honest services.

- Always conduct business in a fair and honest manner in accordance with the highest levels of ethical and professional standards.
- Expected to comply with local, federal, and state laws and regulations as well as the written participation agreement in place.

B. Confidentiality

- All ACH Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities have an obligation to actively protect and safeguard confidential sensitive, and proprietary information.

C. HIPAA and PHI

- ACH is to adhere and maintain compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and enforcement of the HIPAA rules that require healthcare providers ("Covered Entities") and Business Associates to apply appropriate administrative, technical, and physical safeguards to ensure the privacy of the Protected Health Information ("PHI").

- ACH must comply with the requirements of the ACO Model in regard to meeting all of the standards for data use and protection that it receives from the Centers for Medicare & Medicaid Services and is committed in all respects to meeting all such standards at the highest level of compliance, including with respect to the requirements established in the Data Use Agreement and all Data Use Addendums executed with respect to ongoing participation in the ACO Model.
- ACH shall not disseminate individually identifiable information to anyone who is not a Participant Provider, Preferred Provider, or other Provider in a treatment relationship with the beneficiary; a "Business Associate" of such provider; or an ACH "Business Associate" which was hired to carry out work on behalf of ACH or its Participant or Preferred providers.

D. Conflict of Interest
   - All ACH Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities are not allowed to use their position to profit personally or to assist others in profiting in any way at the expense of the organization or its patients.

C. Discrimination and Harassment
   - ACH will not tolerate any form of abuse, discrimination, or harassment of any kind.
   - Derogatory comments based on any persons sex, race, color, national origin, ancestry, citizenship, religion, age, physical or mental disability, medical condition, sexual orientation, gender identity, marital status, or any other characteristic protected by applicable law, unwelcome sexual advances or any similar types of behavior are strictly prohibited.

E. Marketing
   - ACH shall conduct, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing services related to ACH to comply with Marketing Activities, including Voluntary Alignment Activities, only in accordance with the ACO Reach Model Participation Agreement Article V and with Beneficiary Voluntary Alignment guidelines in appendix C of the Agreement.

D. Reporting
   - ACH shall require its Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities are required to report any non-compliance through the Compliance Hotline whenever they suspect that an unethical or criminal conduct has occurred. Reporting can also be done with their direct supervisor.
   - There are two ways to report Non-Compliance using Compliance hotline:
     i. Web Form: http://ach.ethicspoint.com/

ii. **Telephone Line: 1-833-996-3912**

- The hotline should be used if one prefers to place an anonymous report in confidence, you are encouraged to use this hotline, hosted by a third-party hotline provider.
- Corrective action will be taken as necessary to ensure compliance with the Code of Conduct.

E. ACH Participating Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to ACH's are required to comply with this policy.

F. Any ACH Participating Provider, ACH Preferred Provider, ACH Professional or other individuals or entities performing functions or services related to ACH's activities that knowingly violate the Code of Conduct shall be subject to appropriate adverse action, up to and including termination of the individual's relationship with ACH.

G. The policy will be reviewed at least annually to ensure changes to existing laws, regulations, identified risks, and corporate best practices are incorporated, and revisions applied.

Reporting

A. The Compliance Designee will report on a Quarterly basis to the Compliance Committee and the Governing Body on all compliance activities including, but not limited to, training, reports of non-compliance and violations of this policy, responses to those violations, and results of internal audits.

Communication of Regulatory Guidance & Changes

Effective Date: February 15, 2023

Policy

It is the policy of American Choice Healthcare (ACH) to maintain formal processes to ensure that all CMS information and/or requirements for the ACO REACH Model are communicated to ACH Participant Providers, ACH Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities in a timely manner.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Participant Providers, ACH Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. When notifications are received from CMS, the ACH Compliance Committee will work together to determine the process for responding to the notification. The process will include identification of action items, deadlines for those items, and the creation of any supplemental documentation needed.

B. If actions are required by the Executive Directors (EDs) or by ACH Participant Providers, ACH Preferred Providers or ACH Professionals:

   1. Communications will be sent in a timely manner after receipt from CMS. The communication may include but is not limited to:
      a. Any deliverables/deadlines;
      b. Assigned Action Owners; and/or,
      c. Any necessary supplemental documentation.

C. If actions are not required by EDs or by ACH Participant Providers, Providers, or ACH Professionals, Compliance will work to ensure completion of the request and be responsible for any communications with CMS.

D. Emails will be sent to the Governing Body before any official disclosures of non- compliance are made to CMS.

E. When there is a change in applicable laws and/or regulations related to the ACO, the Compliance Officer or Designee will submit an explanation of how the ACO plans to modify its processes to address the legal and/or regulatory changes to CMS.

The Senior Director of Operations will help communicate any compliance updates to the providers.

2. If any attestations are required for communications that need to be sent, information is to be forwarded over to the contracting department.

Reporting

A. Compliance will keep record of all communications sent by CMS in the shared drive, and will quarterly report to the Governing Body, as appropriate.

Compliance Guidelines, Reinforcement & Terminations

Effective Date: December 2022

Policy

It is the policy of American Choice Healthcare (ACH) to have well documented and publicized guidelines for compliance with all applicable state and federal rules and regulations.

ACH requires all ACH Participants, Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to the GPDC Model Participation Agreement activities to agree to comply with all applicable federal laws, including compliance with all provisions in the GPDC Model Participation Agreement between ACH and CMS.

Applicability

This policy and procedure applies to all ACH Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. The Governing Body fully supports all compliance efforts and expects that each of the ACH Participants, Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities will be active participants in the Compliance Program.

B. The Compliance Officer will make recommendations to the Governing Body related to issues, conduct or situations that may arise where discipline is necessary. When appropriate, Corrective Action Plans (CAPs) will be established per CMS requirements to address noncompliance by ACH Participants, Preferred Providers, and ACH Professionals.

C. The Governing Body will have primary responsibility for making determinations regarding the denial of new applicants that do not meet the criteria or standards set by ACH and any termination of existing ACH Participants or Preferred Providers. Failure of such individuals to meet any such criteria or standards may result in termination of the agreement between the GPDC Model and the ACH Participant or Preferred Provider.

D. **Denial to Participate**

1. ACH has the right to review requests for participation in the GPDC Model and accept or deny participation. This applies to ACH Participants and Preferred Providers.
2. If ACH determines that the request to participate will be denied, a letter will be sent to the ACH Participant or Preferred Provider to inform them of the decision. A copy of the letter is maintained by ACH.

E. Compliance Guidance

1. Compliance training and the Code of Conduct are provided upon hire or contracting and annually thereafter to all ACH Participants, Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities.
2. Compliance training and the Code of Conduct provide clear expectations of conduct of all ACH Participants, Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities. Similarly, there is clear and specific information on disciplinary actions for violations of compliance and ethical standards in the Code of Conduct.
3. ACH has implemented procedures that allow the prompt, thorough investigation of possible misconduct by ACH Participants, Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities, as appropriate.
4. ACH is committed to complying with applicable federal and state statutory and regulatory requirements including, but not limited to:
    a. Anti-Kickback Statute;
    b. Stark Law and Physician Self-referral Regulations;
    c. Beneficiary Inducement Law;
    d. Gain sharing;
    e. Health Insurance Portability and Accountability Act (HIPAA);
    f. Federal and State False Claims Acts;
    g. Plain Writing Act of 2010; and,
    h. Other State laws and regulations, as applicable.
5. Contracts with Preferred Providers include a provision that violations of compliance and/or ethical standards may result in termination of the contractual relationship.

F. Corrective Action Plans

1. Disciplinary guidelines are applied consistently for violations. CAPs may be required by CMS or as part of remediation efforts because of Compliance monitoring.
2. ACH will follow all CMS requirements if corrective action is required by CMS.

G. Immediate Removal or Suspension from ACH

1. An immediate removal or suspension from participation in ACH activities may be imposed by the Governing Body under certain circumstances. Examples of conduct warranting a removal or suspension might include documentation of the following:
    a. Repeated use of vile, loud, intemperate, offensive or abusive language to Beneficiaries or individuals performing functions or services related to ACH's activities;
    b. Repeatedly acting in a rude, insolent, demeaning or disrespectful manner;
    c. Verbal or physical threats, intimidation or coercion;
    d. Actual physical abuse, or unwanted touch;
    e. Illegal discrimination against persons, or refusal to provide Beneficiary care;
    f. Services based upon unlawful criteria;
    g. Lack of cooperation or unavailability to other practitioners for exchange of pertinent Beneficiary care information or resolution of Beneficiary care issues;
    h. Sexual or other forms of harassment, including unwelcome physical conduct of a sexual nature which has the purpose or effect of substantially interfering with the individual's work performance or creating an intimidating, hostile or offensive work environment;
    i. Overt breach of confidentiality; or,
    j. Inappropriate entries in Beneficiary medical records which have the primary purpose or effect of attacking or belittling other providers, imputing stupidity or incompetence of other providers, or impugning the quality of care of other providers.
2. During the investigation, the ACH Participant, Preferred Provider or ACH Professional will not have contact with Beneficiaries.
    a. If, upon investigation, the allegations are unfounded, the Compliance & Ethics

Subcommittee will make recommendations to the Governing Body for reinstatement of practice.

b. If, upon investigation, the allegations are not deemed to be as serious as initially claimed, then a CAP or other actions may be recommended as appropriate.
c. If the allegations are deemed to be true, the termination processes will be initiated.

Reporting

A. All requests and recommendations for participation or termination are reported to Governing Body, as required.

Compliance Hotline

Effective Date: December 2022

Policy

It is the policy of the American Choice Healthcare (ACH), its Participants and Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities to provide a mechanism by which employees or contractors can anonymously report suspected problems to the compliance official.

Applicability

This policy and procedure applies to all ACH Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. ACH will maintain a Compliance Hotline to serve as a mechanism to receive, record, and respond to compliance questions and concerns, reports of improper conduct, reports of suspected non-compliance, and allegations of fraud, waste, and abuse. This hotline allows for anonymous reporting. Reports of wrongdoing may be made orally or in writing.

B. There are two ways to report Non-Compliance using Compliance hotline:
    1. Web Form: http://ach.ethicspoint.com
    2. Telephone Line: U.S. 833-996-3912

C. The hotline should be used if one prefers to place an anonymous report in confidence, you are encouraged to use this hotline, hosted by a third-party hotline provider.

D. Corrective action will be taken as necessary to ensure compliance with the Code of Conduct.

E. ACH will ensure that the Compliance Hotline number is provided upon hire or contracting and annually thereafter. ACH will also ensure that the number can be found in the Code of Conduct, on the ACH website.

F. Following a call to the Compliance Hotline, the call and issues reported will be recorded in a database for investigation, tracking, compilation, and reporting.
    1. The individual can request information and progress reports, as appropriate, on a confidential basis.

G. Issues identified through the investigative process are escalated, as appropriate, to the Governing Body and reported on a quarterly basis. The Governing Body is responsible for ensuring all appropriate investigation protocols are followed and identified issues are resolved.
H. All reported compliance issues are investigated, documented, and reported to the Governing Body, as appropriate.
I. ACH maintains a policy of non-retaliation regarding those who repot potential compliance items in good faith.
J. Issues will be escalated to law enforcement authorities in accordance with federal guidance and ACH's policies and procedures, as appropriate and in a timely manner.

Reporting

A. Issue reports are provided on a quarterly basis to the Governing Body, as appropriate.

Compliance Policy & Plan

Effective Date: December 2022

Policy

It is the policy American Choice Healthcare (ACH) to ensure all American Choice Healthcare (ACH) Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's Activities comply with the applicable terms of the ACO REACH Model Participation Agreement between ACH Participant and/or Preferred Providers and CMS and all applicable statutes, regulations and guidance, including without limitation: (a) federal criminal laws; (b) the False Claims Act (31 U.S.C. Section 3729 et seq.); (c) the anti-kickback statute (42 U.S.C. Section 1320a-7b(b)); (d) the civil monetary penalties law (42 U.S.C. Section 1320a-7a); and (e) the physician self-referral law (42 U.S.C. Section 1395nn)..

Applicability

This policy and procedure applies to all ACH Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities

Procedure

A. ACH has developed a Compliance Plan document which outlines the elements of ACH's Compliance activities and is designed to promote a culture of integrity, ethical behavior, and compliance with applicable laws and regulations.
    1. The Compliance Plan is drafted and updated by Compliance then reviewed and approved by the Governing Body.
    2. The Compliance plan is reviewed and updated at least annually, and as needed, to meet the most updated legal and regulatory requirements.

B. As part of the Compliance Plan, ACH has established the following:
    1. A designated Compliance Officer or individual who is not legal counsel to ACH and reports directly to the Governing Body;
    2. Mechanisms for identifying and addressing compliance problems related to ACH's operations and performance;
    3. A dedicated Compliance Hotline number for employees or contractors of ACH, its ACH Participants and Preferred Providers, and other individuals or entities performing functions or services related to ACH's Activities to anonymously report suspected problems related to the Compliance Officer;
    4. An effective training program for ACH and its ACH Participants and Preferred Providers, to be performed during orientation upon hire or contracting, at least annually and when

changes in applicable laws and regulations warrant dissemination of updated information and training, including training on the Compliance Program, the Health Insurance Portability and Accountability Act (HIPAA), and fraud, waste, and abuse (FWA); and

5. A requirement for ACH to report probable violations of law to an appropriate law enforcement agency

Reporting

A. N/A

Board of Managers Conflict of Interest Policy

Effective Date: October 2023

Policy

It is the policy of American Choice Health Care (ACH) to ensure its Board of Managers is free of conflicts of interest that could adversely influence, or be perceived to adversely influence, their judgment, objectivity, or loyalty to ACH. This policy:

1. Requires each Manager to disclose relevant financial interests;
2. Provides a procedure to determine whether a conflict of interest exists;
3. Sets forth a process to address any conflicts that arise; and
4. Addresses remedial actions for Managers who fail to comply with this policy.

Applicability

This policy and procedure applies to ACH's Board of Managers and to each Manager.

Procedure

A. **Types of Conflicts of Interest**

1. Using one's own knowledge. No Manager may use his or her position, or the knowledge gained through having that position, in such manner that a conflict of interest between ACH's interests and his or her personal interest might arise or appear to arise.
2. Holding another position. No Manager may hold a position with, or have a substantial interest in, any other business enterprise that would create a conflict of interest or could be perceived to create a conflict of interest with ACH without first disclosing that relationship completely and fully to, and obtaining approval from, the Board of Managers.
3. Accepting business courtesies. No Manager may accept business courtesies from third parties in exchange for decisions, business judgments, or favor that benefit the third party to the detriment of ACH.

B. **Identification of Conflicts of Interest**

1. Using one's own knowledge. A conflict of interest may exist where a Manager uses his or her position in, or knowledge of, ACH to benefit his or her personal interests without regard to the effect his or her actions would have on ACH.
2. Holding another position. A conflict of interest may exist where a Manager's relationship with another business enterprise affects, might tend to affect, or may be

perceived to affect his or her duties, responsibilities, or independent judgment with respect to transactions between ACH and the other business enterprise.

3. Accepting business courtesies. A conflict of interest may exist where the Manager accepts business courtesies, because such action can create the appearance that business decisions are being influenced by other factors. Accordingly, all Managers are required to avoid circumstances in which personal interests' conflict with or may appear to conflict with ACH's interests.
4. Financial Interests. A conflict of interest may exist when a Manager or the Manager's family member (defined below) directly or indirectly benefits as a result of a decision, policy or transaction made by ACH. For example, when a Manager or the Manager's family member has ownership in or is employed by any outside entity which does business with ACH, a conflict of interest may exist. This does not apply to stock or other investments held in a publicly held corporation, provided that the person does not own stock of the corporation that, in the aggregate, represents more than (5%) of the corporation's stock value. ACH may, following a review of the relevant facts, permit ownership interests which exceed this amount if the unaffected Managers conclude that such ownership interests will not adversely impact ACH's business interest or the judgment of the Manager. Another example of a potential conflict of interest would be where ACH contracts to purchase or lease goods, services, or properties from a Manager or the Manager's family member. A third example of a potential conflict of interest would be where ACH either refers business, such as patients for health care services, to a Manager or Manager's family member, or receives referrals of business from a Manager or Manager's family member. Financial interests are not necessarily a conflict of interest. A financial conflict of interest exists only when the unaffected Managers determine that a Manager with a financial interest has a conflict of interest. For the purpose of this policy, a "family member" means, as to any Manager, his or her spouse or domestic partner, parents, in-laws, stepfamily, siblings, grandparents, children (whether natural, adopted, foster, step or others legally placed), grandchildren, aunts, uncles, cousins, or individuals living in the same household.
5. Examples of prohibited activities include, but are not limited to:
    a. **Disclosing Trade Secrets** – Disclosing any trade secrets or confidential, sensitive, or proprietary information about ACH or its providers to persons outside ACH;
    b. **Conducting Competitive Business** – Owning or operating, or being employed as an employee, contractor or consultant by, or having a business relationship with, any business that competes, directly or indirectly, with ACH;
    c. **Preferential treatment** – Seeking to obtain preferential treatment by ACH or recognition for himself or herself or another Manager;

d. **Maintaining a Financial Conflict** – Having a direct or indirect financial relationship with a competitor, customer, or supplier;
    i. No conflict of interest will exist where the Manager owns less than one percent (1%) of the publicly traded stock of a corporation.

e. **Improper Dealings** – Engaging in any activity, agreement, business investment, or interest that constitutes a conflict, poses a potential conflict, or may be perceived to pose a conflict, with ACH's interests or that may interfere with the Manager's duties and ability to best serve ACH.

f. **Personal Service to ACH** – Serving as a representative capacity as the agent of, or as a spokesperson for, another agency or organization that may be interested in business with ACH, or any of its affiliates.

g. **Corporate Opportunity** – Taking advantage of a corporate opportunity or enabling another interested person or other organization to take advantage of a corporate opportunity that he or she has reason to believe would be of interest to ACH, without first offering the opportunity to ACH. Corporate opportunity means a business opportunity that ACH is financially able to undertake; is in ACH's line of business and could be of practical value to ACH.

h. **Accepting Gifts** – Seeking or accepting any gifts from anyone seeking to have a business relationship with ACH in his, her or its professional capacity. Gifts are defined as cash or any other item or service given, without proper compensation, to a Manager, whether from a person or organization.
    i. Exceptions to this policy include common promotional items, as well as reasonable meals and entertainment.
    i. Unless otherwise prohibited by the nature of the contract or relationship, a Manager may accept meals, refreshments, tickets, or other entertainment paid for by third parties as long as:
        a. The acceptance of such is related to a bona fide business cause;
        b. The acceptance of such does not violate any law or ethical standards otherwise imposed upon the Manager; and,
        c. The cost, extent, and frequency of such is reasonable and does not become excessive.
    ii. Discretion should be used when considering the few exceptions noted above. Compliance or an appropriate supervisor must be notified immediately upon receipt of such items.
    iii. Additional restrictions upon accepting gifts or other items of value may exist through governmental contracts. It is the Manager's obligation to understand and abide by all such restrictions.

C. **Conflict of Interest Education & Documentation**

1. Each Manager shall be given a copy of the Conflict of Interest Policy upon appointment or election as a Manager.
    a. Each Manager shall submit a signed ACH Conflict of Interest Questionnaire Form *(please see exhibit A)* annually to customerservice@americanchoicehealthcare.com . The statement confirms that the Manager: (1) has received a copy of the Conflict of Interest Policy; (2) has read and understands the policy; (3) is in compliance with the policy; and (4) has agreed to comply with the policy.

D. **Disclosure of Conflicts**

1. Each Manager must complete and submit a declaration of potential conflicts of interest form to customerservice@americanchoicehealthcare.com . The form will be provided to the Managers, and Compliance shall raise any issues arising from such disclosure to the Board of Managers, if and as appropriate. The process should be done annually.
2. The duty to identify and disclose potential conflicts of interest is a duty that is ongoing. All Managers shall immediately disclose such potential conflict or duality of interest as soon as the interest occurs.

E. Addressing Conflicts of Interest

1. If a question arises about whether or not a conflict of interest has occurred, it should be brought to the attention of the Chief Compliance Officer of Cano Health, Inc. Compliance will be handled by the compliance department of Cano Health, Inc. ("Compliance"), the sole Member and manager of ACH.
2. When a potential conflict of interest is disclosed, the Manager should refrain from further participation in matters to which the conflict relates until the question of conflict has been resolved. The Compliance Officer, who may seek the guidance of the general counsel, will review, and determine the appropriate course of action to address the conflict. Disclosure of any actual or potential conflicts of interest will not necessarily permanently restrict the Manager's activities. Conduct that may appear questionable at first may be deemed acceptable and permissible when all facts regarding the activity are examined. The Board of Managers, excluding the Manager(s) with the potential conflict(s), shall review all conflict-of-interest disclosures and decide whether a disclosed conflict of interest warrants further action.
3. Compliance may request that the Manager present additional information to the Compliance Officer. However, in no event shall such Manager have the right to participate in the deliberations regarding the disclosed conflict of interest.
4. If the Board of Managers determines that a Manager has a conflict of interest that warrants further action, it shall (depending on the circumstances and severity of such conflict of interest) take one or more of the remedial actions outlined in Section F of this policy.

5. If the Board of Managers finds that a Manager has failed to disclose an actual or potential conflict of interest, or the Board of Managers has reasonable cause to believe that a Manager has failed to disclose an actual or potential conflict of interest, the Board of Managers will inform the Manager in writing of the basis for such belief and provide him or her with the opportunity to explain the alleged conflict and failure to disclose. If, after hearing the response and making further investigations, the Board of Managers determines that the Manager has in fact failed to disclose an actual or potential conflict of interest, the Board of Managers shall take one or more of the remedial actions outlined in Section F below.
6. Every conflict of interest, once recognized, must be investigated and evaluated, as necessary, and all findings, conclusions, and recommendations, including but not limited to Annual Disclosure Questionnaire review, must be reported to the Compliance Officer.

F. **Remedial Actions**

1. If a conflict of interest is identified by Compliance as requiring remedial action, the following action(s) may be taken:
    a. Written Warning – This action shall be applied in instances where the conflict of interest has had limited or no adverse consequences on the workings or reputation of ACH.
    b. Suspension – This action shall be applied where the adverse consequences of the conflict of interest demonstrate significant misconduct or where Compliance would deem it necessary to investigate the matter prior to making a decision. Offenses under this category include, but are not limited to, behavior in contradiction to the principles found in the regulatory framework of ACH or in instances where the person has received multiple written warnings.
    c. Removal – This action shall be applied where instances of a significant conflict of interest or penal misconduct (including fraud or moral turpitude) occur and where the repercussions materially or adversely affect the image, reputation, and integrity of ACH or run afoul of the REACH ACO Agreement between ACH and the Centers for Medicare & Medicaid Services, or other applicable Federal or state laws and regulations.
    d. Decisions regarding the type of remedial actions to be applied shall be determined by the Board of Managers in its sole discretion.

Reporting

A. Compliance will oversee that Conflict of Interest questionnaire form attestations have been completed for the Board of Managers.

Exhibit A

NAME (Please Print): _____

Please review the Conflict of Interest Policy and this form.

Please respond to each of the items below by describing any applicable relationship held by you or any family members. Where a relationship exists, please mark the box labeled "Yes" and complete the corresponding information. If no relationship exists, please mark the box labeled "No." Please answer all questions. For the purposes of this Statement the following definitions apply:

Relationship means any relation with any person or organization, whether it is financial (such as an ownership of stocks and bonds), employment (such as a part-time job or as a consultant or independent contractor), fiduciary (such as a board director or officer), or personal.

Family generally includes spouse or domestic partner, parents, in-laws, stepfamily, siblings, grandparents, children (natural, adopted, foster step or others legally placed), grandchildren, aunts, uncles, cousins, or individuals living in the same household.

American Choice Healthcare LLC, and any of their subsidiaries, further referred to in this document as the "Company."

Dishonesty means directly or indirectly cheating or defrauding, whether for monetary gain or other gain, or not disclosing any conflicts as they arise.

Breach of Trust means a wrongful act, use, misappropriation, or omission with respect to property, funds, or proprietary information, especially when in a position of fiduciary or official capacity.

Convicted means proved or found guilty of a crime alleged against him/her/them.

1	a. Do you or any family member(s) have a relationship with any provider of services participating in any Company or Medicare program, including any hospital, nursing home, or other provider; any independent clinical laboratory, renal disease facility, or health maintenance organization?		☐ Yes	☐ No
	If yes, please provide the following information:			
	Name of Provider	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Relationship of You or Family Member(s) to Provider (Include Ownership % if Applicable)	
	b. Do you have any relatives or a personal relationship with someone working at American Choice Healthcare?	☐ Yes ☐ No	If the answer is yes, please specify location and position.	

2	Do you or any family member(s) have a relationship with any supplier of goods or services, subcontractors, vendors to the Company?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Supplier or Business Partner	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Relationship of You or Family Member(s) to Supplier or Business Partner (Include Ownership % if Applicable)		
3	Have you or any family member(s) received any gifts (gift certificates, travel, sporting events tickets, clothing, payments, or loans of any amount from persons or organizations doing or hoping to do business with the Company?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Organization, Person, and Job Title	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Item and Value		
4	Do you or any family member(s) have a relationship with an entity doing business with or receiving payments from the Company?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Entity	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Relationship of You or Family Member(s) to Supplier or Business Partner (Include Ownership % if Applicable)		

5	Do you or any family member(s) have a relationship with an entity in competition with the Company?		☐ Yes	☐ No
	If yes, please provide the following information:			
	Name of Entity	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Relationship of You or Family Member(s) to Entity (Include Ownership % if Applicable)	
6	Do you or any family member(s) serve on the board of any for-profit company not otherwise disclosed herein?		☐ Yes	☐ No
	If yes, please provide the following information:			
	Name of Organization and Position	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.		
7	Have you ever been debarred, sanctioned, reprimanded, excluded, or otherwise disciplined by the United States government in connection with your involvement with any government program?		☐ Yes	☐ No
	If yes, please provide the following information:			
	Name of Government Program	Reason		
8	Have you ever been convicted of a crime of dishonesty or breach of trust?		☐ Yes	☐ No
	If yes, please provide the following information:			
	Date of Conviction	Description of Conviction		

9	Do you or any family member(s) have any financial interests (including income, stock, or other equity) in any competitor company?	☐ Yes	☐ No
	If yes, please provide the following information:		
	Name of specific company, stock, and value	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	
10	Do you have any additional disclosures that are not addressed in statements numbered 1 through 9?	☐ Yes	☐ No
11	If you answered "Yes" to any of the statements listed above, please briefly describe your function at the Company.		
12	I hereby certify that, in my judgment, no situation in which I am involved places me in a position of having a conflict of interest or potential conflict of interest with the Company's affiliated payors or their government programs, except as indicated above, if applicable. I understand that I have an ongoing affirmative duty to bring to the immediate attention of the Company any situations which may be an actual or potential conflict of interest.	☐ Agree	☐ Disagree
13	I have reviewed or had the opportunity to review the Conflict-of-Interest Policy. The information I have given in this statement is complete and accurate to the best of my knowledge.	☐ Agree	☐ Disagree
14	I understand that should an actual or possible Conflict of Interest arise; I shall complete a new form and turn it over to American Choice Healthcare for review and acceptance of the conflict.	☐ Agree	☐ Disagree

Signature	Title	Date

DO NOT PHOTOCOPY

Designation of Compliance Officer and Board of Managers

Effective Date: October 2023

Policy

It is the policy of American Choice Healthcare (ACH) to comply with the federal regulations that require the designation of a Compliance Officer who is not General Counsel to ACH and is approved by and reports directly to ACH's Board of Managers.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACH's activities.

Procedure

A. The role of the Compliance Officer is critical to the ACO REACH Model. The Compliance Officer ensures open communication and active involvement in oversight and monitoring of all aspects of ACH, including compliance with the Participation Agreement.
B. The Compliance Officer is responsible for development, oversight and monitoring of the Compliance and Fraud, Waste, and Abuse (FWA) program.
C. The Compliance Officer offers oversight and implementation of the Compliance Program goals.
D. The Compliance Officer duties are delineated fully in the Compliance Plan.
E. The Compliance Officer periodically, and at least quarterly, reports directly to the Board of Managers on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance Program.
F. The Board of Managers supports the following actions:
    1. Meets on, at a minimum, a quarterly basis;
    2. Develops strategies to promote compliance and the detection of any potential violations;
    3. Ensures training and education is appropriately completed;
    4. Assists with the creation and implementation of the monitoring and auditing work plan;
    5. Assists in the creation of effective corrective action plans and ensures that they are implemented and monitored;
    6. Develops innovative ways to implement appropriate corrective and preventive actions;
    7. Oversees a system of internal controls to carry out the ACH's standards as part of its daily operations;
    8. Supports the Compliance Officer's needs for sufficient staff and resources to carry out his/her duties;

9. Ensures Policies and Procedures are up to date
10. Ensures a system for individuals to ask compliance questions, and report potential instances of FWA, confidentially or anonymously (if desired) without fear of retaliation;
11. Reviews and addresses monitoring and auditing reports for areas in which Compliance risks have been identified and ensures that corrective action plans are implemented and monitored; and,
12. Provides regular and ad hoc reports on the status of compliance with recommendations to the Board of Managers.

G. The Board of Managers of ACH is knowledgeable about the content and operation of the Compliance Program and exercises reasonable oversight with respect to the implementation and effectiveness of the Compliance Program.

Reporting

A. N/A

Board of Managers Structure

Effective Date: October 2023

Policy

It is the policy of American Choice Healthcare (ACH) to maintain an identifiable Board of Managers with authority to execute the functions, as required under the ACO REACH Model Participation Agreement with the Centers for Medicare and Medicaid Services. The board will be consistent with all applicable federal and state laws, regulations, rules, and guidelines.

Applicability

This policy applies to ACH's Board of Managers and Committees, as applicable.

Procedure

A. General

1. The Board of Managers is responsible for the oversight and strategic direction of ACH as well as holding management accountable for the ACO REACH Model activities.
2. The Board of Managers has sole and exclusive authority to execute the functions and make final decisions.
3. The Board of Managers must have a transparent governing process.
4. The members of the Board of Managers have a fiduciary duty to ACH, including the duty of loyalty, and their actions must be consistent with that fiduciary duty.
5. The Board of Managers must be separate and unique to ACH, except as permitted under Section 3.01 C in the Participation Agreement.
6. The Board of Managers shall receive regular reports from the Compliance Officer who satisfies the requirements of Section 15.1 of the Participation Agreement.
7. The Board of Managers shall include at least one Beneficiary Representative who:
    a. Does not have a conflict of interest.
    b. Has no immediate family member with a conflict of interest.
    c. Is not a Participating or Preferred Provider.
    d. Does not have a direct or indirect financial relationship with ACH, an ACH Participating, or a Preferred Provider, except that such person may be compensated for his or her duties as a member of the Board of Managers.
    e. Has voting rights on the Board of Managers.
8. The Board of Managers shall include at least one person with training or professional experience in advocating for the rights of consumers ("Consumer Advocate"), who is not the same person as the Medicare Beneficiary and who:
    a. Does not have a conflict of interest with

b. Has no immediate family member with a conflict of interest
c. Is not a Participating or Preferred Provider
d. Does not have a direct or indirect financial relationship with an ACH Participating, or Preferred Provider, except that such person may be compensated for his or her duties as a member of the Board of Managers.
e. Beginning Performance Year 2023 has voting rights on the ACO's Board of Managers.

9. The Board of Managers shall not include a Prohibited Participant or an owner, employee, or agent of a Prohibited Participant.
10. ACH will reach out to those individuals they wish to invite by sending out the ACH Board of Directors Appointed letter (*see exhibit A)*.
11. Upon accepting the letter, ACH will provide each member of the Board of Managers with a copy of the ACO REACH Participation Agreement and any amendments hereto, Conflict of Interest Policy and Procedure, NDA and the ACH Conflict of Interest Questionnaire Form *(exhibit B)* to attest to.

B. Board of Managers

1. The Board of Managers is created and defined within the ACO REACH Performance Year Participation Agreement and
2. shall not include a Prohibited Participating, or an owner, employee, or agent of a Prohibited Participating
3. Responsibilities of the Board of Managers include the following:
    a. Implement a process for documenting Board of Managers composition, meetings, and decisions, and shall retain such documentation in accordance with Record Retention Policies
    b. Fiduciary Duty to ACH and determining its strategic direction and goals of ACH;
    c. Adopting, monitoring, and reviewing ACH's mission to ensure it reflects ACH's tenants of improving the care and health of Beneficiaries while lowering costs, and setting and planning clear goals and directions for the future;
    d. Promulgation of ACH rules and guidelines, including adopting all ACH Policies and Procedures (P&P) and Committee recommendations.
    e. Defining the Committees and appointing the members; and,
    f. Defining the criteria and approving the distribution of shared savings.

C. Voting Requirements

1. For a committee to hold an official vote, a quorum must be met. For a quorum to be met, at least a majority of the active serving Committee members must be present. If the quorum is not met, then a meeting cannot occur and must be rescheduled.
2. A voting member must be present (in person or telephone) to vote.
3. Voting proxy can be given by a voting member to an individual.

a. The individual to whom the proxy is given can only vote for items that the voting member would have been entitled to vote upon where they are present, and the Proxy must vote as the voting member would have voted.
b. The Proxy cannot vote on new matters which arise during the meeting.
c. A voting member's Proxy does not count towards a meeting's quorum.

D. Miscellaneous

1. A non-cooperative member of a committee can be removed by the Board of Managers.
2. Board of Managers members may be removed by a majority vote of the other members.
3. The Secretary or an ad hoc secretary will be assigned to record the minutes of all Committee meetings.
4. The previous meeting's minutes must be distributed prior to the next meeting. Then, the minutes must be reviewed and ratified by the Committee. Any changes to the draft minutes must also be ratified by the Committee.

E. Conflict of Interest

ACH shall have a Conflict of Interest Policy that applies to members of the Board of Managers and satisfies the following criteria:

1. Each member receives a copy of the Conflict of Interest Policy
2. Each member discloses relevant financial interests and relationships that can pose a conflict to ACH.
3. Establishes a procedure to determine whether a conflict of interest exists and sets forth a process to address any conflicts that arise.
4. That addresses remedial actions for members that fail to comply with the policy.

Reporting

A. Compliance Designee is to ensure oversight that all members of the Board of Managers have signed the ACH Conflict of Interest Questionnaire Form.

Exhibit A

TITLE FIRST LAST MONTH DD, YYYY

Dear TITLE LAST:

On behalf of American Choice Healthcare, LLC (the "Company"), we are pleased to invite you to join the Company's ACO Board of Directors (the "Board"). Your service as a director begins upon execution of this letter (the "Effective Date") and continues until you are not re-elected or your earlier removal or resignation.

The terms of your offer are as follows:

Compensation: In consideration for your service on the Board, you will be compensated in the amount of $500 for attending each Board meeting.

Non-Disclosure and Confidentiality: As a Board member, I am privy to Confidential Information regarding the current, past and proposed business practices of the Company. For the purposes of this document "Confidential Information" means all of the materials, information and ideas of the Company, including, without limitation, its internal documents, such as its organizational documents, rules and regulations; contracts with physicians, physician groups and other third parties, including but not limited to the names of the parties with which it is contracted; vendors; all Company business strategies, including negotiation strategies with payors, and strategies to improve lower health care cost and to improve patient care; performance; operation methods and information; minutes of meetings of the Board or any committee of the Board; any Company accounting and financial information; marketing and pricing information and materials; internal publications and memoranda; written or oral Company business strategies; and all data, materials, information and documents considered confidential by the Company and not made generally available to the public. Therefore, I agree that under no circumstances will I disclose any Confidential Information to any person not on the Board, for any purpose, without the prior written consent of the President of Company, Frank Exposito. This obligation will continue to apply in perpetuity if and when I am no longer a Board member.

Sincerely,

Frank Exposito
President
American Choice Healthcare, LLC

Acceptance: In accepting this offer, you will be required to complete a Conflict and Stark Law Disclosure Form in which you disclose any possible conflicts that would restrict your service on the Board. This letter sets forth the entire compensation you will receive for your service on the Board. Nothing in this letter should be construed as an offer of employment. If the foregoing terms are agreeable, please indicate your acceptance by signing the letter in the space provided below and returning this letter to the Company.

Name _____ Signature _____ Date _____

Exhibit B

NAME (Please Print): _____

Please review the Conflict of Interest Policy and this form.

Please respond to each of the items below by describing any applicable relationship held by you or any family members. Where a relationship exists, please mark the box labeled "Yes" and complete the corresponding information. If no relationship exists, please mark the box labeled "No." Please answer all questions. For the purposes of this Statement the following definitions apply:

Relationship means any relation with any person or organization, whether it is financial (such as an ownership of stocks and bonds), employment (such as a part-time job or as a consultant or independent contractor), fiduciary (such as a board director or officer), or personal.

Family generally includes spouse or domestic partner, parents, in-laws, stepfamily, siblings, grandparents, children (natural, adopted, foster step or others legally placed), grandchildren, aunts, uncles, cousins, or individuals living in the same household.

American Choice Healthcare LLC, and any of their subsidiaries, further referred to in this document as the "Company."

Dishonesty means directly or indirectly cheating or defrauding, whether for monetary gain or other gain, or not disclosing any conflicts as they arise.

Breach of Trust means a wrongful act, use, misappropriation, or omission with respect to property, funds, or proprietary information, especially when in a position of fiduciary or official capacity.

Convicted means proved or found guilty of a crime alleged against him/her/them.

1	a. Do you or any family member(s) have a relationship with any provider of services participating in any Company or Medicare program, including any hospital, nursing home, or other provider; any independent clinical laboratory, renal disease facility, or health maintenance organization?	☐ Yes	☐ No
	If yes, please provide the following information:		
	Name of Provider	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Relationship of You or Family Member(s) to Provider (Include Ownership % if Applicable)
	b. Do you have any relatives or a personal relationship with someone working at American Choice Healthcare?	☐ Yes ☐ No	If the answer is yes, please specify location and position.

2	Do you or any family member(s) have a relationship with any supplier of goods or services, subcontractors, vendors to the Company?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Supplier or Business Partner	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Relationship of You or Family Member(s) to Supplier or Business Partner (Include Ownership % if Applicable)		
3	Have you or any family member(s) received any gifts (gift certificates, travel, sporting events tickets, clothing, payments, or loans of any amount from persons or organizations doing or hoping to do business with the Company?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Organization, Person, and Job Title	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Item and Value		
4	Do you or any family member(s) have a relationship with an entity doing business with or receiving payments from the Company?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Entity	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Relationship of You or Family Member(s) to Supplier or Business Partner (Include Ownership % if Applicable)		

5	Do you or any family member(s) have a relationship with an entity in competition with the Company?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Entity	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	Relationship of You or Family Member(s) to Entity (Include Ownership % if Applicable)		
6	Do you or any family member(s) serve on the board of any for-profit company not otherwise disclosed herein?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Organization and Position	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.			
7	Have you ever been debarred, sanctioned, reprimanded, excluded, or otherwise disciplined by the United States government in connection with your involvement with any government program?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Name of Government Program	Reason			
8	Have you ever been convicted of a crime of dishonesty or breach of trust?			☐ Yes	☐ No
	If yes, please provide the following information:				
	Date of Conviction	Description of Conviction			

9	Do you or any family member(s) have any financial interests (including income, stock, or other equity) in any competitor company?	☐ Yes	☐ No
	If yes, please provide the following information:		
	Name of specific company, stock, and value	☐ Self ☐ Family Member(s) If Family Member(s), please provide Name(s) and Relationship(s) to you.	
10	Do you have any additional disclosures that are not addressed in statements numbered 1 through 9?	☐ Yes	☐ No
11	If you answered "Yes" to any of the statements listed above, please briefly describe your function at the Company.		
12	I hereby certify that, in my judgment, no situation in which I am involved places me in a position of having a conflict of interest or potential conflict of interest with the Company's affiliated payors or their government programs, except as indicated above, if applicable. I understand that I have an ongoing affirmative duty to bring to the immediate attention of the Company any situations which may be an actual or potential conflict of interest.	☐ Agree	☐ Disagree
13	I have reviewed or had the opportunity to review the Conflict-of-Interest Policy. The information I have given in this statement is complete and accurate to the best of my knowledge.	☐ Agree	☐ Disagree
14	I understand that should an actual or possible Conflict of Interest arise; I shall complete a new form and turn it over to American Choice Healthcare for review and acceptance of the conflict.	☐ Agree	☐ Disagree

Signature	Title	Date

DO NOT PHOTOCOPY

Investigation of Reported Incidents & Complaints

Effective Date: December 2022

Policy

It is the policy the policy of American Choice Healthcare (ACH) to fully investigate any reported violations of policies and complaints raised by Beneficiaries. Any actual or potential violations will be mitigated, and the violating party will be disciplined as appropriate based on the nature of the violation. All complaints will be investigated, and appropriate action will be taken to mitigate or eliminate any negative outcomes.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Individuals may submit reports of noncompliance and/or complaints. There are three ways to report noncompliance and/or complaints:
    1. There are two ways to report Non-Compliance using Compliance hotline:
        a. Web Form: http://ach.ethicspoint.com
        b. Telephone Line: U.S. 833-996-3912
    2. The hotline should be used if one prefers to place an anonymous report in confidence, you are encouraged to use this hotline, hosted by a third-party hotline provider.
    3. Corrective action will be taken as necessary to ensure compliance with the Code of Conduct.

B. Quality of Care incidents and complaints are referred to the Governing Body for review and a plan is established for improvement. Quality of Care issues should be reviewed at a high level without discussing specifics of the individual involved.

C. If an issue reported to the Designated Compliance Official requires immediate action in order to assure ACH's ongoing compliance with state and federal law, the Designated Compliance Official may, in consultation with the Legal department and Governing Body, take such actions as considered appropriate.

D. Upon receipt of a compliance issue, the Designated Compliance Official will open a fact-finding investigation as promptly as possible, and no later than seven (7) days after receiving the report. The issue, investigation and resolution should be documented thoroughly. If the issue rises to the level of a Significant Compliance Event, the Governing Body will be promptly apprised of the

issue and will provide input into the investigation. “Significant Compliance Event” includes, but is not limited to, the following: (i) an event jeopardizing ACH’s qualification to participate in ACO REACH, or violating the terms of ACH’s agreement with CMS; (ii) fraudulent or other unlawful conduct by an ACO REACH Party; and (iii) failure of an ACO REACH Party to fulfill the requirements of their respective ACO REACH Participating Provider Agreement. The Compliance Officer, or their Designee, will interview all appropriate individuals to determine the relevant facts.

1. All interviews will be confidential to the extent possible and will be documented as appropriate.
2. Where possible, a signed statement will be taken after the interview.

E. All fact-finding investigations and related activity by the Designated Compliance Official or Compliance Committee shall be conducted such that confidentiality of the investigation, including in some cases the identity of the person reporting the information, is maximized. The Designated Compliance Official shall coordinate with the ACO’s legal counsel during fact-finding investigations as needed, and where application of attorney-client privilege may be a consideration.

F. ACH maintains a policy of non-retaliation regarding those who report potential compliance issues in good faith.

G. The Compliance Officer, or their Designee, will determine whether a violation of ACH’s policies or law has occurred.

1. If the Compliance Officer, or Designee, determines that a violation has occurred, and the offending individual is performing functions or services related to ACH activities, the Compliance Officer will:
    a. Notify the Governing Body.
    b. Work with Human Resources to determine the appropriate course of action.
    c. Follow the Policy for Reporting Probable Violations of Law
    d. Resolve within sixty (60) calendar days of reporting.
    e. Impose a corrective action as necessary in order to remediate compliance issues. The Governing Body may suspend or terminate an ACO Party’s ACO participation, in response to compliance violations.

H. The findings and any corrective measures are reported to the appropriate leadership staff, the President, and the Governing Body.

I. All non-compliance and/or complaints are automatically tracked and documented using the web form.

J. The Compliance Officer or their Designee must notify CMS within 15 days of any ACH Participant and/or Preferred Provider who is under investigation or has been sanctioned by the government or any licensing authority.

K. After all appropriate steps are taken; the incident will be closed.
L. All corresponding documentation shall be securely stored.

Reporting

A. Compliance will record any non-compliance and complaints that have been reported. Information will be reported quarterly to the governing body, as appropriate.

Medical Records

Effective Date: April 2023

Policy

It is the policy of American Choice Healthcare (ACH) to ensure its Providers, Professionals and other individuals or entities performing functions or services related to ACO's activities maintain a medical/health record for every Beneficiary that includes the Beneficiary's health and case history and proper identification. All medical records must meet all requirements in the policy, including applicable federal and state laws.

Applicability

This policy and procedure applies to all ACH Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACO's activities.

Procedure

A. Medical record documentation includes clinical assessments as well as services provided to Beneficiaries. The record shall meet CMS guidelines, professional standards, privacy standards, and any applicable federal and state laws and regulations.

B. Medical Record Contents

The medical record shall include all metrics necessary to report quality measures. Best efforts shall be made to ensure the medical record includes the following general areas and that information is added to each section chronologically.

1. Demographics, examples include but are not limited to:
    a. Name, birthdate, addresses, contact numbers, e-mail, and emergency contacts.
2. Assessments, examples include but are not limited to:
    a. Vital signs
    b. Wellness assessments
    c. Clinical assessments; and,
    d. Behavioral health.
3. Medical History, examples include but are not limited to:
    a. Allergies;
    b. Habits & Risk Factors;
    c. Immunizations; and,
    d. Past Illnesses.
4. Orders and Prescriptions, examples include but are not limited to:
    a. Current medication list; and,
    b. Prescriptive orders – amount, frequency, dose & number of cells.

c. Diagnostic orders
d. Referrals

5. Medical Encounters, examples include but are not limited to:
    a. Individual encounters with summaries of visits, care, and consultation;
    b. Encounters from other settings such as hospitalizations or specialty providers.
6. Progress Notes, examples include but are not limited to:
    a. Response to treatment; and,
    b. Compliance with treatment/recommendations
7. Test Results, examples include but are not limited to:
    a. Blood/lab tests;
    b. X-rays or diagnostic imaging reports; and,
    c. Other tests (such as pulmonary function, biopsy results, etc.).

C. Maintenance and Legibility of Records

1. Medical records (regardless of form or format) should be maintained in their entirety, and no document or entry may be deleted from the record.
2. Handwritten entries should be made with permanent blue or black ink. This is to ensure the quality of electronic scanning, photocopying, and faxing of the document.
3. All entries must be legible to individuals other than the author.
4. Corrections and Amendments to Records
    a. When an error is made in a medical entry, the original entry should not be deleted; the original entry must still be accessible.
    b. The correction must indicate the reason for revision, be dated and signed and stamped by the person making the revision.
    c. Electronic amendments
        i. Add an addendum to the electronic document indicating the corrected information, the identity of the individual creating the addendum, and the electronic signature.
        ii. Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is found prior to signing (Wrong work type, wrong date).
        iii. Once a transcribed document is final it can only be corrected using an addendum affixed to the final copy.
        iv. Documents may need to be moved or re-created in the case of a wrong work type or indexed to the wrong Beneficiary record.
    d. Paper record amendments
        i. Do not place labels over the entry to correct the information.

ii. Draw a line through the incorrect entry and annotate the record with reason, date, and signature.
iii. If already scanned, reprint, make corrections and rescan the document.

e. Late Entries
i. Progress notes should be completed and locked within 72 hours of the encounter and no later.
ii. When an entry is not made in a timely manner or was missed, this can be corrected by identifying a "late entry".
iii. Enter current date and time. Identify the date/time of the original event or circumstance and create the note.
iv. An addendum is a kind of late entry that allows the author to provide additional information or corrections to original entries. These should be written as soon as possible after the original note.

D. Coding and Billing
1. The medical record should contain information that supports billing on insurance claim forms.
2. Training should be provided by the ACH Providers to ensure proper documentation and proper coding for reimbursement.
3. Each Provider is responsible for ensuring their facilities meet billing and coding requirements and ensure that the Health Insurance Portability and Accountability Act (HIPAA) standards for billing transactions are being met.

E. Completion, Timeliness and Authentication of Beneficiary Records As per 42 CFR § 482.24:
1. All medical record entries are to be dated, the time entered and signed in a timely manner or per law.
2. Parts of the medical record that are the responsibility of the physician must be authenticated in writing or electronic form by that physician.
3. Providers are to ensure the proper steps are taken to ensure Confidentiality, Integrity, and Availability CIA of PHI of medical records.

F. Quality performance will be reviewed by CMS using audits to validate data submitted by ACH related to the ACO REACH Model.

G. ACH has the right to request and perform audits of medical records and/or billing for its Participating and Preferred Providers.

H. In its evaluation of ACH and/or the ACO REACH program, CMS may request, audit and/or use data including medical records.

I. If an ACH Provider utilizes the Home Health Homebound Waiver Benefit Enhancement, the ACH Provider shall ensure that a completed and certified "Home Health Homebound Waiver Form" is maintained in the Beneficiary's medical records.

Reporting

A. N/A

Meeting Minutes

Effective Date: February 2023

Policy

It is the policy of the American Choice Healthcare (ACH) to provide guidelines for the taking of minutes for its Governing Body meetings and accurately document the discussions during and create a permanent record for all such meetings.

Applicability

This policy applies to American Choice HealthCare's Governing Body.

Procedure

A. The Secretary or designee of the Governing Body will take minutes during meetings to provide a practical means for conveying information about the issues discussed and the actions taken in a meeting.

B. The minutes format will include, but not be limited to:

1. Name of meeting;
2. Location, time, and date of the meeting;
3. Time Chairperson called meeting to order;
4. People in attendance and absent;
5. Existence of a quorum;
6. Motions made and by whom;
7. Summary of information disseminated and any resulting questions and answers;
8. Brief account of any debates;
9. Voting results;
10. Names of abstainers and dissenters;
11. Reports and documents introduced; and,
12. Future action steps.

C. Minutes of all items discussed will be accurately documented in reasonable detail. The minutes will reflect what was discussed during the meeting, either in chronological order or in a more coherent order, regardless of whether the meeting follows any written agenda.

D. If a formal motion is proposed, seconded, passed, or failed, then it is recorded. The voting tally may also be included, but is not required (e.g., a minute might read "After voting, the

Committee agreed to…"). It is preferable, but is not required, to include the name of the person who seconds a motion.

E. The assignment of a task to an individual is an important decision, and so all actions will be accurately recorded in the minutes.
F. The minutes shall end with a note of the time that the meeting was adjourned. It is preferable, but is not required, to include the name of the person (if any) who moves and seconds a motion to adjourn.
G. After the minutes are written, they will be circulated to the Governing Body members prior to the next meeting.
H. After receiving the minutes from the Secretary or designee, members should review the minutes and forward any mistakes or missing information to the Secretary or designee, who shall then update the minutes accordingly.
I. If minor corrections can be made prior to the next meeting, then approval of the minutes will be part of the agenda. Major corrections or changes should be addressed at the next meeting.
J. Once the minutes are approved by the Governing Body, the Secretary or designee shall permanently archive the document in the shared drive.

Reporting

A. Meeting Minutes are to be shared in the ACH shared drive once they have been approved.

Office of Inspector General (OIG)/General Services Administration (GSA) Exclusion Checks

Effective Date: November 2022

Policy

It is the policy of American Choice Healthcare (ACH) to ensure that Office of Inspector General (OIG)/General Services Administration (GSA) exclusion checks (hereinafter referred to as "OIG/GSA checks") are performed at the time of hire/contract execution and on a monthly basis thereafter for all Collaborative Health Systems (ACH) employees/contractors, American Choice Healthcare (ACH) Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Applicability

This policy and procedure applies to all ACH Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACH's activities.

Procedure

A. ACH performs an electronic OIG/GSA check at the time of hire/contract execution and monthly thereafter for:
    1. Preferred Participants
    2. Preferred Providers
    3. ACH Professionals
    4. ACH employees and contractors
B. ACH shall perform an electronic OIG/GSA check for individuals or entities that perform functions or services related to ACH activities. These checks are also conducted at the time of hire/contract execution and monthly thereafter.
C. ACH shall educate ACH Participant and Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities about the requirement to perform OIG/GSA checks upon hire and monthly thereafter.
    1. Upon request by ACH, a TIN shall need to produce proof that an exclusion screening has been performed within a specified time, to be determined at the time of the request.

D. To access the OIG/GSA Online Searchable Database, go to: https://oig.hhs.gov/exclusions/index.asp

Perform a Batch Review of the Database

Download the entire Excluded Individuals and Entities (LEIE) Database File to a local computer and run the check.

a. About the Updated LEIE (taken from LEIE Website):
   i. The updated LEIE is a complete database containing all exclusions currently in effect.
   ii. Individuals and entities who have been reinstated are not included in this file.
   iii. This file is replaced with an updated version each month. These monthly "supplement.exe" files can be saved to your computer. Then, you may extract the ".dbf" file into either a database program such as Microsoft access or a spreadsheet program such as Microsoft Excel.
b. This file is complete and should not be used in conjunction with the monthly exclusion and reinstatement supplements. If no record appears upon submission, then there is no report of fraud or abuse related to that person.
c. If the name being checked does appear, verify the name by the associated Social Security Number. If there is a match, the name must be reported through the appropriate chain of command within the organization.
d. Keep a monthly record of:
   i. The dates that the OIG/GSA checks are performed; and,
   ii. Evidence that the OIG/GSA checks are performed, such as the file or a screen shot.

E. If there is a match, the name of the individual must be reported as follows:
   1. ACH shall notify CMS within 15 days after becoming aware that a Participant or Preferred Provider is under investigation or has been sanctioned by the Government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges).
   2. Any positive exclusion check result must be reported to the Compliance Officer or their delegate for review and immediate action.

F. Ad hoc OIG/GSA checks may be performed at any time there is a significant incident that warrants investigation.

Reporting

A. An OIG/GSA report will be sent to the Governing Body when issues are identified, and escalation is needed.

Oversight of Marketing Materials

Effective Date: April 2023

Policy

It is the policy of the American Choice Healthcare (ACH) to ensure that direct and online Marketing Materials and Activities used to educate, solicit, notify, and/or contact Beneficiaries or Providers adhere to CMS regulations.

Applicability

This policy and procedure applies to all ACH Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. ACH shall conduct, and shall require its Providers, Professionals and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to conduct Marketing Activities, including Voluntary Alignment Activities in accordance with Article V and Appendix C of the Participation Agreement.

B. Requests for Materials used by ACH Provider and/or for Beneficiaries shall be sent to compliance@americanchoicehealthcare.com.

   1. Upon approval, the Marketing and Communications departments will create the appropriate Materials.

C. Materials must go through Marketing, Brand, and Compliance for review and approval to ensure that CMS regulations, federal laws, and organizational guidelines, are met.

D. To ensure that Beneficiaries are not misinformed or misled about the Model, CMS may develop and provide template language for certain Marketing Materials. ACH shall use any template language for Marketing Materials provided by CMS.

E. If no CMS developed template language is available, to the extent possible, plain language that adheres to Federal Plain Language Guidelines will be used for Materials.

F. Materials will be clear, concise, well organized, and follow best practices appropriate to the subject or field and intended audience.

G. Materials will not be inaccurate, misleading, or discriminatory.

H. In using Marketing Materials and conducting Marketing Activities, the ACO shall not, and shall require its Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities not to do any of the following:

1. Engage in activities that could mislead or confuse a Beneficiary regarding the Model, another model currently tested or under development by CMS under the authority of section 1115A of the Act, the Medicare Shared Savings Program, Medicare benefits, or the ACO; or
2. Claim the ACO is recommended or otherwise endorsed by CMS or that CMS recommends that the Beneficiary select a Participant Provider as his or her main doctor, main provider, and/or the main place the Beneficiary receives care; or
3. Expressly state or imply that selecting a Participant Provider as the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary receives care removes a Beneficiary's freedom to choose to obtain health services from providers and suppliers who are not Participant Providers or Preferred Providers.

I. Materials will not be used in a discriminatory manner or for a discriminatory purpose (e.g., to avoid at-risk Beneficiaries).

J. ACH will translate Marketing Materials into any non-English language that is the primary language of at least 5 percent of REACH Beneficiaries.

K. All Materials must be reviewed and approved by Compliance prior to use to ensure compliance with all requirements, including those specified in the ACO REACH Agreement released by CMS.

L. Descriptive Materials and Activities must be reviewed and filed with CMS per the ten (10) day file & use approval submission requirements.
    1. Determination of applicability of CMS file & use requirements will be made by Compliance and Compliance will be responsible for submitting any Materials to CMS in accordance with the ACO REACH Model Descriptive Materials and Activities Guidance released by CMS.
    2. Materials submitted to CMS are deemed approved ten (10) business days following their submission to CMS if:
        i. ACH certifies Compliance with all applicable requirements under the ACO REACH Model Participation Agreement Section 5.04 and, if the ACO has selected to participate in SVA, Appendix C of the Agreement; and
        ii. CMS does not disapprove the Marketing Materials or Marketing Activities.
    3. CMS may disapprove Materials at any time, including after the expiration of the initial ten (10) day review period.
    4. If a Material that was deemed approved is later disapproved by CMS, ACH must discontinue use of the Material.
    5. Any material changes to CMS-approved materials must be reviewed and resubmitted by CMS before use.
    6. ACH will retain copies of all written and electronic Marketing Materials and appropriate records for all Marketing Activities in a manner consistent with under the ACO REACH Model Participation Agreement Section 16.02.

M. CMS approval must be obtained for the publication or release of any press release, external report or statistical/analytical material that materially and substantially references ACH's participation in the Model or financial arrangement with CMS. External reports and statistical/analytical material may include, but are not limited to paper, articles, professional publications, speeches, and testimony.
    1. All external reports and statistical/analytical materials must include the following statement on the first page: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

N. ACH may provide materials in languages other than English. In the event that the English version of these materials were submitted to CMS for approval, ACH will attest that the foreign language versions are accurate translations of the CMS approved materials. CMS does not provide distinct approval of translated materials.

O. Materials will not offer gifts, cash, or other remuneration as inducements for:
    1. Receiving items or services from any ACH Provider, or ACH Professional; or,
    2. Remaining with an ACH Provider, or ACH Professional in particular.
    3. Aligning with a specific Provider or Facility

Reporting

A. Compliance is to ensure Materials and activities do not violate ACO REACH Model Participation Agreement.

Personal/Appointed Representatives of Individuals

Effective Date: April 2023

Policy

It is the policy of American Choice Healthcare (ACH) to ensure ACH Providers treat an individual's personal/appointed representative as with respect to the Protected Health Information (PHI) of the individual. As per 45 CFR 164.502(g) The personal/appointed representative of an individual is a person who, under applicable state law, has the authority to act on behalf of the individual in making decisions related to health care.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Providers, and ACH Professionals performing functions or services related to the ACO's activities.

Procedure

A. ACH Providers may use or disclose an individual's PHI based on a written authorization from that individual.
    1. ACH Providers must obtain written documentation of a person's authority under applicable state law to act as the individual's personal representative before allowing the person to act as the individual's personal representative in connection with the use or disclosure of the individual's PHI.
    2. ACH Providers shall maintain the written documentation of a person's authority to act as the individual's personal representative in that individual's record. ACH Providers shall also maintain the personal representative's name, address, telephone number and relationship to the individual in the individual's record.

B. Different categories of personal representatives hold different obligations and responsibilities.
    1. A Power of Attorney is the most robust of the personal representative forms. This would permit the power of attorney to effectuate any action on matters the Beneficiary normally would. The formats for these vary and are usually drawn up by a Beneficiary with their legal counsel.
    2. A Third-Party Authorization permits another to receive information on behalf of the Beneficiary. This third party may only receive information and cannot effectuate any changes to the Beneficiary's record.
    3. An Appointment of Representative Form/CMS 1696 allows a Beneficiary to exercise his or her right only to an initial determination or appeal and to appoint a representative to act on the Beneficiary's behalf.

C. Procedures for Certain Categories of Individuals:

1. Adults
    a. If the individual is an adult, Providers will treat a person who has authority under applicable state law to act on behalf of the individual in making decisions related to health care as such individual's personal representative with respect to PHI relevant to such personal representation.
2. Deceased Individuals
    a. If under applicable law an executor, administrator, or other person has authority to act on behalf of a deceased individual or the individual's estate, Providers will treat such person as a personal representative with respect to PHI relevant to such personal representation.
    b. Providers may disclose a deceased individual's information to family members and others who were involved in the care or payment for care of the individual prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the covered entity.
3. Abuse, Neglect, Endangerment Situations
    a. Notwithstanding state law or any requirement of this policy to the contrary, ACH Providers may elect not to treat a person as the personal representative of an individual if:
        i. The ACH Provider has a reasonable belief that:
            a. The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or,
            b. Treating such person as the personal representative could endanger the individual.
        ii. ACH Providers, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

Reporting

A. N/A

Beneficiary Data Sharing

Effective Date: April 2023

Policy

It is the policy of the American Choice Healthcare (ACH) to provide guidelines for the secure sharing of Beneficiary identifiable data among CMS, ACH Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities. The Beneficiary's identifiable data is shared by CMS on the condition that all care coordination activities, and those involved in such activities, observe the relevant statutory and regulatory provisions of use, including confidentiality and privacy, and comply with the data use agreement.

These guidelines are in accordance with 45 CFS § 164.530(c) and the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act and a level and scope of security that is not less than the level and scope of security requirements established for federal agencies by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix I--Responsibilities for Protecting and Managing Federal Information Resources.

Applicability

This policy and procedure applies to all ACH Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACH's activities.

Procedure

A. Providers, Professionals, and other individuals or entities performing functions or services related to its activities shall take reasonable steps to limit the use or disclosure of, and requests for, protected health information (PHI) to the minimum necessary to accomplish a permitted use of the data.

B. Providers and other individuals or entities performing functions or services related to its activities will preserve Beneficiary confidentiality, including protecting the confidentiality of Beneficiaries' health and medical records. Strict adherence to this policy to protect the confidentiality of PHI from improper or illegal use or disclosure shall be enforced.

C. Compliance shall ensure Policies and Procedures are in place to identify and report any breach of PHI or PII, and risks associated with potential noncompliance with the privacy and security mandates of federal regulations, including but not limited to the ACO REACH Model

Participation Agreement, the Data Use Agreement between CMS and ACH, the Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

D. Any documentation that contains PHI should be sent using secure means:
    1. Mailings should be sent via a trackable method and include return service postage, sealed envelopes and only the minimum necessary addressee information shown on any outer envelopes.
    2. All emails containing confidential information must be sent via secure email.
    3. Documents sent by fax to external sources must include a cover sheet identifying the confidentiality of the information, and are sent to a single, verified fax number.

E. **Data privacy and security, and Beneficiary Rights regarding Data Sharing**
    1. All records, documents and any other information containing PHI should be kept in a secure location according to applicable regulations.
    2. Electronic medical records will follow HITECH standards for PHI protection.
    3. Claims data is provided by CMS for the purpose of:
        a. Evaluating performance of Providers
        b. Conducting quality assessment and improvement activities; and,
        c. Improving the health and quality of care for the Beneficiaries.
    4. Providers should provide Beneficiaries who inquire about or wish to modify their preferences regarding claims data sharing for care coordination and quality improvement purposes with information about how to modify their data sharing preferences via 1-800-MEDICARE.
        a. Such communications shall note that, even if a Beneficiary has elected to decline claims data sharing, CMS may still engage in certain limited data sharing for care coordination and quality improvement activities for REACH Beneficiaries, and population-based activities relating to improving health or reducing health care costs.
    5. CMS will maintain the data sharing preferences of Beneficiaries who elect to decline data sharing in this Model or who have previously declined data sharing under the Medicare Shared Savings Program, ACO Model, or the Next Generation ACO Model.
    6. Providers may affirmatively contact a REACH Beneficiary who has elected to decline claims data sharing no more than one time during a Performance Year to provide information regarding data sharing. Such contact includes mailings, phone calls, electronic communications, or other methods of communicating with Beneficiaries outside of a clinical setting.

7. In the event that a Provider is terminated from the ACO REACH MODEL for any reason, if that departing Provider is the sole Provider in the ACO to have submitted claims for a particular Beneficiary during the 12-month period prior to the effective date of the termination, CMS will administratively opt the Beneficiary out of all claims data-sharing within 30 Days of the effective date of the termination, unless the Beneficiary has selected another ACO Professional as his or her main doctor, main provider, and/or main place they receive care (whether through MVA or SVA) or has become the patient of another Participating Provider or Preferred Provider.
8. Notwithstanding the foregoing, if CMS elects to offer substance use disorder (SUD) data sharing ACH will receive claims data regarding SUD treatment only if the Beneficiary has not elected to decline data sharing or otherwise been opted out of data sharing and has also submitted a CMS-approved SUD opt in form.

F. **Aggregate Reports**

1. CMS will initially aggregate metrics on AHC's-assigned Beneficiary population based on historical claims data.
2. CMS will utilize the historical claims data to calculate a benchmark.
3. ACH may receive data from CMS for the purposes of improving Beneficiary health, reducing growth in healthcare costs, improving care coordination and process improvement initiatives.
4. Any use of CMS data in the creation of any document concerning the purposes specified in this policy and the CMS HIPAA-Covered Data Disclosure Request Form must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer Beneficiaries may be displayed. Also, no percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer Beneficiaries. A cell that represents or uses percentages or other mathematical formulas to represent zero Beneficiaries may be displayed.

G. **Patient Identifiable Data**

1. Under the ACO REACH Participation Agreement, CMS may provide certain data and report request by ACH.
2. ACH represents and warrants that the use of data received from CMS will be used solely for care management, care coordination, and quality improvement activities for REACH Beneficiaries, population-based activities relating to improving health or reducing health care costs, and such other purposes described in the Agreement.

3. ACH will disclose, use, and reuse the data only as specified in the ACO REACH Performance Agreement or as CMS shall authorize in writing or as otherwise required by law, and not for any other purpose, including but not limited to conducting communications or activities related to Medicare Advantage or any other Medicare managed care plan.
4. ACH further agrees not to sell, rent, lease, loan, or otherwise grant access to the data covered by the ACO REACH Performance Agreement.
5. Information derived from the CMS data and requested via the HIPAA-Covered Data Disclosure Request Form may be shared and used within the legal confines of ACH and its Participating Providers and Preferred Providers to enable ACH to improve care integration and be a patient-centered organization.
6. ACH may reuse original or derivative data without prior written authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, population-based activities relating to improving health or reducing health care costs, and provider incentive design and implementation, but shall not disseminate (unless required by law) any individually identifiable original or derived information and requested via the HIPAA-Covered Data Disclosure Request Form to anyone who is not a HIPAA CE, a HIPAA BA, an individual practitioner in a treatment relationship with the subject Beneficiary(ies), or that practitioner's business associates.
7. When using or disclosing PHI or personally identifiable information ("PII"), obtained from data requested via the HIPAA-Covered Data Disclosure Request Form, ACH must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure, or request.
8. ACH will limit its disclosure of such information to the types of disclosures that CMS itself would be permitted to make under the "routine uses" in the applicable systems of records listed in the HIPAA-Covered Data Disclosure Request Form.
9. Subject to the limits specified above and elsewhere in the Agreement and applicable law, ACH Providers may link individually identifiable data requested via the HIPAA-Covered Data Disclosure Request Form (including directly or indirectly identifiable data) or derivative data to other sources of individually identifiable health information, such as other medical records available to ACH and its Participating Providers or Preferred Providers.
10. ACH may disseminate such data that has been linked to other sources of individually identifiable health information provided such data has been deidentified in accordance with HIPAA requirements in 45 CFR 164.514(b).

11. ACH's process for Data Sharing must ensure that unique Beneficiary identifiers and claims data is limited to only necessary data and that management, efficiency and quality of care improvement activities will be applied uniformly to all Beneficiaries.
12. Data will not be used to reduce, limit, or restrict appropriate care for individual Beneficiaries.
13. ACH Providers, Professionals, or other individuals or entities performing functions or services related to it's activities shall report within one hour any breach of PHI or PII from or derived from the CMS data files, loss of these data or improper use or disclosure of such data to ACH and the CMS Action Desk by telephone at (410) 786-2580 or by email notification at cms_it_service_desk@cms.hhs.gov. Furthermore, ACH shall cooperate fully in any federal incident security process that results from such improper use or disclosure.

H. Evaluate Performance of Participating and Providers:
    1. Historical claims data will enable ACH to develop outcomes-based benchmarks from which performance patterns for utilization and spending for the assigned population can be measured against specific improvement goals.
    2. Non-compliance with ACH policies or the ACO REACH Participation Agreement by a Provider, Professional, or other individual or entity providing functions or services related to ACH's activities shall be reported using ACHs Ethics and Compliance Hotline. There are two ways to report:
        a. Web Form: http://ach.ethicspoint.com
        b. Telephone Line: 1- 833-996-3912
    3. Providers, Professionals and other individual or entities providing functions or services related the ACO REACH Participation Agreement are to meet all privacy and security standards and regulations in their facilities and ensure privacy with use of any electronic devices where PHI might reside.

Reporting

A. Compliance is to maintain record of any reported incidents, remediation, and document any notices sent via mail.
B. Compliance shall ensure Policies and Procedures are in place and accessible to Providers to identify and report any risks or of PHI or PII and risks associated with potential non-compliance with the privacy and security.

Privacy Breach Response Plan

Effective Date: December 2022

Policy

It is the policy of American Choice Healthcare (ACH) to respond to any potential privacy breach quickly and effectively, and, to the extent practicable, minimize any harmful effect that is known or a disclosure of Protected Health Information (PHI) in violation of ACH's HIPAA Privacy policies and procedures or the requirements of 42 C.F.R. Part 164, Subpart E by either American Choice Healthcare (ACH) Participants, Preferred Providers, ACH Professionals, or any other individuals or entities performing functions or services related to ACH's activities (hereinafter referred to as "Business Associates").

Applicability

This policy and procedure applies to all ACH Participants, Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACH's activities

Procedure

A. Information regarding any suspected or expected breach of PHI by an ACH Participant or Preferred Provider or any of its Business Associates discovered by any individual or entity shall be reported no later than twenty-four (24) hours after discovery using ACH's Compliance Hotline.
   - There are two ways to report Non-Compliance using Compliance hotline:
     a. Web Form: http://ach.ethicspoint.com
     b. Telephone Line: U.S. 833-996-3912
   - The hotline should be used if one prefers to place an anonymous report in confidence, you are encouraged to use this hotline, hosted by a third-party hotline provider.
   - Corrective action will be taken as necessary to ensure compliance with the Code of Conduct.

B. The Compliance Dept. will contact those who are relevant to the report.
   - The contacted group, in response to such reports, including self-disclosures made by the Business Associates pursuant to the terms of each Business Associate's contract or

other agreement with ACH or its Participant or Preferred Providers, shall develop and implement a plan as soon as reasonably practicable to mitigate any known or reasonably anticipated harmful effects of such act.

a. Examples of immediate actions which may need to be considered are:
    i. Shutting down accesses or systems which may be vulnerable.
    ii. Shutting down public access to web pages where information is found.
    iii. Contacting the recipient of the information that was disclosed and instructing such recipient to either destroy or return the information and to make no further use or disclosure of such information.

- If necessary, the Compliance Officer will contact Counsel to help analyze the situation.
- Once the incident has been contained, the contacted group will discuss and perform a risk assessment to determine whether a Reportable Breach has occurred. This assessment will include:
    a. Whether there has been impermissible access, use or disclosure of PHI;
    b. Who impermissibly accessed, used or received PHI and to whom the PHI was potentially disclosed, if applicable;
    c. Whether the PHI involved in the incident was Unsecured PHI;
    d. The type and amount of PHI involved; and,
    e. What steps have been taken (or should be taken) to mitigate risk.

C. If it is determined that a Reportable Breach has occurred, the Compliance department may determine it is necessary to contact outside Counsel.

- The breach should be reported to appropriate State and Federal entities, as required.
    a. Reporting to the Office of Civil Rights:
        i. If less than 500 individuals are impacted, the disclosure shall be logged with the OCR at http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html not later than 60 days after the end of the calendar year.
        ii. If more than 500 individuals are impacted, the disclosure must be logged with the OCR at http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html within 60 days of the discovery and a press release issued to the media in the state impacted.
    b. Reporting to CMS
        i. The update to the Medicare Regional Office Account Manager will include:
            - If the Office of Civil Rights was notified, a copy of the breach

report is provided to the Office of Civil Rights.

- If the Office of Civil Rights was not notified yet, the notice to the Medicare Regional Office Account Manager should include an account of the breach with as much information as possible.
- The number of Beneficiaries impacted.
- Any actions being taken to mitigate the risk to the Beneficiaries.

D. Compliance, in conjunction with the other relevant business areas, will determine what steps are required to mitigate the situation, including offering credit monitoring for affected individuals.

E. Compliance will prepare a Notice Letter to Beneficiaries, as required.

- Individual Notifications will be made without unreasonable delay, but in no event more than 60 days from the date of discovery of the Reportable Breach. ACH may delay notifications if a delay is requested by a law enforcement official.
- Notice must be provided through a press release to prominent media in the state of the disclosure if more than 500 individuals of a state are impacted.
- Notifications will be written in plain language, at an appropriate reading level, and must include the following information:
    a. A brief description of what happened, including the date of the Reportable Breach and the date of discovery of the breach, if known;
    b. A description of the types of Unsecured PHI that were involved in the Reportable Breach;
    c. Any steps individuals should take to protect themselves from potential harm resulting from the Reportable Breach;
    d. A brief description of ACH's efforts to investigate the breach, mitigate harm to individuals, and protect against further Reportable Breaches; and,
    e. Contact information for individuals to ask questions or learn information about the Reportable Breach, which must include a toll-free telephone number, an email address, website, or postal address.
- Notices should be sent via certified mail, return receipt, and should also be tracked and documented.

F. The Compliance Officer will follow up to determine whether changes to ACHs Privacy Policies, disciplinary action, or additional training are necessary to prevent further incidents.

Reporting

A. Reporting may be required under State and Federal Laws.

B. Compliance is to maintain record of any reported incidents, remediation, and document any notices sent via mail.

Public Reporting

Effective Date: April 2024

Policy

It is the policy of American Choice Healthcare (ACH) to promote transparency within the ACH Model by ensuring compliance with all Public Reporting requirements put in place by CMS and the ACO REACH Model Participating Agreement signed by ACH.

Applicability

This policy and procedure applies to all ACH Participant and Preferred Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACH's activities.

Procedure

A. ACH will maintain a publicly accessible website, which discloses participation in the model. The website will be reviewed and updated as necessary to ensure information posted on the website is accurate and current. The website will include reporting of, at a minimum, the following:

1. Organizational information, including:
    a. Name and location of ACH;
    b. Primary contact information for ACH;
    c. Identification of active Participants and Preferred Providers;
    d. Identification of a joint ventures between or among ACH and any of its Participants and Preferred Providers;
    e. Identification of clinical and administrative leaders and the name of any company by which they are employed; and
    f. Identification of members of the Board of Managers and the name of any entity by which they are employed.
    g. Identify downstream participants.
2. Shared Savings and Shared Losses information, including:
    a. The amount of any Shared Savings or Shared Losses for any Performance Year;
    b. The proportion of Shared Savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for Beneficiaries; and
    c. The proportion of Shared Savings distributed to Participants and Preferred Providers.
3. ACH's performance on the quality measures, as listed in Appendix A of the ACH Participant and Preferred Provider Agreements.

B. ACH's website will be considered a Marketing Material for purposes of internal compliance review. All changes must be submitted to Compliance for review and approval prior to use on the website, except:
    1. Operations may update the list of ACO REACH Providers as needed without submitting those changes for approval.
C. The Senior Director of Operations will be responsible for maintaining the website and ensuring all public information is updated in a timely manner.
    1. The Senior Director of National Contracting and/or Contracting Department will communicate changes made to the list of ACO REACH Providers on a monthly basis.
    2. Updates to the website are to be done within 30 calendar days
    3. For purposes of:
        a. Adding an ACH Participant or Preferred Provider, the effective date will be the date in the 4i platform;
        b. Termination of the individual or entity will be effective on the date when the individual or entity's;
            i. Agreement with ACH to participate in the Model is terminated, or
            ii. If the Provider advises ACH that the individual should no longer be in the Program
            iii. If the provider discontinues billing for items and services to beneficiaries under a Medicare plan.

Reporting

A. Quarterly audits of the ACH website shall be performed to ensure that information is accurate as per the requirements in this policy.

Record Retention Requirements

Effective Date: April 2023

Policy

It is the policy of the American Choice Healthcare (ACH) to comply with relevant federal and state regulations governing document retention. This will include, but is not limited to, the ACO REACH Participation Agreement between CMS and ACH and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Applicability

This policy and procedure applies to all ACH Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACO REACH MODEL Participation Agreement activities.

Procedure

A. ACH Providers will:

1. Maintain and give CMS, the Department of Health and Human Services (DHHS), the Comptroller General, the Federal Government or their designees access to all books, contracts, records, documents, Beneficiary charts/medical records, and other evidence (including data related to Medicare utilization and costs, quality performance measures, and other financial arrangements related to the ACO REACH Model activities) sufficient to enable the ACO REACH Model Participation Agreement, the quality of services performed, right to and distribution of any shared savings payment, Cost-Sharing Support Arrangements with Participating Providers and Preferred Providers, records regarding the Chronic Disease Management Reward Beneficiary Engagement Incentive and other similar programs (if applicable), or obligation to repay any Shared Losses or Other Monies Owed to CMS;
2. Maintain such books, contracts, records, documents, and other evidence for a period of 10 years from the expiration or termination of the ACO REACH Model Participation Agreement between ACH and CMS, or from the date of completion of any audit, evaluation, inspection, or investigation whichever is later, unless:

a. CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies ACH at least 30 days before the normal disposition date; or,

b. There has been a termination, dispute, or allegation of fraud or similar fault against ACH, its Providers, Professionals or other individuals or entities performing functions or services related to ACH's activities, in which case ACH must retain records for an additional 6 years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

3. The data sources disclosed to ACH Providers pursuant to the HIPAA-Covered Data Disclosure Request Form may be retained by the Provider until 30 Days after the completion of Final Financial Settlement for the final Performance Year of the Agreement Performance Period, except as CMS shall authorize in writing or as otherwise required by law.
4. Providers are permitted to retain any individually identifiable health information from such data sources or derivative data after the expiration or termination of the Agreement if the Provider is a HIPAA CE, and the data has been incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. Furthermore, any HIPAA CE to whom an ACH Provider gives such data in the course of carrying out the Model may also retain such data if the recipient entity is a HIPAA CE or BA, and the data is incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA.
5. Providers will assign a designee to destroy all other data and send written certification of the destruction of the data sources and/or any derivative data to CMS within 30 Days of completion of Final Financial Settlement for the final Performance Year of the Agreement Performance Period, except as CMS shall authorize in writing or as otherwise required by law.
6. CMS may require the Provider to destroy all data and send written certification of the destruction of data files and/or any derivative data files to CMS at any time if CMS determines it necessary due to a program integrity concern.
7. Except for disclosures for treatment purposes, providers shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this paragraph.
8. These retention provisions survive the expiration or termination of the Agreement.

B. ACH requires all Providers, Professionals and other individuals or entities performing functions or services related to the ACO activities or Marketing Activities to comply with the sections above.
C. Documents that are no longer in use will be appropriately archived by the ACH Provider in a manner consistent with their record-keeping practices and prevailing regulatory guidelines.
D. Archived files are retained for a period of ten (10) years from the end date of an ACO REACH contract or the completion date of an audit, whichever is later, in accordance with the ACO REACH Model Participation Agreement.

Reporting

A. N/A

Reporting Probable Violations of Law

Effective Date: December 2022

Policy

It is the policy of American Choice Healthcare (ACH) to report any probable violations of law to an appropriate law enforcement agency, and to ensure that no individual will be discriminated against or be subject to any reprisal for Good Faith reporting.

Applicability

This policy and procedure applies to all ACH (American Choice Healthcare) Participants, Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Any individual who, in Good Faith, knows of, or suspects, any instance of probably violation(s) of law must immediately report it using any of the following:
    1. There are two ways to report Non-Compliance using Compliance hotline:
        a. Web Form: http://ach.ethicspoint.com
        b. **Telephone Line: 1-833-996-3912**
    2. The hotline should be used if one prefers to place an anonymous report in confidence, you are encouraged to use this hotline, hosted by a third-party hotline provider.
    3. Corrective action will be taken as necessary to ensure compliance with the Code of Conduct.

B. Upon the finding of credible evidence to support a report of non-compliance the Compliance Officer shall cause appropriate action to occur immediately, and in no event later than sixty (60) calendar days after a Determination is made.

C. Credible probable violations of law will be brought to the attention of the Governing Body, as necessary.

D. If any reported probable violation of law involving a person who is also a director or executive officer is, after preliminary examination and investigation by the Compliance Officer, determined to have merit, the Compliance Officer shall immediately refer the matter to the Governing Body for full investigation and determination of proper response.

E. Any violation that is deemed by the Compliance Officer and General Counsel to be a probable violation of law will be reported to an appropriate law enforcement agency.

F. ACH will report any probable violation of law to an appropriate law enforcement agency considering and including, as appropriate, the following:

1. A statement noting that the ACO is required to report violations and probable violations to an appropriate law enforcement agency
2. A description of how compliance issues are analyzed to determine whether they may be "probably violations of law"
3. A description of the ACO's process for reporting probably violations of law to a law enforcement agency, including the steps the ACO should take to self-report violations to an appropriate government authority or law enforcement agency and the individuals responsible for self-reporting.
4. Details on the roles and responsibilities that clearly state that the compliance official has the authority to report misconduct to CMS, its designee, and law enforcement.

G. **Investigation Procedure**

1. The Compliance Officer and/or General Counsel may act as Investigator or assign a designee to perform such investigation. The Investigator compiles all investigation notes.
2. Once the investigation is concluded, the Investigator reviews the case with the Compliance Officer and/or General Counsel.
3. The Compliance Officer or General Counsel makes a Determination:
    a. if the Determination is Unsubstantiated or Inconclusive, the case will be closed
    b. If the Determination is Substantiated, the Compliance Officer or General Counsel makes recommendations for action, including but not limited to the following:
        i. Immediate reporting to CMS of the non-compliance together with a written Corrective Action Plan;
        ii. Immediate reporting to a law enforcement agency, disciplinary action of a person or persons, up to and including termination; and,
        iii. Additional training and education for the operational departments affected by the non-compliance.
    c. When appropriate, Substantiated Determinations are reviewed with Compliance Officer and/or General Counsel for preparation of a Compliance Issues Investigation Report to be made to the appropriate governmental authority and, if required, law enforcement agency, including but not limited to the Office of Inspector General.
    d. The Investigator and Compliance Officer or General Counsel shall recommend operational process improvements and/or other necessary corrective actions to

the senior most managers of the operations department affected by the non-compliance as appropriate.

4. The privileges of the attorney-client communication and the attorney work product, as well as the privileges available under the federal and state constitutions, statutes and common law, may attach to certain information, documents and communications or other information related to investigations of suspected violations.
    a. Nothing in this policy shall be construed to be a waiver of these privileges or to require production of materials protected by such privilege and/or doctrine.

Reporting

A. Reports of probable violation of law will be provided to the Governing Body, CMS, and governmental authorities, as appropriate.
B. Compliance is to maintain record and track all non-compliance issues reported. Information will be reported quarterly to the governing body, as appropriate.

Annual Compliance Training

Effective Date: February 2023

Policy

It is the policy of American Choice Healthcare (ACH) to maintain an effective compliance training program that includes formal educational sessions, informal e-mail communications or ad hoc training based on identified risks.

Applicability

This policy and procedure applies to all ACH (American Choice Healthcare) Participant Providers, Preferred Providers, Professionals, and other individuals or entities performing functions or services related to the ACH's activities.

Procedure

A. **Compliance Training**

1. ACH encourages that Compliance training should be performed upon hire or within 90 days of the effective date of contracting, and at least annually thereafter.
    a. ACH Compliance Trainings should happen between January and march by all Participant and Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to ACH's ACO REACH activities.
2. Any changes in rules or regulations will be communicated to the ACH Participant Providers, ACH Preferred Providers, ACH Professionals and other individuals or entities performing functions or services related to the ACH's activities as outlined by Compliance through written notifications.
    a. Such changes in rules or regulations may necessitate additional training.

B. **Distribution of Compliance Training**

1. The ACH Compliance Committee, or designee, will give final approval on training content to ensure all relevant information is covered.
2. <u>Participant and Preferred Provider Training Process</u>
    a. ACH Marketing team will distribute the approved ACH Compliance training via email blast from Constant Contact.
        i. ACH Marketing team will communicate with ACH Compliance team on the email engagement

- If email is opened, ACH Participant and Preferred Providers are attesting to reading understanding the training material and training all existing and newly hired employees within 90 days from effective date.

3. ACH Participant and Preferred Providers, or designees will be responsible for ensuring all required individuals complete the training.
4. Post Training Paperwork:
   a. ACH will be responsible for maintaining training records. Records will be kept for a minimum of 10 years.
   b. The records to maintain include e-mails distributing the ACH Compliance Training. The records may be maintained in online storage.

Reporting

A. Compliance will report to the Governing Body on training progress when appropriate.

Non-Intimidation & Non-Retaliation

Effective Date: June 2023

Policy

It is the policy of the American Choice Healthcare (ACH) to ensure that a Compliance Program exists and includes a practice on non-intimidation and non-retaliation for good faith reporting of compliance concerns.

Applicability

This policy and procedure applies to all ACH Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACO's activities.

Procedure

A. All ACH Providers, ACH Professionals and other individuals or entities performing functions or services related to the ACH's activities, shall have an affirmative duty to report all potential incidents of non-compliance using the Compliance Hotline
   - This hotline allows for anonymous reporting. Reports of wrongdoing may be made orally or in writing.

B. There are two ways to report:
   - Web Form: http://ach.ethicspoint.com
   - Telephone Line: 1- 833-996-3912

C. Any individual reporting potential non-compliance in good faith shall not be subject to any intimidation or retaliation. Intimidation or retaliation against anyone who raises a concern or makes a report will not be tolerated.
   - This should be reported through the ACH Compliance Hotline.

D. Training on the Non-Intimidation & Non-Retaliation Policy will be provided upon hire and annually thereafter.

Reporting

A. Issue reports are provided on a quarterly basis to the Governing Body, as appropriate.

Reporting a Provider Under Investigation to CMS

Effective Date: June 2023

Policy

It is the policy of the American Choice Healthcare (ACH) to notify CMS within 15 Days after becoming aware that any ACH Provider is under investigation or has been sanctioned by the government or any licensing authority.

Applicability

This policy and procedure applies to all ACH Providers, ACH Professionals, and other individuals or entities performing functions or services related to the ACO's activities.

Procedure

A. ACH Providers
   1. Direct Contracting defines categories of Medicare providers and suppliers based on their respective relationships to ACH.
   2. The two primary categories are ACH Participant Providers and Preferred Providers.
   3. ACH Participant Providers are the core providers and suppliers in Professional and Global.
      - Beneficiaries are aligned to ACH through the ACH Participant Providers and these providers are responsible for, among other things, reporting quality through ACH and committing to beneficiary care improvement.
   4. Preferred Providers contribute to ACH's goals by extending and facilitating valuable care relationships.
   5. Each provider that intends to enter into an agreement with ACH as an ACH Participant Provider or Preferred Provider must be a Medicare-enrolled provider.

B. Monitoring and Oversight
   1. To ensure that no beneficiary is harmed or that the integrity of the Participation Agreement is not negatively impacted, ACH is required to monitor compliance with the terms of the model and to comply with rigorous safeguards that are specified in the participation agreement.
   2. Under the terms of the Participation Agreement, ACH will be required to, among other things:
      a. Report probable violations of law immediately to an appropriate law enforcement agency.

b. Report to CMS, within 15 days after becoming aware that any ACH Participant Provider or Preferred Provider is under investigation or has been sanctioned by the government or any licensing authority.

3. ACH Participant Providers and Preferred Providers have an obligation to promptly, but no later than 7 days of discovery, notify ACH in writing if Provider is under investigation or has been sanctioned by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges).
   a. This requirement is outlined in section 3.04, letter G12 page 24 of the Participation Agreement.
4. As outlined in the ACH Compliance Plan, All ACH Members, personnel, preferred and participating providers have a duty to report any violations of law or other wrongdoing through the Company's Ethics & Compliance Hotline.
5. There are two ways to report Non-Compliance using Compliance hotline:
   a. Web Form: http://ach.ethicspoint.com
   b. Telephone Line: 1-833-996-3912
6. Reports received will be promptly responded to and if warranted, investigated.

C. Reporting to CMS
1. Following receipt of a notification of any AC Participant Provider or Preferred Provider that is under investigation or has been sanctioned by the government or any licensing authority, ACH shall promptly, within 15 days, report to CMS.
2. The Compliance Officer, or Designee for ACH shall be responsible for making the report.
3. As per the agreement, any Provider found to be sanctioned or excluded and a result of an investigation, shall have the agreement with ACH terminated.

Reporting

A. Reports of non-compliance and violations will be provided to the Governing Body, CMS, and governmental authorities, as appropriate.

Compliance Audit Plan

Effective Date: June 2023

Policy

It is the policy of American Choice Healthcare (ACH) Compliance Department to develop an audit plan designed to evaluate and guarantee all ACO REACH Model Participation Agreement requirements and CMS guidelines are being met and adhered to.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Compliance is to develop the audit plan document that includes the frequency, timing, and status of items being audited.

B. Plan must cover the following areas:
   - Governance
   - Compliance
   - Data & Reporting Compliance/HIPAA
   - Beneficiary Notifications
   - Marketing
   - Voluntary Alignment
   - ACH Publicly Accessible Website
   - Beneficiary Data sharing
   - Providers & Provider Contracting
   - Financial Guarantee
   - Policies and Procedures

C. Compliance will perform the audits, follow-up and report all findings to the Compliance Committee and Governing board as needed.
   - A written report will be prepared with findings and corrections that need to be made.

D. Documentation of audit results are to be maintained in the ACO reach Shared folder.

E. ACH's Compliance Plan Audit will be updated as needed, and on a yearly basis.

Reporting

A. Any non-compliance must be communicated in a timely manner.
B. Compliance is to maintain Audit Plan and results up-to-date and stored in the ACO shared drive.

Notices to Proposed Providers and TINs

Effective Date: June 2023

Policy

It is the policy of American Choice Healthcare (ACH) to set guidelines and standards on how to send and document notices to those individuals and entities identified on the Proposed Revised Participant and Preferred Provider List, and to the executive of any TIN through which such individuals or entities bill Medicare, in accordance with the ACO REACH Participation Agreement **Article IV section 4.05.**

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Providers, Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Notice Letters are not to be altered in any way after they have been reviewed by Legal and Compliance.
   1. ACH Notice to Proposed Participant Providers
      i. By a date specified by CMS, ACH shall furnish written notification to each NPI individual or entity to which ACH wishes to include on their Proposed Revised Participant List for the following pay year. Such notice shall include items listed on the ACO REACH Participation Agreement **Article IV section 4.05 A.**
   2. ACH Notice to Proposed Preferred Providers
      i. By a date specified by CMS, the ACH shall furnish written notification to each individual or entity the ACO wishes to include on the Proposed Revised Preferred Provider List. Such notice shall include items listed on the ACO REACH Participation Agreement **Article IV section 4.05 B.**
   3. ACH Notice to TINs
      i. By a date specified by CMS, ACH shall furnish written notification to the executive of any TIN through which an individual or entity on their Proposed Revised Participant Provider List or Proposed Revised Preferred Provider List bills Medicare. Such notification must include items listed on the ACO REACH Participation Agreement **Article IV section 4.05 C.**

B. Provider Success team to:
   1. Confirm existing Provider NPIs for each new year.
   2. Attempt to collect e-mails addresses from all NPIs and TINs

3. Verify mailing address are up to date.
4. If possible, collect their Compliance Department contact information.

C. Outgoing Communication Notice to Proposed Providers and Notice to TINs
   1. All communications are to follow the *MC-001 Provider Mass Communication* Policy.
   2. Notice to proposed Participant and Preferred Providers
      i. All those who have e-mails on file will receive their notice electronically.
      ii. If no email is on file, the notice is to be printed and mailed out.
         - Notices that have the same address are to be collected and mailed together in an appropriate envelope/box.
   3. Notice to TIN letters
      i. All those who have e-mails on file will receive their notice electronically.
      ii. If no email is on file, the notice is to be printed and mailed out.

D. Tracking Notices
   1. Documentation/proof that NPIs and TINs that have been sent out shall be maintained electronically.
   2. If notices were mailed out, a receipt from the mailer shall be obtained.
   3. All documentation is to be stored in the ACO Shared drive.

E. Returned Mail

Return mail marked undeliverable will be directed back to the Growth or Provider Success Team depending on if it is an existing or prospective providers.

1. Address is to be verified to ensure it was mailed out to the correct address on record.
2. An attempt to contact the provider by phone, email or online research should be made to correct the mailing address in a timely manner.
3. Once information has been confirmed, a second attempt shall be made to deliver the NPI/TIN Letter.
4. Any returned mail after the second attempt, letters are to be stored until the end of the following Performance Year.
5. All attempts to contact the provider must be documented using Salesforce.

Reporting

A. Compliance to audit NPI and TIN letters were sent out as required by CMS. Summary of findings is saved in the ACO shared drive. Any discrepancies found must be shared with the Contracting Department.
B. Compliance is to ensure documentation and storing of the returned letters is being done in case CMS request proof ACH attempted to contact the Provider.

Individual Right of Access to Protected Health Information

Effective Date: April 2024

Policy

It is the policy of American Choice Health Care (ACH) to recognize the right of an individual to have access to inspect and obtain a copy of their own Protected Health Information (PHI) and to follow the procedures when approving or denying an individual's request to access their PHI.

Applicability

This policy and procedure applies to all ACH Providers, ACH Professionals, and other individuals or entities performing functions or services related to ACH's activities.

Procedure

A. Individuals have the right to access any of their PHI maintained in the Providers designated record sets. The individual will have access to any PHI that is used, in whole or in part, to make decisions about them.

B. All requests by individuals to inspect or to obtain a copy of their PHI (hereinafter referred to as "Request" must be made in writing and submitted to their provider for processing.

C. All requests to inspect or obtain a copy of PHI must include, at a minimum, the following information for the individual who is the subject of the PHI:
    1. Full legal name;
    2. Unique personal identification number (e.g., HICN, SSN);
    3. Address and phone number;
    4. Date of birth;
    5. Signature (of the individual or authorized representative); and,
    6. Date range of records requested.

D. Providers shall not provide an individual with access to the following types of information, maintained in a designated record set:
    1. Psychotherapy notes
    2. Information compiled in reasonable anticipation of, or for the use in, a civil, criminal, or administrative action or proceeding
    3. Management records that are used for business decisions, quality assessment or improvement records, patient safety activity records, or business planning and development records
    4. The underlying PHI from the individual's medical or payment records or other records used to generate the above types of excluded records or information remains part of the designated record set and subject to access by the individual.

E. **Action on the Request for Access**

1. Providers should act on the Request within 30 days of receiving the Request.
2. If the provider is unable to act on a Request within 30 days of receiving the request, it may extend the deadline once by no more than 30 days by providing the individual with a written statement of the reasons for the delay and the date in which the Provider will complete its action on the Request.
3. Providers may grant or deny access to an individual's PHI for defined reasons.
4. If the provider grants access to the information, in whole or in part, they must:
    a. Notify the individual of the decision and arrange for a mutually convenient time and place to provide the access requested.
    b. Provide the individual with access to summaries of PHI and to the underlying information in a timely fashion.
    c. If the same PHI is maintained in more than one designated record set or at more than one location, the Provider should only produce the information once per Request.
    d. Provide the requested information in the form or format requested, provided that the information is readily producible in such form or format. If it is not, they shall produce it in readable hard copy form or in another form or format on which the individual and Provider can agree.
    e. Once they have located the requested PHI, and the individual has been granted access to the PHI, the individual has the right to inspect the information, copy the information, or to do both.
    f. If the individual requests that the provider mail a copy of the requested information, they may do so.
        i. If the records requested are maintained electronically and the individual requests the records electronically, the provider should provide individual copies of the records in the electronic form and format requested by the individual, if readily producible.
        ii. If the electronic form and format requested by the individual is not readily producible, providers may offer the individual other electronic formats that are available on their system.
        iii. All electronic data will be produced in an encrypted format.
5. If the provider denies access to the information, in whole or in part:
    a. A written denial shall be provided to the individual containing:
        i. The basis for the denial;
        ii. A statement of the individual's right to have the denial reviewed and description of how to exercise such right, if applicable;

iii. A description of how the individual may make a complaint to the provider or to the Secretary of the Department of Health and Human Services; and,

iv. The name or title and telephone number of designated contact person or office responsible for receiving complaints.

b. Providers may deny an individual access, provided that the individual is given a right to have the denial reviewed by a licensed health care professional who was not directly involved in the denial to review the decision to deny access. Such review may occur where a licensed health care professional has determined that:

i. Providing such access is reasonably likely to endanger the life or physical safety of the individual or another person;

ii. The PHI makes reference to another person (unless such other person is a healthcare provider) and a licensed health care professional has determined, in the exercise of professional judgement, that the access requested is reasonably likely to cause substantial harm to another person; or

iii. The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

c. Providers may, but is not required to, deny a request without providing the individual with a right to have the denial reviewed where:

i. The requested information is subject to the Privacy Act (5 U.S.C. §552a), and denial of access is permitted under the Privacy Act; or,

ii. ACH obtained the requested information:

1. From someone other than a health care provider;
2. Under a promise of confidentiality; and,
3. Granting the individual access would be reasonably likely to reveal the source of the information.
4. This exception does not apply to PHI obtained from another health care provider.

d. An individual's access may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

F. Providers shall retain written or electronic documentation of its designated record sets that are subject to access by individuals and the titles of the persons or offices responsible for receiving and processing Requests for such access. Such documentation shall be retained for six (6) years after the later date of its creation or the date it was last in effect.

G. The individual's request must be provided to the provider in writing and must clearly state that the disclosure of all or part of the information to which the request pertains could endanger the individual. No specific description or proof of such endangerment shall be required.

H. An individual also has a right to direct the covered entity to transmit the PHI about the individual directly to another person or entity designated by the individual. The individual's request to direct the PHI to another person must be in writing, signed by the individual, and clearly identify the designated person and where to send the PHI. This request may be made as part of the initial written request for PHI.

Reporting

A. N/A

Beneficiary Risk Identification & Stratification

Effective Date: April 2024

Policy

It is the policy of American Choice Healthcare (ACH) to identify Beneficiary risk and perform assessments to evaluate Beneficiary needs.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Providers, and ACH Professionals performing functions or services related to the ACO's activities.

Procedure

A. Beneficiaries will be stratified using two different methods to identify those who require immediate or more frequent interventions.

B. Beneficiaries will be engaged based on stratification, Beneficiary inbound calls, and requests for follow-up from ACH Participants and Preferred Providers. Efforts to collect data will be ongoing and reassessments will be made based upon clinical need to assist the Beneficiary throughout the continuum of care.

C. No "at-risk" Beneficiary will be denied the highest quality treatment, education, or care coordination due to his/her pattern of adherence, socioeconomic status, health condition, disease, or disability. ACH's sees the "at-risk" Beneficiary as an opportunity to provide a higher level of resources in order to reduce Beneficiary risk and exceed quality standards.

    1. ACH and its ACH Participants and Preferred Providers shall not take any action to avoid treating At-Risk Beneficiaries or to target certain Beneficiaries for services with the purpose of trying to ensure alignment in a future period.

D. Risk Scoring & Methodology

ACH may utilize the following measurement tools in order to identify potentially high-risk Beneficiaries. These various methods will allow ACH Participants and Preferred Providers to develop individualized care plans for targeted populations.

    1. Risk Stratification based on the Johns Hopkins ACG
        a. An initial risk stratification is performed based on an analysis of medical claims supplied by CMS which includes HCC codes using the Johns Hopkins ACG System to risk stratify Beneficiaries based upon utilization patterns, medical health conditions, and care coordination to identify those with Beneficiaries with potentially high-risk needs and determine how intensively to assist them.
    2. Clinical Intervention

a. Care coordinators will attempt to contact each Beneficiary identified as high risk to assess the Beneficiary's need for inclusion in the care coordination program by completing additional assessments, as needed.
b. An assigned care coordinator will use clinical expertise and judgment to determine the Beneficiary's clinical level and the appropriate follow-up once assessments have been completed.
c. ACH Participants will collaborate with the care coordination team as risk levels change for Beneficiaries, in order to develop new treatment plans and refer to appropriate programs to enhance Beneficiary care.

E. Periodic Reassessment of Risk Status and Clinical Intervention Updates
1. Clinical Intervention programs may require reassessment based upon changing Beneficiary health, HCC codes and ongoing utilization patterns.
a. Johns Hopkins ACG Risk Scores are recalibrated weekly as CMS claims and clinical data is ingested. Beneficiary stratification level will fluctuate based upon review of more recent data.
b. A care coordinator may reassess the Beneficiary during any engagement opportunity and determine that the clinical level needs to be revised. The care coordinator will document reassessment findings in the care coordination documentation system. If the clinical level indicates that a change in the level of care coordination is identified, the Beneficiary's information will be shared with the Primary Care Physician (PCP), as needed.

Reporting

A. N/A.

Beneficiary Rosters

Effective Date: April 2024

Policy

It is the policy of American Choice Healthcare (ACH) to ensure that all data regarding Beneficiaries that are assigned and presented to an ACH Provider is current and accurate.

Applicability

This policy and procedure applies to all American Choice Healthcare (ACH) Providers, and ACH Professionals performing functions or services related to the ACO's activities.

Procedure

A. ACH receives a beneficiary alignment file (BAR/ALGC) monthly and a provider alignment file (PALMR) quarterly. These files are loaded via FTP to the Population Health platform, Lightbeam Health Solutions. Completed Beneficiary rosters will be reviewed by the Health Economics team, consisting of BI and Pop Health subdepartments, for accuracy, completeness, and quality.

B. The data will be assessed for additions, changes, and deletions in the rosters, and is presented via a recurring meeting to ACH leadership, known as the Monthly Pulse.

C. ACH will then provide monthly reports of the roster changes to the ACH Participants and Preferred Providers via Tableau dashboards within Lightbeam Health Solutions. Outside of claims information, providers will have the following fields available:

   i. HICN/MBI;
   ii. Beneficiary First Name;
   iii. Beneficiary Last Name;
   iv. Sex;
   v. Date of Birth;
   vi. Deceased Beneficiaries.
   vii. Additions of Beneficiaries to the roster;
   viii. Deletions of Beneficiaries from the roster; and,
   ix. Other Beneficiary changes, such as deceased Beneficiaries, HICN changes, TIN assignment changes, and Beneficiaries who have declined to have Medicare share their personal health information.

D. The ACH Participants and Preferred Providers will review their rosters with the Provider Success or Network Success team through monthly meetings. Although provider feedback is appreciated, the ultimate source of truth for alignment is the CMS alignment report.

E. The following reports are available to Participant Providers, Preferred Providers, the Provider Success Team, and the Network Success Team:

Module	Dashboard/Report Name
OCG Analytics	4i Participant List
OCG Analytics	Advanced Payment Summary
OCG Analytics	Alignment Attribution Summary
OCG Analytics	CCLF Waterfall
OCG Analytics	Cost V Target Masterfile
OCG Analytics	Enterprise Masterfile
OCG Analytics	Practice Report Card
OCG Analytics	HCC Face Sheet Masterfile
OCG Administration	HIE Management Console
OCG Analytics	Patient Masterfile
OCG Analytics	Patient Roster
OCG Analytics	Post-Acute Masterfile
OCG Analytics	PQEM Biweekly Claims Payment Summary
OCG Analytics	Quality Report Card
OCG Analytics	Rendering Provider Map
OCG Analytics	Commercial ACO Dashboard
OCG Analytics	Voluntary Alignment Response Summary

Reporting

A. N/A