AmeriHealth Caritas Next

FirstChoice Next
A Product of Select Health of South Carolina, Inc.

CONNECTIONS

A Provider's Link to AmeriHealth Caritas Next and First Choice Next

Fall 2024

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A Letter From the Chief Medical Officer

Breast cancer screening for women with schizophrenia — An opportunity for improvement

Women with schizophrenia and other psychotic disorders are less likely to receive preventive cancer screenings.[1] As a result, the incidence and mortality rates of breast cancer in women with pre-existing severe mental illness, such as schizophrenia, is higher relative to rates in the general population.[1] Contributing factors include payer type, primary care provider (PCP) utilization, and late entry into treatment.[2,3]

AmeriHealth Caritas Next/First Choice Next is seeing similar screening disparities where less than 17% of eligible women with schizophrenia received mammograms. As an AmeriHealth Caritas Next/First Choice Next behavioral health provider, I am requesting your support to combat this disparity.

Please encourage and remind women within your practice to see their primary care provider to get their needed screenings. If your member doesn't have a PCP, they can select one from our online provider directory, at www.amerihealthcaritasnext.com.

AmeriHealth Caritas Next/First Choice Next will continue to educate and reach out to members on the importance of preventive screenings. Together, we can make a difference.

Best regards,

Angela Perry, MD

Chief Medical Officer — Exchange

1. Steve Kisely et al., "Breast Cancer Treatment Disparities in Patients With Severe Mental Illness: A Systematic Review and Meta-Analysis," *Psychooncology,* Vol. 32, No. 5, May 2023, pp. 651 – 662.
2. Alison Hwong et al., "Breast Cancer Screening in Women With Schizophrenia: A Systematic Review and Meta-Analysis," *Psychiatr Serv,* Vol. 71 No. 3, March 2020, pp. 263 – 268.
3. Braden O'Neill et al., "Breast Cancer Screening Among Females With and Without Schizophrenia," *JAMA Net Open,* Vol. 6, No. 11, 2023.

Electronic claims submission (EDI)

The plan encourages all providers to submit claims electronically using electronic data interchange (EDI). For those interested in electronic claim filing, please contact your EDI software vendor or Change Healthcare. Providers who wish to submit electronic claims through ConnectCenter, Change Healthcare's claims management system, may call Change Healthcare at **1-800-527-8133**, **option 2,** for assistance on how to enroll in ConnectCenter.

Electronic claims that are submitted though Change HealthCare's Connect Center use a four-digit ConnectCenter Payer identifier (CPID).

There are many different products that may be used to bill electronically. If you have the capability to send EDI claims to Change Healthcare, whether through direct submission via ConnectCenter or through another clearinghouse/ vendor, you may submit claims electronically.

Providers interested in sending claims electronically may also contact EDI Technical Support by calling Provider Services to arrange transmission and for assistance in beginning electronic submissions. When ready to proceed:

- Contact your EDI software vendor or Change Healthcare's ConnectCenter at **1-800-527-8133**, **option 2,** to inform them you wish to initiate electronic claim submissions to AmeriHealth Caritas Next or First Choice Next, depending on your Next plan.
- Be prepared to inform the vendor of the plan's electronic payer identification number.

Use the correct payer ID when filing claims

Please note that AmeriHealth Caritas and First Choice may operate different health plans in the same state. To enable prompt payment, please be careful to charge your claim to the correct payer ID for AmeriHealth Caritas Next or First Choice Next. Please consult the table below for the appropriate plan payer ID.

Table: AmeriHealth Caritas Next and First Choice Next plan payer IDs*

State	Plan payer ID
Delaware	47073
Florida	45408
North Carolina	83148
South Carolina (First Choice Next)	57103

*Improper claim submission could result in rejected claims, denied claims, and payment delays.

NIA is becoming Evolent

Evolent (formerly National Imaging Associates, Inc., or NIA) has consolidated its various companies (Evolent Care Partners; NIA Magellan; Vital Decisions; Evolent Health Services, IPG; and New Century Health) under a single brand: Evolent.

This branding change will have negligible impact on providers, but you will start to see the logo on materials switch from NIA to Evolent. Providers should continue to use RadMD.com to obtain prior authorizations. Phone numbers to reach Evolent will also remain the same as they were for NIA. For future updates, please see RadMD.com.

Enhancing cultural competency in health care settings

The plan encourages providers and their staff to report their race and ethnicity, the languages they speak, and the language services available through their practice. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare (CAQH).

The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.

The provision of culturally appropriate care requires an understanding of the social and cultural differences of the patient population served and the impact culturally appropriate care can have on patient satisfaction and adherence during a medical encounter. Cultural awareness and ongoing education are important when it comes to improving the quality of care and health outcomes and addressing racial and ethnic disparities in culturally diverse patient populations.

Cultural competency training

Providers are encouraged to complete the free eLearning cultural competency training offered by the Health & Human Services Department (HHS) Office of Minority Health titled "A Physician's Practical Guide to Culturally Competent Care." This training offers up to nine continuing education units (CEUs) and can be accessed at: https://cccm.thinkculturalhealth.hhs.gov/.

For additional cultural competency resources and training, including continuing medical education (CME) offerings, please visit the Provider Training page found in the provider section of your Next plan website.

Additional resources:

- Health Resources and Services Administration: Health Literacy
- National Institutes of Health: Clear Communication
- The Health Literacy & Plain Language Resource Guide (PDF)
- The Fenway Institute, National LGBTQIA+ Health Education Center
- Do Ask, Do Tell: LGBT People: An Overview
- Health Literacy Universal Precautions Toolkit
- Office of Minority Health – Cultural and Linguistic Competency
- National Center for Cultural Competence

Provider credentialing rights

The criteria, verification methodology, and processes used by the plan are designed to credential and recredential providers in a nondiscriminatory manner, regardless of race, ethnic or national identity, gender, age, sexual orientation, specialty, or procedures performed.

During the review of the credentialing application, applicants are entitled to certain rights. Every applicant has the right to:

- Review the information submitted to support their credentialing application, except for recommendations and peer-protected information obtained by the plan.
- Correct erroneous information. When the Provider Services department receives information that varies substantially from the information the provider gave, the Provider Services department will notify the health care provider to correct the discrepancy.
- Make corrections in writing to the Provider Services department within 10 business days of identification. If the change is not reflected in 10 business days, please contact your Provider Network Management Account Executive. Please refer to the provider manual to learn more.
- Be updated on the status of their credentialing or recredentialing application by requesting this update from the Provider Services department. The Provider Services department will share all information with the provider, except for references, recommendations, or peer-review protected information (e.g., information received from the National Practitioner Data Bank). Applicants can ask for updates by phone, email, or writing. The Provider Services department will respond to all requests within 24 business hours of receipt. We will respond by email or phone call to the provider.
- Be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision.
- Review all credentialing application and primary source verification policies and procedures by requesting them from the Provider Services department.

To ask for any of the above, please contact the Provider Services department.

Timely filing of claims

Providers must submit all original paper and electronic claims to the plan within 180 calendar days from the date services were rendered (or the date of discharge for inpatient admissions). This applies to both capitated and fee-for-service claims. Please allow for normal processing time before resubmitting a claim either through the electronic data interchange (EDI) or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: The EDI vendor must receive a claim by 9 p.m. for it to be sent to the plan the next business day.

Unless otherwise agreed to by the plan and provider, failure to submit a claim within the 180-day timely filing deadline does not invalidate or reduce any claim if:

- It was not reasonably possible for the provider to file the claim within the 180-day period.
- The claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider or in the case of a force majeure, later than one year from the time of submittal of the claim. Force majeure is defined as any act of God, governmental act, act of terrorism, war, fire, flood, earthquake, hurricane or other natural disaster, explosion, civil commotion, or other event beyond the provider's reasonable control.

Type of claim	Description and time frame
Original claim	Must be submitted to the plan within 180 calendar days from the date services were rendered or compensable items were provided.
Rejected claim	Is not registered to the claims processing system and can be resubmitted as a new claim. They may be corrected and resubmitted within 180 calendar days from the date of services.
Denied claim	Has been processed in the claims system. It may have a payment attached or may have been denied. A corrected claim can be reprocessed if submitted within 365 calendar days of the original date of service.
Out-of-network provider claim	Must be submitted to the plan within 180 calendar days from the date services were rendered or compensable items were provided.

Provider web pages

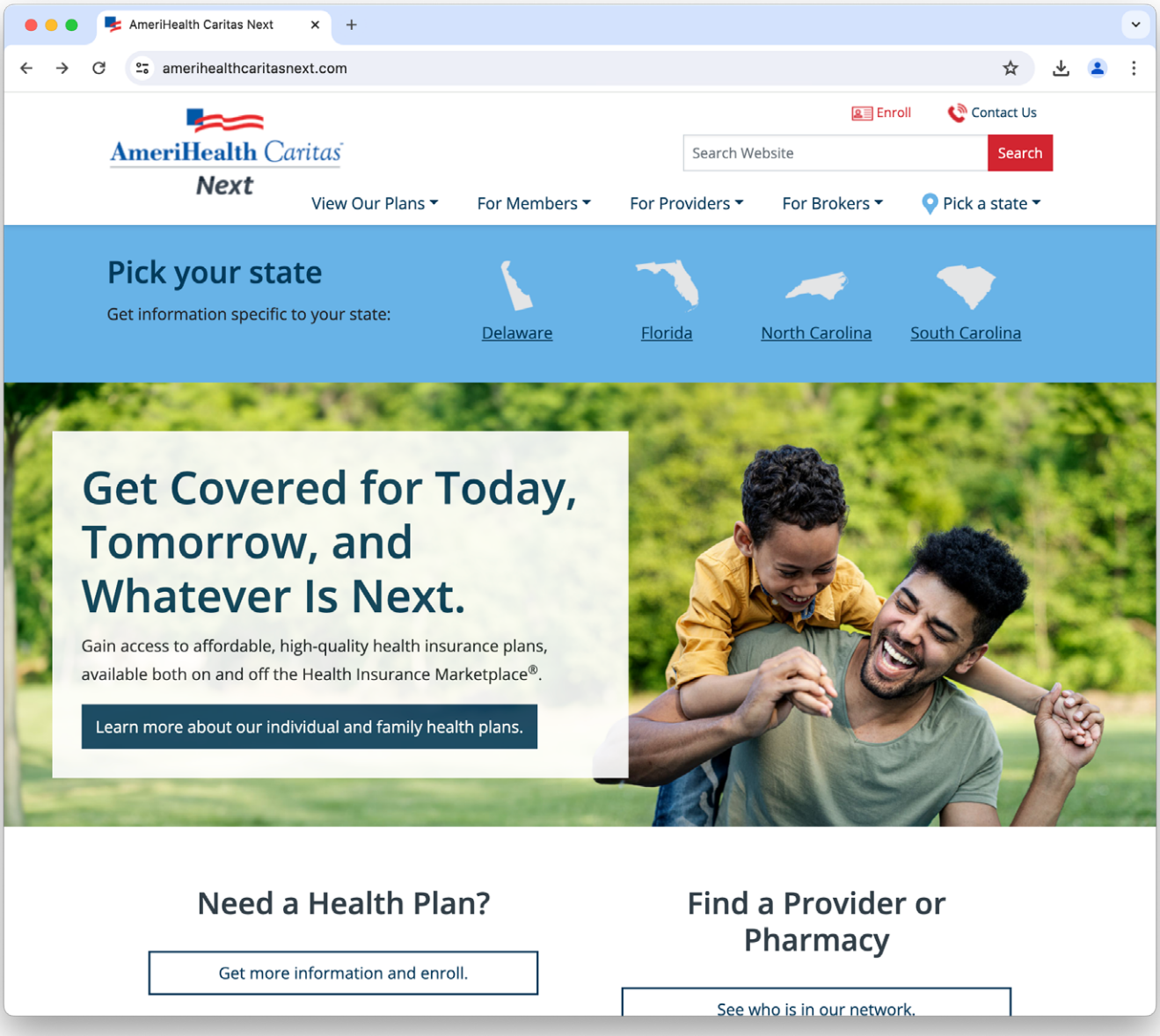
Our provider-dedicated web pages feature up-to-date news and information of interest to providers and the health care community. The site has a user-friendly interface that allows you to easily navigate the latest news and information of interest to you and your office. Additionally, you can easily access resources including forms, NaviNet, and provider publications. Provider pages can be found at www.amerihealthcaritasnext.com. Select your state and then select **For Providers**.

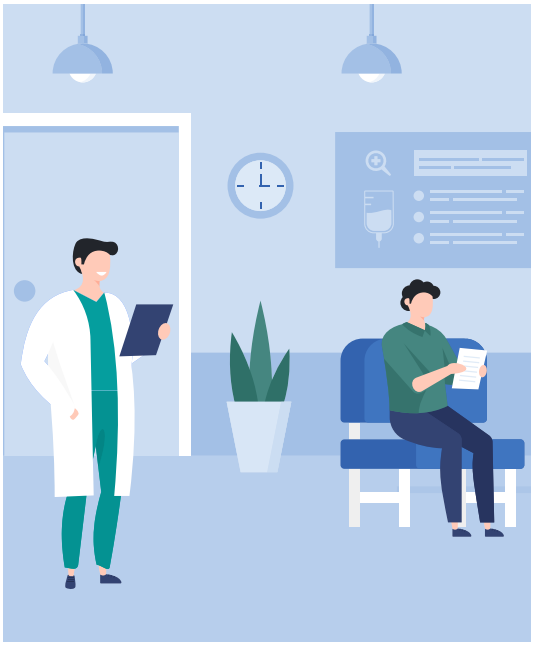
Clinical practice guidelines

AmeriHealth Caritas Next and First Choice Next are dedicated to providing the most comprehensive, outcomes-driven health solutions for our members. Part of this approach means making it a priority to reduce unnecessary variations in care. We've used the latest scientific evidence and research to create our clinical practice guidelines, which represent the latest in current professional standards.

While these clinical practice guidelines are intended to inform, they aren't intended to replace a physician's clinical judgment. The physician remains responsible for determining the applicable treatment for each individual.

Providers can learn more about clinical practice guidelines by visiting the Clinical Resources page of the plan's website.





Participating provider office standards for access and availability

The Quality Management (QM) department, in collaboration with Provider Network Management, establishes an annual access and availability plan to address the sufficiency of the plan's provider network in number, type, and geographic location of practitioners who practice primary and specialty care, in accordance with relevant regulatory and accreditation standards. The cultural needs of the plan members are taken into consideration, and mechanisms are implemented to provide adequate access to primary and specialty care practitioners. Availability of practitioners is assessed annually by the Provider Network Management department.

Through the QHP Member Experience survey, the QM department also establishes and measures the accessibility of services, such as regular and routine appointments, urgent care appointments, after-hours care, emergent care, and access to customer service.

We collect and analyze this data to identify opportunities for improvement. Interventions are implemented to improve performance.

Access standards for PCPs and specialists are as follows:

Appointment availability

PCPs

- Emergent/immediate — 24 hours per day, seven days per week
- Urgent — Within one calendar day
- Routine and regular (well or preventive) care — Within four to six weeks

Specialists/chiropractors/podiatrists

- Emergent/immediate — Members should call 911 or go to the nearest emergency room
- Urgent — Within one calendar day
- Routine appointment — Within 30 calendar days
- OB/GYN routine appointment — Within 30 calendar days

Mental health providers (non-medication prescribers and medication prescribers)

- Emergency — Within 15 minutes of presentation at a service delivery site
- Urgent, nonemergency — Within one hour of presentation at a service delivery site or within 24 hours of telephone contact with the provider or contractor.
- Non-life-threatening emergency — Within 6 hours
- Routine mental health services (in follow-up to intake assessment and upon determination) — Within 21 calendar days of the request for an appointment
- Initial visit for routine care — Within 10 business days

Internal waiting time

Patients should be seen within 30 minutes of the time of the scheduled appointment.

Availability

Coverage must be provided 24 hours per day, seven days per week, for our members. Covering practitioner must be a participating provider. Providers who use answering machines for after-hours services are required to include the following in the outgoing message:

- Urgent/emergent instructions as the first point of instruction
- Information on contacting a covering provider
- Telephone number for after-hours provider access

After-hours phone response

For an urgent/emergent problem, the provider should respond within 30 minutes. Auto-response messages should direct callers with emergent needs to dial 911 or go to their nearest emergency room.

Billing the member

Providers may collect copayments, coinsurance, and any unpaid portion of the deductible at the time of service.

Balance or surprise billing

Members are protected from balance billing for the following services:

Emergency services

If a member has an emergency medical condition and gets emergency services from an out-of-network provider or facility, the most the provider or facility may bill the member is the plan's in-network cost-sharing amount (such as copayments and coinsurance). A provider cannot balance bill a member for these emergency services. This includes services the member may get after they are in a stable condition, unless they give written consent and give up their protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When a member gets services from an in-network hospital or ambulatory surgical center, certain providers within such facilities may be out of network. In these cases, the most those providers may bill the member is the plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Providers can't balance bill the member and may not ask the member to give up their protections not to be balance billed.

Out-of-network providers

Out-of-network providers may need to bill the member for an unpaid balance after the time of service. It is the out-of-network provider's responsibility to advise the member and obtain the member's acknowledgment in writing if products or services extend beyond the plan's coverage so that the member understands that they are liable for any costs beyond what the plan will pay.

Member rights and responsibilities

Member rights

A member has the right to:

- Receive information about the health plan, its benefits and services that are included or excluded from coverage policies, and network providers' and members' rights and responsibilities. Written and web-based information provided to the member must be readable and easily understood.
- Be treated with respect and recognized for their dignity and right to privacy.
- Participate in decision-making with providers about their health care. This right includes candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage.
- Voice grievances or appeals about the health plan or care provided and receive a timely response. The member has a right to be notified of the disposition of appeals or grievances and the right to further appeal, as appropriate.
- Make recommendations about the plan's member rights and responsibilities policies by contacting Member Services.
- Choose providers, within the limits of the provider network, including the right to refuse care from specific providers.
- Have confidential treatment of personally identifiable health or medical information. The member also has the right to have access to their medical record per applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive health care services without discrimination based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.
- Formulate advance directives. The plan will provide information about advance directives to members and providers and will support members through our medical record-keeping policies.
- Obtain a current directory of network providers, on request. The directory includes addresses, phone numbers, and a listing of providers who speak languages other than English.
- File a complaint or appeal about the health plan or care provided with the applicable regulatory agency, and receive an answer from the health benefit plan to those complaints within a reasonable period of time.
- Appeal a decision to deny or limit coverage through an independent organization. The member also has the right to know that their provider cannot be penalized for filing a complaint or appeal on the member's behalf.
- Members with chronic disabilities have the right to get help and referrals to providers who are experienced in treating their disabilities.
- Have candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage, in terms the member understands. This includes an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the member is unable to easily understand this information, they have the right to have an explanation provided to their designated representative and documented in the member's medical record. The plan does not direct providers to restrict information regarding treatment options.
- Have available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week, for urgent and emergency medical conditions.
- Call 911 in a potentially life-threatening situation without prior approval from the plan, and to have the plan pay for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Continue receiving services from a provider who has been terminated from the plan's network (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the provider is terminated for reasons that would endanger the member, public health, or safety, or which relate to a breach of contract or fraud.
- Have the rights afforded to members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands.

- Receive prompt notification of terminations or changes in benefits, services, or the provider network.
- Have a choice of specialists among network providers following an authorization or referral as applicable, subject to their availability to accept new patients.

Member responsibilities

A member has the responsibility to:

- Communicate, to the extent possible, information that the plan and network providers need for the member's health care.
- Follow the plans and instructions for care that they have agreed on with their providers. This responsibility includes considering the possible consequences of not adhering to recommended treatment.
- Understand their health problems and participate in developing mutually agreed-on treatment goals to the degree possible.
- Review all benefits and membership materials carefully and follow health plan rules.
- Ask questions to ensure understanding of the provided explanations and instructions.
- Treat others with the respect and courtesy they expect to receive.
- Keep scheduled appointments or give adequate notice of delay or cancellation.

Prior authorization guidelines

Prior authorization is required to evaluate the medical necessity of certain health care products and services. When referring members to a hospital, the PCP only needs to refer to the admitting/performing physician, who is then responsible for obtaining prior authorization for the hospital admission.

Responsibilities of the admitting/performing physician for hospital admissions:

- Make hospital admission arrangements.
- Acquire the following required information:
  - Member name and date of birth
  - Member ID number
  - Admission date
  - Place of admission
  - Diagnosis
  - Planned procedure
- Provide medical information to support the prior authorization review request.
- Notify the member's PCP of the diagnosis, planned procedure, and hospital arrangements.
- Contact the hospital with the prior authorization code.

Criteria used for utilization management determinations are available on request to all AmeriHealth Caritas Next and First Choice Next providers and members free of charge. Members and providers can learn more about the availability of review criteria and how to obtain clinical criteria used for a utilization management determination through the provider manual, Member Handbook, and written utilization management determination letters.

Population Health program

The plan's Population Health program is a holistic solution to provide comprehensive care management services. This fully integrated model allows members to transition seamlessly from one level of care to another for their unique needs. From this integrated solution, the plan delivers and coordinates care across all programs. We offer this program to all plan members.

The Population Health program includes:

- Assessment
- Screening for social determinants of health
- Care planning
- Health and wellness education to encourage self-management
- Service coordination
- Treatment
- Reassessing and adjusting the person-centered care plan and its goals as needed

The Population Health program uses evidence-based practice guidelines and is structured around a member-based decision support system that drives both communication and person-centered care plan development through a multidisciplinary approach to management.

The plan's Population Health team works proactively to meet our members' needs at all levels to maximize health outcomes. The team includes:

- Nurses
- Licensed mental health and substance use disorder professionals
- Care Connectors
- Clinical pharmacists
- Plan medical directors
- PCPs
- Specialists
- Community agencies
- Members and their caregivers, parents, or guardians

Population Health program participation

We offer all plan members the chance to participate in Population Health programs. Members can opt out on request. Providers may also contact the plan to enroll members in a program, and members may contact the plan to self-refer into a program.

For specific Population Health-related needs, members are identified when they enroll in the plan through systematic risk stratification. We include a new member assessment in the member's welcome packet to help identify current health conditions and health care services. Based on their responses to this initial health assessment, we identify members for participation in the appropriate care management program. We also identify members for participation through telephonic outreach.

The plan systematically restratifies members quarterly. Members are encouraged to let the plan know if they have a chronic health condition or special health need, or if they are receiving ongoing care.

Let Us Know program

We encourage providers to refer members to Population Health Management as needs arise or are identified. If you recognize a member with a special, chronic, or complex health condition who may need the support of one of our programs, including Complex Care Management, Care Coordination, or the Bright Start® program, please contact our Rapid Response and Outreach Team. Providers can also complete our Let Us Know member intervention request form and fax it to our Rapid Response and Outreach Team for members who have missed appointments or who may need transportation services or further education on their treatment plan or chronic condition. You can download this form from our website at: www.amerihealthcaritasnext.com.

Members are also referred to the Population Health programs through internal plan processes. Identified issues and diagnoses that result in a referral to the Population Health program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses)
- Risk score indicating over- or under-utilization of care and services
- Infants receiving care in the NICU
- Members with dual medical and behavioral health needs
- Members with substance use disorder-related conditions
- Members who are developmentally or cognitively challenged
- Members with a special health care needs
- Members with polypharmacy use
- Pregnant members
- Members with high trauma exposure
- Members who need long-term services and supports to avoid hospital or institutional admission

Pharmacy overview

The plan strives to provide members with high-quality and cost-effective drug coverage. PerformRx℠, our pharmacy benefits manager and AmeriHealth Caritas Next or First Choice Next delegated entity, handles the administration and claims processing of the plan prescription drug benefit. As part of our commitment to comprehensive coverage, we offer a range of plans covering prescription drugs approved by the U.S. Food and Drug Administration (FDA).

The Pharmacy and Therapeutics (P&T) Committee oversees our pharmacy policies and procedures and promotes the selection of clinically appropriate, safe, effective, and economically advantageous medications for our members. The P&T Committee objectively appraises, evaluates, and selects drugs and/or drug classes for the formulary; evaluates, analyzes, and reviews policies and procedures to ultimately educate and inform health care providers about drug products, usage, and committee decisions; and evaluates, analyzes, and reviews protocols and procedures for the use of, and access to, non-formulary drug products. The committee is comprised of internal and external clinical pharmacists and physicians in a variety of specialties.

The P&T Committee meets on at least a quarterly basis to review and update the formulary.

Prescription drug programs

Members with an AmeriHealth Caritas Next or First Choice Next prescription drug benefit may have coverage through one of the programs listed in this section. Coverage for drugs is based on the member's health benefit plan. The formulary is reviewed over the course of the year for value, quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the Health Insurance Marketplace®. As a result, the formulary is updated throughout the year. Some drugs may be subject to utilization management programs to ensure appropriate clinical use and cost efficiency.

- Prior authorization program
- Step therapy protocol
- Quantity limit program
- Generic drug program
- Brand drug program
- New-to-market drugs
- Non-formulary drug program
- Specialty drug program

Formulary tiers

Tier 1 — Generics

Tier 2 — Preferred Brands

Tier 3 — Non-Preferred Brands

Tier 4 — Specialty

Before you prescribe drugs to members, we recommend that you become familiar with the Pharmacy section in the provider manual. In it you will find information about our prescription drug programs, formulary, and prior authorization process.

Provider Data Intake Form (PDIF)

Updating your provider information

Whether submitting claims, reporting changes in your practice, or completing recredentialing applications, it is essential that the information you transmit is timely and accurate. When changing key provider demographic information, you are contractually required to notify us in writing with at least 30 days' advance notice.

Every 90 days, before the due date, you will be sent a reminder to verify that your provider data is accurate. You will have 30 days to attest to the accuracy of information or submit any corrections through the **Provider Data Intake Form** on NaviNet. Providers who do not respond in this time frame may be removed from our provider directory until they validate their data. This validation process is only used for our AmeriHealth Caritas Next and First Choice Next products. It does not apply to our Medicaid plans.

To review or update your provider information, follow these steps:

1. Log in to NaviNet.
2. Select the appropriate health plan.
3. Click the **Provider Data Information Form** link (in the upper left corner of the plan homepage).
4. On the **Provider Selection** screen, click the **Please Select a Provider** option. Select a provider and then submit.
5. You will be taken to the **Provider Self-Service screen**. In the bottom right portion of the page, click the box titled **Proceed to Provider Updates**.
6. Click the box titled **PDIF Update**.
7. Click **Location Selection**.
8. Click the box for the provider(s) for whom you want to attest and/or make changes. Click the **Next** box in the bottom right corner of the page.
9. Review and make changes to the provider summaries, if applicable.
10. Provide required documentation, if applicable.
11. Attest and click the **Next** box in the bottom right corner of the page.

Provider directory data changes will be reflected within the online provider directory within 14 business days. If the change is not shown in 14 business days, please contact your Provider Network Management Account Executive.

NaviNet

The NaviNet Provider Portal is an easy-to-use, secure platform that links providers to health plan members. Our Provider Portal at www.navinet.net allows you to share critical administrative, financial, and clinical information with AmeriHealth Caritas Next or First Choice Next, all in one place.

This tool can help you manage patient care through quick access to:

- Member eligibility and benefits information, including information for members in pending status
- Panel roster reports
- Care gap reports to identify needed services
- Member clinical summaries
- Social determinants of health information
- Admission and discharge reports
- Medical and pharmacy claims data
- Electronic submission of prior authorization requests

If you do not already use NaviNet to keep informed of your member accounts, you can register at www.navinet.net. All you need is a federal taxpayer ID number.

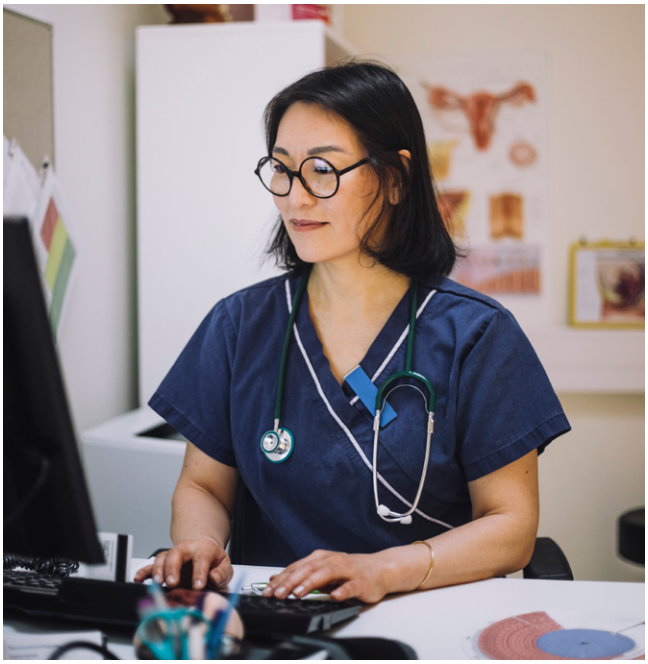
Medical records requirements

Participating providers must maintain medical records in a manner that is current and detailed and allows for effective and confidential patient care and quality review. Provider office medical record filing systems should facilitate access, availability, confidentiality, and organization of records at all times.

Providers must retain all medical records, whether electronic or paper, for a period of no less than 10 years after the rendering of covered services to the member.

Providers are required to make medical records accessible to all appropriate government agencies, including but not limited to the Department of Insurance and their respective designees for quality assurance, investigation of complaints or grievances, enforcement, or other activities related to compliance with applicable laws.

Providers must follow the medical record standards outlined in the provider manual for each member's medical record, as appropriate.



Fraud, waste, and abuse

The plan has an established enterprise-wide Program Integrity department with a proven record in preventing, detecting, investigating, and mitigating fraud, waste, and abuse. Local AmeriHealth Caritas Next and First Choice Next staff, including a Special Investigation Unit Manager and Investigator, will be supported by the Program Integrity department.

As a network provider, you are responsible for reporting suspected fraud, waste, and abuse.

Reporting issues to AmeriHealth Caritas Next or First Choice Next

If you are aware of potential or actual fraud, waste, or abuse, we encourage you to report the issue to the Special Investigations Unit by:

- Calling the toll-free Fraud, Waste, and Abuse Hotline at **1-866-833-9718**. The hotline is available 24/7 and allows anonymous reporting of issues.
- Emailing **fraudtip@amerihealthcaritas.com**
- Completing the anonymous online fraud intake form found at **www.amerihealthcaritasnext.com**.
- Mailing a written statement to:
  Special Investigations Unit
  AmeriHealth Caritas Next/First Choice Next
  P.O. Box 7318
  London, KY 40742

Beware of phishing scams — Don’t take the bait!

One of the biggest information security risks for most organizations occurs when an associate opens a phishing email and clicks on the link. It only takes one associate clicking a phony link to impact an organization’s cybersecurity efforts.

Why it’s important

Phishing scams are emails that look real but are designed to steal important information. A phishing email with malicious software can allow cybercriminals to take control of your computer and put protected health information (PHI) and personally identifiable information (PII), as well as a company’s confidential and proprietary information, at risk.

It may be a phishing email if it:

- Promises something of value (e.g., “Win a free gift card.”)
- Asks for money or donations
- Comes from a sender or company you don’t recognize
- Links to a site that is different from that of the company the sender claims to represent
- Comes from a trusted business partner that has experienced a security incident. All emails sourcing from outside your organization should be scrutinized.
- Asks you for personal information, such as your username and password/passphrase.
- Includes misspelled words in the site’s URL or subject line.

If you suspect an email may be phishing, here are some tips:

- Do not click any links in the email.
- Do not provide your username and password; you should never share your username or password, even if you recognize the source. Phishing scams frequently mimic well-known companies, such as retailers (like Amazon) or banks.
- Do not reply or forward the email to anyone within your organization.
- Familiarize yourself with your organization’s process for reporting suspicious emails. If you suspect an email is a phishing attempt, report it immediately.
- Your organization's information security department may have additional information and guidance on how to protect yourself from phishing scams.