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Quality Improvement Health Equity Committee Voting Packet Meeting Minutes & Provider Manual

August 8, 2025

Please click on the hyperlink(s) below to direct you to
corresponding material for each item.

QIHEC Meeting Minutes: 5/9/2025

Access & Availability Meeting Minutes : 5/21/25

Cultural and Linguistic Services Subcommittee Meeting
Minutes: 4/23/25

Internal Quality Improvement Committee Meeting Minutes:
7/16/25

Utilization Management Committee Meeting Minutes:
5/30/25, 6/27/25, 7/25/25

Alameda Alliance for Health Provider Manual



Quality Improvement Health Equity Committee
5/9/2025

Committee Member Name and Title	Specialty	Present
Donna Carey MD, Chief Medical Officer, Alameda Alliance for Health		X
Lao Paul Vang, Chief Health Equity Officer, Alameda Alliance for Health		X
Aaron Chapman, MD, Medical Director, Alameda County Behavioral Health Care Services	Psychiatry	X
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	X
Peter Currie, Ph.D. Senior Director, Behavioral Health, Alameda Alliance for Health		X
Michelle Stott, Senior Director, Quality, Alameda Alliance for Health		X
Anchita Venkatesh, DMD MA	Program Director, General Practice Residency, Highland Hospital	X
Kristin Nelson	Director, Behavioral Health Services Student Services Division, Alameda County Office of Education	
Chaunise "Chaun" Powell, MD	Sr. Chief of Student Services, Alameda County Office of Education	X
Anthony Cesspooch Guzman, MSW	Chief Cultural Officer, NAHC	
Deka Dike	CEO, Omotochi	X

Staff Member Name and Title	Present
Ashley Asejo, Clinical Quality Programs Coordinator	X
Kalkidan Asrat, Quality Improvement Project Specialist II	X
Linda Ayala, Director of Population Health and Equity	X
James Burke, Lead Quality Improvement Project Specialist	

Rosa Carrodus, Disease Management Health Educator	X
Tiffany Cheang, Chief Analytics Officer	
Andrea DeRochi, Behavioral Health Manager	
Gil Duran, Manager, Population, Health and Equity	X
Kathy Ebido, Senior Quality Improvement Nurse Specialist	X
Michelle Findlater, Director, Utilization Management	X
Kisha Gerena, Accreditation Manager	
Kimberly Glasby, Director, Long Term Services and Supports	X
Richard Golfin III, Chief Compliance Officer & Chief Privacy Officer	X
Sanya Grewal, Healthcare Services Specialist	
Bob Hendrix, Quality Improvement Outreach Coordinator	
Megan Hills, Quality Improvement Project Specialist II	X
Lily Hunter, Director, Social Determinants of Health	
Jessica Jew, Population Health and Equity Specialist	X
Shatae Jones, Director Housing & Community Services Program	X
Beverly Juan, Medical Director Community Health	
Jennifer Karmelich, Director, Quality Assurance	
Allison Lam, Senior Director, Health Care Services	X
Daphne Lo, Medical Director Long Term Supportive Services	
Homaira Momen, Quality Review Nurse	
Angela Moses, Quality Review Nurse	X
Fiona Quan, Quality Improvement Project Specialist I	
Christine Rattray, Quality Improvement Supervisor	
Tanisha Shepard, Quality Improvement Project Specialist	X
Sangeeta Singh, Quality Improvement Project Specialist I	X
Grace St. Clair, Director, Compliance & Special Investigations	
Yemaya Teague, Senior Analyst of Health Equity	
Loc Tran, Manager, Access to Care	X
Matthew Woodruff, Chief Executive Officer	
Farashta Zainal, Quality Improvement Manager	X
Hellai Momen, Quality Review Nurse	
Mao Moua, Manager, Cultural and Linguistic Services	X
Ami Ambu, Quality Improvement Project Specialist II	X

Sarbjit Lal, Quality Improvement Project Specialist	X
Sean Pepper, Compliance Special Investigator	
Michelle Lewis, Senior Manager Communications & Outreach	
Ang Yen, Director Health Equity	X
Cecilia Gomez, Senior Manager Provider Services	
Katrina Vo, Senior Communications & Content Specialist	
Patricia Carrillo, Quality Improvement Project Specialist I	
Falmata Abatcha, Quality Improvement Project Specialist II	X
Jaini Goradia, Director, Stars Strategy and Program Manager	X
Emily Erhardt, Population Health and Equity Specialist	X
Stephen Smythe, Director, Program Compliance & Privacy Operations	X
Jessica Adams, Accreditation and Regulatory Compliance Specialist	X
Eileen Ahn, Accreditation and Regulatory Compliance Specialist	X
MyLe Hillard, Manager, HEDIS Strategy & Program Management	X
Community Members in Attendance	
Elizabeth Mahler, Interim CMO, AHS	X

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
I. Call to Order	D. Carey	The meeting was called to order at 9:04am A. Asejo conducted voting member roll call.		
II. Alameda Alliance Updates	D. Carey	- Alameda Alliance is progressing well towards D-SNP implementation by January 1, 2026, with a model of care approved at 96.25%. - The network has been deemed adequate, and hiring is underway. - They are preparing numerous Policies & Procedures for QIHEC approval. - Recruitment for medical director positions is ongoing.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		The state has issued two new policy guides for the Community Supports Program, which the team is working to operationalize.		
III. Chief of Health Equity Updates	L. Vang	L. Vang updated the committee on health equity initiatives, including the imminent rollout of a DEI pilot training, expected between next week and the end of June, with a broader rollout from July to December. - The TGI training is nearing completion for the remaining 5% of staff and will expand to member-facing vendors in July, pending budget allocation. - A three-year roadmap with six milestones is being finalized, aiming for implementation by July of the next fiscal year.		
IV. Policies & Procedures	D. Carey	The Policies & Procedures packet was sent out prior to QIHEC for committee review. - CS-001: Community Supports – Oversight, Monitoring & Controls - CS-005: Community Supports – Asthma Remediation - CS-006: Community Supports – Recuperative Care (Medical Respite) - QI-114: Monitoring of Access and Availability Standards - QI-133: Inter-Rater Reliability (IRR) -Testing for Clinical Decision Making - MBR-024: Exempt Grievance	Move to Approve: 1 st : M. Stott 2 nd : A. Chapman	
V. Meeting Minutes	D. Carey	The meeting Minutes packet was sent out prior to QIHEC for committee review. - QIHEC: 4/11/25 - UMC: 4/25/25 - CLSS: 1/22/25 - A&A: 3/25/25	Move to Approve: 1 st : J. Florey 2 nd : D. Dike	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
VI. Quality Improvement Health Equity (QIHE) Program Description, Evaluation & Work Plan	QI Leadership	• M. Stott introduced the QIHE Trilogy 2025 Program Description, Evaluation from 2024, and Work Plan for 2025. • The program aims to monitor, evaluate, and improve the quality of care and health equity. • M. Stott encourages feedback from committee members to enhance the program for its members. • The presentation will highlight accomplishments and future plans, with a tag team effort from various individuals reporting on different aspects of the program. Quality Performance/HEDIS • F. Zainal presented the final HEDIS rates for 2024, highlighting that the plan met benchmarks for 15 out of 18 measures, with misses in asthma medication ratio and high blood pressure control. • Behavioral health and diabetes measures were met, and improvements were noted in breast and cervical cancer screenings. • For children's health, the plan missed topical fluoride for children by 1131 kids. • In reproductive health, all measures were met. • State-mandated projects included equity performance improvement for African American children and blood pressure control outreach. • Quality performance activities in 2024 focused on outreach, education, and data collection, with plans for an immunization campaign and ED utilization focus in 2025.	Move to Approve: 1 st : A. Chapman 2 nd : P. Currie	

Commented [MS1]: Please correct as we had 3 MPLs

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		Potential Quality Issues (PQI) & Facility Site Reviews/Medical Record Reviews (FSR/MRR) - The clinical safety program was discussed, highlighting the potential quality issue (PQI) dashboard for 2024, showing a decline in referrals over the year. - Most PQIs were resolved within 30 days, with a maximum turnaround time of 120 days. - Corrective action plans were primarily from C2 or C3 cases. - Continue oversight and monitoring of core areas for clinical safety. - Address corrective action plan trends and any trends related to provider preventable conditions. K. Ebido reported 178 reviews in 2024, with all corrective action plans closed within 120 days. - The state's new FSR and medical record review tool, updated in 2022, led to a 7-8% decrease in provider scores. - Focus areas for 2025 include clinical safety oversight, process improvements, and addressing provider trends. Member Experience & Access L. Tran discussed the CAHPS survey results for February to May 2024, highlighting a slight drop in response rates for commercial adults but overall exceeding expectations. - Key measures included "getting needed care" and "getting care quickly," with improvements in the latter but declines in the former. - Asian populations consistently rated below the plan average. Office wait times and call return times met compliance, but non-life-threatening appointment availability fell short.		

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		• Provider engagement strategies, such as open access scheduling and extended office hours, were discussed. Internal CAHP issues and top non-compliant providers were identified, with ongoing efforts to improve access and member education. • Continuing provider education, including on-site and virtual visits, to promote the best practices and encourage the use of open access scheduling. • Develop a member-facing document to educate members on alternative care options such as urgent care, telehealth, and weekend clinics. Population Health & Equity • G. Duran reviewed the Health Education and Population Health Programs, highlighting the population health management (PHM) strategy, needs assessment, and collaboration with counties. • In 2024, the PHM strategy and deliverables were approved, focusing on primary care, chronic disease management, and wellness. • They fulfilled over 2,500 health education requests and enrolled over 600 members in the diabetes program. • The doula benefit saw significant growth, with 16 contracted doulas in Alameda County. • Four disease management programs were offered, reaching thousands of members. • Future plans include improving doula utilization, enhancing disease management programs, and aligning emergency department definitions.		

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		Cultural & Linguistic Services - In 2024, the cultural linguistic services program saw significant growth, with over 97,000 interpreter services encounters across 135 languages, a 70% increase from 2023. - The team maintained a fulfillment rate of 95% or above and launched the first timely access requirement survey, receiving positive feedback. - Key initiatives included adding a community advisory committee member, establishing a selection committee, and completing the first annual demographic report. - For 2025, the focus is on improving accessibility, streamlining services, and enhancing quality assurance. - The team plans to increase on-demand interpreter usage by 5% and continue tracking member satisfaction through surveys. - Strategic priorities for the year include audit readiness and preparing for upcoming NCQA surveys. Findings: Quality Improvements & Health Equity – The program prioritizes monitoring, evaluation, and timely actions to enhance care quality, with a strong focus on health equity. Key Accomplishments – Engagement coordinators were hired, the Well child campaign increased outreach, supplemental data collection improved insights, and provider networks received funding support. 2025 Focus Areas – State-mandated quality projects, multidisciplinary work groups, and an immunization campaign are targeted to improve declining immunization rates and continue provider support.		

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		• Performance Improvement Projects – Efforts include boosting well child visit rates for African American children, improving outreach for SUD and mental health issues, and enhancing blood pressure control through provider engagement. • Clinical Safety & Provider Accountability – Potential quality issues are tracked via dashboards, corrective action plans ensure response to adverse events, and SNF/long-term care performance is monitored. • Member Experience & Population Health Programs – Efforts have led to improved access to timely care, including promoting the doula benefit for maternal and child health. • Cultural & Linguistic Services – Interpreter services encounters increased, accessibility surveys were launched, and strategies focused on enhancing member satisfaction. Recommendations: • Enhance Provider Education – Continue training providers on scheduling interpreter services and managing timely access concerns. • Expand Outreach Strategies – Strengthen equity-focused initiatives, particularly well-child visit outreach for minority communities. • Boost Immunization Efforts – Address declining immunization rates through expanded campaigns and provider engagement. • Improve Provider Support for SUD/Mental Health – Streamline outreach efforts for members using emergency services to improve care coordination. • Strengthen Performance Tracking – Continue refining dashboards and corrective action plans to identify and address systemic provider-related issues.		

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		• Maintain Member Satisfaction Efforts – Build upon successful cultural and linguistic strategies and continue surveying accessibility needs.		
VII. Population Health: Assessment, Impact & Strategy Documents	G. Duran L. Ayala	• Linda Ayala, Director of Population Health and Equity, presented the 2025 population health management strategy, emphasizing data-driven approaches to address member needs and social determinants of health. • The strategy includes health analytics, risk stratification, and a continuum of care services from low to high risk. • Key metrics include a 20% increase in blood pressure monitor outreach and a 5% rise in well-child visit rates for Black African American members. • The strategy also focuses on disease management, health education, and transitional care services, aiming for 80% member satisfaction and 5% weight loss in the diabetes prevention program. Findings: • Data-Driven Population Health Approach – The strategy relies on health analytics, member assessments, and public health data to identify gaps and improve services. • Risk Stratification & Continuum of Care – Members are classified from low to high risk, with tailored interventions such as health education, diabetes prevention, care coordination, and complex case management. • Provider & Community Engagement – The strategy emphasizes provider support, care gap reports, and collaborations with community-based organizations (CBOs) to strengthen member services.	Move to Approve: 1 st : J. Florey 2 nd : A. Chapman	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Health Equity Focus – Social determinants of health are integrated into decision-making to ensure equitable healthcare delivery. • Continuous Strategy Evaluation – Annual assessments help refine the approach by reviewing member needs, program effectiveness, and updating strategy goals. • Identified Member Needs – Key areas include improved access to preventive care, follow-up appointments, mental health services, and culturally responsive outreach. • Successes in 2024 – Strong outreach in high-risk programs, partnerships with providers and community organizations, and maintaining high breast cancer screening rates for Black/African American members. • Improvement Opportunities – Focus on increasing case and disease management outreach, boosting survey response rates, expanding incentives, and enhancing well-child visits. Recommendations: • Strengthen Outreach & Education – increased awareness about available services and ensure culturally and linguistically appropriate communication. • Expand Care Coordination Efforts – Improve integration between case management and disease management programs to enhance patient engagement. • Enhance Preventive Care & Screening – Maintain high breast cancer screening rates, promote well-child visits, and develop standing orders for mammography.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Improve Staff Training & Internal Coordination – Refine provider education, strengthen interdepartmental collaboration, and ensure seamless service delivery. • Leverage Community Partnerships – Deepen collaborations with hospitals, community health workers, and faith-based organizations for broader support. • Optimize Incentive Programs – Assess the impact of incentives on target populations and explore strategies to increase their effectiveness.		
VIII. Network Cultural Linguistic Capacity	M. Moua	• The 2024 network capacity report evaluated the health plan's ability to meet cultural, racial, and linguistic needs, focusing on English, Spanish, Chinese, Vietnamese, and Tagalog speakers. • Key findings included a 6% increase in Spanish speakers and a 5% decrease in English speakers. • Underrepresentation of provider representation in the network was noted among certain racial and ethnic groups. • Spanish-speaking member-to-provider ratios exceeded the third quartile benchmark, indicating potential access gaps. • Interpreting services usage increased by 70% in 2024. • Grievances related to language assistance rose by 75%, while discrimination cases declined by 41%. • Action steps include partnering with community organizations, expanding provider education, and ongoing data collection. Questions/Comments:	Move to Approve: 1 st : J. Florey 2 nd : A. Chapman	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		This conversation focuses on ensuring equitable language access in healthcare. D. Carey stresses the importance of providing services in members' preferred languages, while J. Florey points out challenges, such as longer visit times and delays due to interpreter use. Efforts to educate providers on scheduling interpreters in advance and using different modalities are discussed. L. Ayala clarifies that children can only be used as interpreters in emergencies and that qualified interpreters must be offered. If a member insists on using a family member, it is acceptable. They also express a willingness to collaborate with clinics to streamline interpreter services. The conversation highlights structural challenges, including the cost burden of interpreter services and staffing constraints for bilingual providers. Findings: • Language Access and Network Capacity – The network is evaluated for its ability to meet members' cultural, racial, ethnic, and linguistic needs as part of NCQA health plan accreditation. • Member Language Trends – Spanish-speaking membership increased by over 6% for medical, while English speakers decreased by 5%. Chinese-speaking members saw slight growth in group care. • Provider Representation Gaps – Underrepresentation persists among Latinx PCPs, behavioral health providers, Black specialists, and Pacific Islander providers, though limited self-reported data affects full analysis. • Language Capacity Challenges – Spanish member-to-provider ratios exceeded the acceptable benchmark for PCPs in medical		

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		care, signaling a possible access gap. Improvements were noted in specialist and behavioral health language capacity over the year. • Interpreter Service Utilization – Usage increased by 70% in 2024, with Spanish, Mandarin, and Hmong seeing the highest demand. Despite an increase, some members still rely on family and friends for interpretation, particularly among Chinese-speaking adults. • Grievances and Discrimination Cases – Language-related grievances increased by 75%, mostly concerning provider scheduling and PCP changes due to language preferences. Discrimination cases declined by 41%, with only one substantiated incident. • Ongoing Efforts and Next Steps – No major provider network gaps were identified, but continued targeted efforts will focus on improving language assistance, provider education, and equity strategies. <u>Recommendations:</u> • Increase Provider Recruitment and Diversity Efforts – Address underrepresentation among PCPs and behavioral health providers by refining outreach and recruitment strategies. • Enhance Language Access Initiatives – Expand interpreter services and ensure members are educated on qualified interpretation options. • Strengthen Provider Education and Training – Improve awareness of scheduling practices for interpreter services and monitor compliance with language accessibility standards. • Monitor and Refine Language Assistance Programs – Continue tracking trends and grievances to guide targeted interventions.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		- Expand Community Partnerships – Leverage cultural liaisons and collaborate with community organizations to support multilingual outreach. - Optimize Data Collection on Provider Demographics – Improve race and ethnicity reporting among providers to better inform equity strategies.		
IX. 2024 DHCS Audit Findings	M. Stott	M. Stott provided an update on the 2024 DHCS audit findings, highlighting ongoing corrective action plans (CAPs). - Blood Lead Screening – The state accepted actions taken, including chart reviews for initial health appointments, as of February 15th. - Appointment Wait List & Access Issues – A delegate had issues with appointment wait times, leading to a temporary panel closure (September 2024). The panel partially reopened in February for select assignments. The state accepted the corrective actions as of April 15th, but monitoring continues. - Office Wait Times & Provider Monitoring – Measures were implemented to track specialist and behavioral health provider wait times through the CG CAP survey. The state accepted this resolution as of March 15th. - Cultural & Linguistic Services (CLS) – Partially accepted, pending vendor interpreter qualification verification. This final deliverable, expected in May, will be reported at a quarterly vendor meeting to fully resolve the issue. Questions/Comments: J. Florey raises concerns about the impact of Anthem’s departure from the area, which led to a significant enrollment transfer to The Alliance. Previously, providers managed patients across both plans without a		

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		cap, but now, with all patients under one system, the 2000-member cap limits access to highly sought-after doctors. Florey suggests increasing the cap to 2500 or more, citing advancements in virtual care and patient education that have expanded provider capacity. The current cap, which dates back nearly 40 years, may no longer be appropriate. Alliance acknowledges the concern and commits to investigating the issue. They assure Florey that they will follow up on his request. Findings: • Blood Lead Screening Compliance – The state accepted actions taken to ensure lead screening in initial health appointments, including chart reviews, as of February 15th. • Appointment Wait List Management – A delegate faced challenges with appointment wait times, leading to a temporary panel closure. The state accepted corrective actions as of April 15th, but monitoring continues. • Office Wait Time Monitoring – Measures were implemented to track specialist and behavioral health provider wait times through the CG CAP survey. The state approved this as of March 15th. • Cultural & Linguistic Services (CLS) Compliance – Actions were partially accepted, pending verification of vendor interpreter qualifications. The final deliverable is expected in May to fully close out the issue. Recommendations:		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Enhance Provider Compliance Monitoring – Continue tracking appointment wait lists and office wait times to prevent future access concerns. • Strengthen Lead Screening Procedures – Maintain strict oversight of screenings during initial health visits to ensure compliance and early detection. • Improve Language Services Oversight – Ensure timely verification of interpreter qualifications and expand education on CLS standards. • Sustain Ongoing Provider Engagement – Regular monitoring and meetings should continue to assess corrective action effectiveness and prevent recurring issues.		
X. Access & Availability Update - MY2024 After Hours Survey Results	L. Tran	• The 2024 after-hours survey results were discussed, showing a similar response rate to the previous year, with specialists having the highest rate. • The compliant rate dropped slightly to 80% for all provider types except Behavioral Health which was included for the first time. • Issues such as providers using personal phones and incorrect contact information were noted, particularly affecting behavioral health services. • Efforts to update provider repositories and educate new providers are ongoing. • Future steps include sending information as part of the provider's calling package and offering training to improve timely access to care. Questions/Comments:		

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		D. Carey requests feedback on the effectiveness of quarterly provider packets, questioning whether providers engage with them and exploring alternative dissemination methods. J. Florey suggests discussing the matter in greater detail with Sharon at CFMG, who has insights into provider engagement. He also shares a technological approach using KOZIVA, which tracks whether encrypted emails are opened and monitors the duration of engagement. Florey recommends considering similar tracking methods to assess whether materials are being read and how long recipients interact with them. Findings: • Survey Participation & Compliance Trends – Response rates for 2024 were similar to previous years, with specialists maintaining the highest engagement. Compliance rates dipped slightly, particularly among behavioral health (BH) providers, who were included starting in Q2 2024. • Provider Access Issues – Some behavioral health providers used personal phones without emergency instructions, contributing to lower compliance. Specialists also had incorrect phone listings, affecting accessibility. • New Behavioral Health Providers – Many newly onboarded BH providers were unfamiliar with after-hours service standards, necessitating additional education and support. • Timely Access Challenges – Updates to provider repositories and outreach efforts aim to improve accessibility for members needing after-hours services. Recommendations:		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Enhance Provider Education – Expand training for new BH providers to ensure awareness of after-hours and timely access requirements. • Improve Provider Contact Accuracy – Continue updating provider repositories to ensure correct phone listings and eliminate accessibility gaps. • Increase Compliance Monitoring – Strengthen oversight of behavioral health provider practices, ensuring emergency instructions are available. • Expand Outreach & Training Efforts – Conduct more virtual and onsite visits to reinforce timely access policies and educate providers on compliance expectations.		
XI. Public Comment	D. Carey	none		
XII. Adjournment	D. Carey	Meeting adjourned at 10:34am		

X _____ Date _____
 Dr. Donna Carey
 Chief Medical Officer, Alameda Alliance for Health
 Chair

Minutes prepared by: Ashley Asejo - Clinical Quality Programs Coordinator

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Member Name and Title	Present	Member Name and Title	Present
Dr. Donna Carey, MD, Chief Medical Officer	X	Michelle Stott, Sr. Director of Quality	X
Dr. Beverly Juan, MD, Community Health	X	Dr. Peter Currie, Sr. MD, Behavioral Health	
Jessica Pedden, Quality Analytics Manager		Rommel Cuevas, Regulatory Compliance Specialist	
Tiffany Cheang, Chief Analytics Officer		Gia Degrano, Director, Medical Services	
Cecilia Gomez, Manager, Provider Services	X	Jennifer Karmelich, Director, Quality Assurance	
Christine Rattray, Supervisor, Quality Improvement		Darryl Crowder, Director, Provider Services	
Donna Ceccanti, Manager, Peer Review and Credentialing		Linda Ayala, Manager, Health Education	X
Homaira Momen, Quality Review Nurse	X	Hellai Momen, Quality Review Nurse	
Richard Golfin III, Chief Compliance Officer		Marie Broadnax, Manager, Compliance	X
Lily Hunter, Manager, Case Management		Dr. Rosalia Mendoza, MD, Utilization Management	
Loc Tran, Manager, Access & Availability	X	Farashta Zainal, Manager, Quality Improvement	X
Angela Moses, Quality Review Nurse	X	Allison Lam, Senior Director, Health Care Services	X
Fiona Quan, Project Specialist, Quality Improvement	X	Judy Rosas, Manager, Member Services	X
Heidi Torres, Quality Programs Coordinator	X	Kathy Ebido, Sr. QI Nurse Specialist	X
Tanisha Shepard, Project Specialist, Quality Improvement		Sophia Noplis, Compliance Auditor – Delegate Oversight	
Mao Moua, Manager, Cultural and Linguistic Services	X	Alma Pena, Grievance & Appeals Manager	X
Gil Duran, Manager, Population Health and Equity	X	Kathrine Goodwin, Supervisor, Health Plan Audits	X
Carlos Lopez, Manager, Quality Assurance and Regulatory Reporting		Sarbjit Lal, Project Specialist, Quality Improvement	X
Megan Hickman, Compliance Auditor – Delegation Oversight		Ami Ambu, Project Specialist II, Quality Improvement	
Crystal Hung, Quality Review Nurse		Rahel Negash, Pharmacy Supervisor	
Kayla Williams, Manager Member Experience & Program Management		Alexandra Loza, Quality Assurance Specialist	X
Robert Smith, Regulatory Compliance Specialist	X	Donna Wong, Senior Human Resources Generalist	X

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
I. Welcome/Agenda Review	L. Tran	The meeting was called to order by L. Tran at 1:02PM.		
II. Policy Updates • QI – 105 • QI – 107 • QI – 108 • QI - 116	L. Tran	M. Stott presented the policy updates for QI-105 Facility Site Review (FSRs), Medical Records Reviews (MRRs) and Physical Accessibility Review Surveys (PARS). The changes made are as follows: DSNP has been added to the document. HCQC was updated to QIHEC. Lastly, to clarify the monitoring of missed appointments are applicable to all providers. It was originally listed at the beginning of the policy but ensured that this stayed consistent throughout the policy. L. Tran went over the updates for policy QI – 107, QI – 108 and QI – 116. • QI – 107 Appointment Access and Availability Standards • QI – 108 Access to Behavioral Health Services • QI – 116 Provider Appointment Availability Survey (PAAS) Policies were all updated to include DSNP. • QI – 107 updated to include appointment wait time for DSNP. Include definition for routine and preventative care for DSNP. Also, monitoring of missed appointments to include all providers within the Alliance network. Historically, it was stated for Alliance physicians. • QI – 108 updated include DSNP line of business. • QI – 116 updated to include appointment wait time requirement for DSNP. - Urgent/Emergency without prior authorization needs to be reviewed immediately - Non-Urgent (PCP) – 7 business days of request - Routine/Preventive Care – 30 business days of request Montion for Approval: Michelle Stott Second: Dr. Beverly Juan		
III. APL 25 – 006 Timely Access Standards Update	L. Tran	L. Tran spoke on the new APL 25 – 006 DHCS released on April of 2025. DHCS will continue to utilize 3 rd party vendor to administer the QMRT survey.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		Minor changes were made to the Timely Access Standard which now include Specialist for both the Urgent Care Appointment with No Prior Authorization within 48 hours and Urgent Care Appointment with Prior Authorization within 96 hours. DHCS now included a new Minimum Performance Level (MPL) requirement of 70% effective 01/01/2025 to 12/31/2026. In 1/01/2027 the MPL will raise to 80% and finally by 01/01/2028 the MPL will rise to 90%. Currently, the Access team is meeting with providers and sharing the new APL. Updates to the quarterly provider packet and provider manual to include the new APL. Scheduling follow-up meetings with Compliance and cross functional teams to review the new APL as this will impact multiple departments.		
IV. Compliance Updates	M. Broadnax	M. Broadnax provided compliance updates. Compliance hired two new staff members: • Catherine Knezevic is the new Privacy Manager who started about 3 or 4 weeks ago. • Lisa Sciutto is the new Regulatory Affairs Specialist who started 1 week ago. She will be working directly under M. Broadnax and Jill. Her primary role would be focusing on the policies for the DSNP line of business. M. Broadnax wanted to thank everyone involved in the submission for the DMHC Timely Access Reporting/Annual Network Review – Documents were submitted on May 1, 2025, on its due date without incident. DHCS Subcontractor Network Certification (CHCN and CFMG Network) – is still ongoing. Rommel is currently working internally with the department’s subject matter experts. DHCS Annual Network Certification (Direct Network) – Expecting phase 2 instruction submission from DHCS. DHCS APL 25-006 – Timely Access Requirements: Rommel is leading the charge to ensure new APL is implemented.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		DHCS APL 25-007 – Enforcement Actions: Specific call out requirements for network adequacy and timely access. Health Services Advisory Group (HSAG) contracted with DHCS to conduct the Network Adequacy Validation (NAV) Audit. There is a technical Assistance Webinar on June 5, 2025, to learn the next steps. Broadnax noted there was a webinar last year that was more of a general overview, but the webinar in June should be more in-depth. More information to come after the webinar. Alliance Wellness DNSP: - The compliance team had created a CARE form that should be rolled out soon to help manage/track teams who need access to HPMS (Health Plan Management Systems). Questions: C. Gomez asked a question pertaining to the DHCS ANC Audit. She noted in one of the technical calls with DHCS, DHCS mentioned they would share documentation showing where the Alliance fell on the ratios for provider types. Has there been an update on that information? - M. Broadnax answered that no updates have been received and would have Rommel follow up on that information. M. Stott asked to clarify the access Operational Leaders will have for the HPMS account. Will the Operational Leaders be able to enter in information for submission or does the report go through Compliance and Compliance will submit the request. - M. Broadnax answered that she is aware there are certain reports that Operational Leaders can download and have access to self-serve in HPMS. When it's in regard to submission, most reports will go through Compliance and the Compliance team will submit on behalf of the organization. The Compliance team is working on figuring out the various roles within HPMS in comparison to department to identify who needs access within HPMS. More to come once everything is laid out.	M. Broadnax and Rommel will follow-up with DHCS on the document showing where Alliance fell on the ratios for provider types.	
V. MY2024 PAAS Updates	L. Tran	L. Tran went over the MY 2024 PAAS (Provider Appointment Availability Survey) results. As a reminder, since 2023 an additional seven specialty types were added equaling to a total of 10 specialty types: Cardiology, Endocrinology, Gastroenterology, Dermatology, Neurology, Oncology, Ophthalmology, ENT, Pulmonology, and Urology.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		<u>Compliance Rates:</u> Alameda Alliance compliance rate for Urgent and Non-Urgent appointments is 75% while DMHC compliance rate is 70% <u>Ancillary:</u> Comparing 2023 and 2024 compliance rate, roughly a 27% decrease in compliant score for non-urgent appointment standards. The 70% DMHC compliance goal was met for this provider type but not for the Alliance compliance goal in MY2024. <u>PCP:</u> Comparing the 2023 and 2024 compliance rates. For IHSS Urgent appointments there was a 16.7% decrease in compliance rate, and a 7.9% decrease for the MCL line of business. For the Non-Urgent appointment there was a 1.2% decrease for IHSS and a 2.8% decrease for MCL. Overall, PCPs scored 55.4% for Urgent appointments and 69.9% for non-urgent appointments, resulting in both standards not meeting the threshold goal. <u>NPMH:</u> Urgent appointments, IHSS had a 4.8% decrease while MCAL had a 5.3% decrease. For the Non-Urgent appointment, IHSS had a 9% increase and a 6.6% increase for MCAL. Overall, Urgent appointment received an 81.6% compliance score and Non-Urgent appointment scored 91.1% for MY2024. Even though there was a slight decrease in the Urgent Appointment compliance score, both appointments scored well above the compliance threshold goal year after year. <u>Psychiatrist:</u> Urgent appointments had a 3.5% increase for both lines of business while Non-Urgent appointments had a 3.9% increase for both line of business. Overall, Urgent appointments scored an 80.4% compliance rate and Non-Urgent appointments scored an 96.2% compliance rate, both meeting the threshold goal in MY2024. <u>Specialist:</u> Urgent appointments for IHSS decreased by 20.7% while MCAL decreased by 7.2%. For Non-Urgent appointments, there was a decrease of 5.5% for IHSS and 4.9% for MCAL. Overall, Urgent appointments had a compliance score of 48.1% and Non-Urgent appointments had a score of 51.5%, both appointment standards did not meet the compliance threshold goal. <u>Provider Response Rates:</u>		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		Comparing the ineligible providers percentages between 2023 and 2024 there was improvement for Psychiatrist, PCP and Specialists provider types. Increases in ineligible providers were noted for Ancillary and NPMH. For Non-Responsive percentages broken down by provider type, Specialist had the highest non-responsive rate compared to other provider types. <u>Compliance Breakdown by Provider Type:</u> <u>Ancillary:</u> For measurement year 2024, 40 surveys were sent for the Ancillary provider type. 22 eligible survey responses were received. Of the 22 responses 16 were compliant for non-urgent appointments, resulting in a compliance rate of 75.7%. Of the 20 unique providers surveyed, 4 were non-responsive and 5 were ineligible due to contact information issues or provider not in network. <u>Primary Care Physician:</u> Of the 756 surveys sent out in 2024, 463 survey responses were Eligible. 220 were compliant for urgent appointments and 318 were compliant for non-urgent appointments. The survey also showed a high number of 66 providers not offering urgent appointments. Of the 434 unique providers, 99 providers did not respond to the survey. Of those 99 providers, 97 did not answer the phone. 60 providers were ineligible with the top three reasons being: contact information issues, providers not offering appointments, or providers not in the county. <u>Non-Physician Mental Health:</u> Of the 600 surveys sent out in 2024, 328 eligible responses were received. The compliance rate for urgent appointments was 81.6% while for non-urgent appointments is 91.1%. Overall, NPMH scored well in MY2024 but there were still 72 providers noting they do not provide urgent appointments. Of the 307 unique providers, 117 were not responsive and 25 for ineligible. The top two reasons being contact information issues and provider does not offer appointments. <u>Psychiatrists:</u> Of the 146 surveys sent to 2024, 104 survey responses were eligible. Psychiatrists scored well in compliance rate for MY2024, with 80.4% for urgent appointments and 96.2% for non-urgent appointments. Of the 73 unique providers surveyed 15 providers were non-responsive and 6 were ineligible. Of the 6 ineligible the top reason was for providers not offering appointments.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		<u>Specialist:</u> Total survey conducted in MY2024 was 3929. 1081 of those survey responses were eligible with 344 compliant responses for urgent appointments and 553 compliant responses for non-urgent appointments. There were also 298 providers who did not offer urgent appointments. Of the 2005 unique providers surveyed, 1254 unique providers were non-responsive. 644 providers did not answer the phone while 610 providers declined to answer the survey. 194 unique providers were ineligible with the top three reasons being: providers do not offer appointments, contact information issue, and provider listed under incorrect specialty. Questions: M. Stott asked if the change in methodology in MY2024 affected the compliance rate? - L. Tran noted this is possible. MY2024 is the first year where a vendor (Q-Metric) was used to conduct the survey. Historically, the PAAS would be conducted in-house and once the sample size requirement by DMCH was reached the survey will conclude. However, with Q-Metrics, we are now surveying all providers within the Alliance network, and this is also the first year Kaiser is not included as part of the survey. Both changes can play a part in affecting the compliance rate for MY2024.		
VI. OBGYN A&A Monitoring Q1 2025	S. Lal	S. Lal presented on the OBGYN A&A Monitoring report for Q1, 2025. This quarter the number for PQI related to OBGYN has dropped to 6. Of the 6 QOAs received 2 were related to Highland Hospital, 1 for Highland Wellness, 1 for Tiburcio Vasquez, 1 for Stanford Healthcare, and 1 for individual provider. For the six PQIs, after conducting confirmatory surveys, 1 was found to be compliant and five were non-compliant. For the providers who were non-compliant, the A&A team will continue to track and trend for two consecutive quarters, identify areas of improvement and issue corrective action plans if applicable.		
VII. Geo-Access Update - ANC - SNC (CHCN & CFMG)	S. Lal	S. Lal presented Geo-Access Updates for Q2, 2025. Distance is within 15 miles Time is within 30 minutes ANC: Specialties and cities listed did not meet both Time and Distance. <u>Tracy</u> continued to not meet: Adult Endocrinology, Adult/Pediatric Ent/Otolaryngology, Adult/Pediatric General Surgery, Adult/Pediatric Hematology,		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		Adult HIV AIDS ID, Pediatric Nephrology, Adult/Pediatric Neurology, Adult/Pediatric Oncology, Adult/Pediatric Orthopedic Surgery, Pediatric Physical Medicine RH, and Pediatrics Pulmonology. • <u>Mountain House</u> did not meet: Pediatric General Survey, Pediatric Hematology, Adult HIV AIDS ID, Pediatric Nephrology, Adult/Pediatric Orthopedic Surgery, Pediatric Physical Medicine RH, and Pediatrics Pulmonology. • <u>Byron and Discovery Bay</u> did not meet: Pediatric Nephrology, Pediatric Physical Medicine RH, and Pediatrics Pulmonology. Improvement was noted from Q1, 2025 to Q2, 2025 for Dublin, Livermore and Pleasanton for Pediatrics Nephrology, we're compliant with Geo access for Q2. SNC CFMG: For Q2, 2025 not much has changed from the previous quarters, there are still specialties like Endocrinology, Hematology, HIV AIDS ID, Nephrology, Neurology, OBGYN, Oncology, Physical Medical RH, and Pulmonology which have zip codes that we're not meeting both time and distance. These deficiencies will be highlighted and discussed at future CFMG meetings. The A&A team is also taking a deep dive into the clinics around these cities for these specialties who are not contracted with CFMG but might be interested too. SNC CHCN: For Q2, 2025 Livermore had appeared back on the list as not meeting both time and distance for PCP. Majority of the specialties do not meet time & distances are in the Livermore area. A&A team investigated zip code 94550 where a majority of the Livermore members reside. We also found that Livermore also has members who reside more on the outskirts that can be far from the main city where all the clinics are located. At the last Geo-Access meeting, the analytics team reported that the Alliance has 3006 members who reside in the Livermore area and of those 2998 members have access. There is a possibility that the remaining members who do not have access reside on the outskirts of Livermore. Moving forward, the Geo-Access team will take a deeper dive into other zip codes not meeting time and distance. Questions: M. Stott asked what are the specific steps to be taken for cities not meeting time and distance? - S. Lal answered for the eight members noted not having access to Livermore. The team will investigate the specific zip code and area the members reside in at Livermore.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		- L. Tran added that areas which are not meeting distance time, we have to understand how many members are then impacted by those zip codes. This information will be shared with the delegate groups (CHCN and CFMG) at their monthly joint meetings. With this information, we would suggest the delegate groups outreach to nearby clinics to contract with. In addition, every year the SNC report is submitted to the State noting the areas that are not meeting time and distance and alternative access is request for those zip codes. M. Stott asked if all these non-compliant specialties have alternative access in place already? - L. Tran confirmed, yes. Even with the alternative access in place, we are still required to monitor on a quarterly basis and provide updates internally and externally.		
VIII. Access- Related PQI Dashboard	H. Torres	H. Torres presented the Q1, 2025 QOA PQI Dashboard. QOA PQI (Quality of Access Potential Quality Issues) can fall within any of the following categories: Time to Answer Call, Call Return Time, In-Office Wait Time, Urgent Appointment, and Non-Urgent Appointment. For Q1, 2025, there was a total of 571 QOA PQIs, with Non-Urgent Appointment being the highest category that received the most PQIs and Time to Answer Call being the second. There was a total of 21 PQIs related to Behavioral/Mental Health with Time to Answer Call being the highest and Call Return Time and Non-Urgent Appointment being the second. There were no PQI exceeding the 120 days. For tracking and trending referrals in Q1, 2025 there are still 196 cases still opened and 375 closed out of the total 571. In Q1, 2025 a total of 48 providers were trended for 2 consecutive quarters and after reassessment 32 of those providers were found to be non-compliant. Most of the facilities that received 15 or more referrals mainly belong to the CHCN or Alameda Health Systems clinics. Most of the CAPs issued for this quarter belong to CHCN and Alameda Health System clinics. The A&A team continues to meet with providers virtually and/or onsite to provide timely access to care training and to be aware of any barrier's providers may experience. A&A continues to work with providers to decrease grievances related to access.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		L. Tran added that the number of providers who are trending for two consecutive quarters has gone down quarter after quarter. Compared to Q1, 78 providers were trended for Q2 and there were around 100 providers were trended in Q1. A&A continue to meet with providers via virtual or in-person to educate the providers and their supporting staffs regarding the timely access requirement.		
IX. CG-CAHPS Q4 2024	F. Quan	F. Quan went over the Q4, 2024 CG-CAHPS report. PCP – In-Office Wait Time: <i>Question: how many minutes did you typically wait in the waiting room and exam room until you/your child saw the provider?</i> - Less than 60 minutes is the compliant answer - Percentage goal is 80% In Q4 2024 there was a slight drop of 3.4% in percentage score, but the metric continues to score above the 80% threshold goal at 90.5%. All network providers continue to score above the 80% threshold goal for In-Office Wait Time. PCP – Call Return Time: <i>Question: when you called this provider's office during regular office hours, when did you get a call back?</i> - Within 1 business day is the compliant answer - Percentage goal is 70% There was a 12.4% increase from Q3, 2024. The metric score was 85.9% in Q4, 2024 which is the highest percentage score received compared to the past rolling quarters where all compliance scores were around 70%. The percentage increase was also reflected in percentage increases for all network providers, especially Alameda Health Systems, which received a significant increase of 27.4%. All network providers scored above the 70% goal in Q4, 2024. PCP – Time to Answer Call: <i>Question: when calling the provider's office during regular office hours, how long did you wait to speak to a staff member?</i> - Within 10 minutes is the compliant answer - Percentage goal is 70% There was a 3.4% compliance rate increase from Q3, 2024 which brought the compliance score to 80% this quarter. All provider networks met the 70% threshold goal this quarter.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		PCP – Urgent and Non-Urgent Appointment: This surveys how accessible members feel when scheduling an urgent and non-urgent appointment. - Within 48 hours of request for Urgent Appointment - Within 10 business days of request for Non-Urgent Appointment. - Percentage goal is 75% Like the PAAS survey, Non-Urgent appointment standard usually scores better than the Urgent appointment Standard. Across the four quarters, Urgent appointment had a compliance rate around 60% while Non-Urgent Appointment had a steady increase from 70% and scored 89.4% this quarter. PCP – Tracking and Trending Q2, 2024 to Q4, 2024: Tracking and trending are done for 3 consecutive quarters before issuing a Corrective Action Plan. Compared to Q3, 2024 tracking and trending list, improvement across all three metrics In-Office Wait Time, Call Return Time, and Time to Answer Call was noted. Both In-Office Wait Time and Time to Answer Call had no trending providers. As for Call Return Time, eight providers were trended in Q3, 2024 while only one provider trended for CHCN – Baywell East Oakland. Currently, A&A team is in the process of securing a meeting with Baywell to discuss survey results. Reminder: Behavioral Health (BH) was included in the CG-CAHPS survey starting Q2, 2024. Q4, 2024 is the first quarter in which there were three quarters worth of data to compare. BH – In-Office Wait Time: <i>Question: how many minutes did you typically wait in the waiting room and exam room until you/your child saw the provider?</i> - Less than 60 minutes is the compliant answer - Percentage goal is 80% There was a slight decrease in percentage score from 90.5% in Q3, 2024 to 89.7% in Q4, 2024. However, metric continues to meet the percentage goal of 80%. All provider networks continue to score above the threshold goal this quarter. BH – Call Return Time:		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		<i>Question: when you called this provider's office during regular office hours, when did you get a call back?</i> - Within 1 business day is the compliant answer - Percentage goal is 70% When the survey was initially conducted in Q2, 2024, our compliance rate was 72% which we met the compliance goal. In Q3, 2024 the score dropped below compliance rate threshold at 61.9%. This quarter a significant increase of 11.8% was noted and brought the compliance rate back and we exceeded the threshold goal at 73.7%. Increase in percentage score was noted for all provider types. CFMG and CHCN are now meeting the threshold goal while the Alliance is about 2% below the 70% goal. BH – Time to Answer Call: <i>Question: when calling the provider's office during regular office hours, how long did you wait to speak to a staff member?</i> - Within 10 minutes is the compliant answer - Percentage goal is 70% There was a 1.8% increase in percentage score for the Time to Answer Call metric. The metric along with all provider types continue to meet the percentage goal of 70% this quarter. BH – Non-Life Threatening Emergency: <i>Question: when calling the provider's office to get an appointment for emergency mental health care that was not life threatening, when was your appointment scheduled?</i> - With 6 hours is the compliant answer - Percentage goal is 80% In Q4, 2024 our score was at 77.6% which show an increase of 5.8% from Q3, 2024. However, the metric is still slightly below the 80% compliance goal. Overall, percentage increases were seen in all network providers. BH – Urgent and Non-Urgent Appointment: - Within 96 hours of request for Urgent - Within 10 business days for Non-Urgent - Percentage goal is 75% Similar to the PCP's Urgent appointment rate, BH also scores around the 60% range. For the Non-Urgent appointment, the compliance score fluctuated between the quarters. In Q3, the		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		compliance dropped below the compliance goal at 71.8% but in Q4 there was a 5.8% increase that brought the non-urgent appointment metric back above the 75% threshold goal. BH – Tracking and Trending Q2, 2024 to Q4, 2024: This is the first time that we’ve had three consecutive quarters worth of data for tracking and trending. No providers trended for In-Office Wait Time. Call Return Time, Time to Answer Call, and Non-Life-Threatening emergency appointment availability, Alameda Health Systems and Davis Street Primary Care were trended for all three metrics.		
X. Access CAP Dashboard	F. Quan	F. Quan went over Q2, 2024 to Q1, 2025 Access CAP dashboard. During this timeframe a total of 411 CAPs were issued with majority of the CAPs related to PAAS as it’s our biggest survey. After PAAS it would be PQI and QMRT where we issued the most CAPs since QMRT is surveyed quarterly and PQI monthly. There are 225 CAPs open with majority of them relating to the PAAS since it has many individual providers and requires extra time to conduct follow-up with providers. A total of 261 CAP has been closed. The A&A team is working diligently to follow up with providers to close CAP by following the escalation process. We also work with Donna (Credential) and Provider Services team to acquire additional contacts if the A&A team is unable to reach providers. Top five trending providers continue to be: • Alameda Health Systems • David Street Primary • John Muir Physician Network • Stanford • UCSF A&A team continue to have QI monthly and JOM meetings with Alameda Health System to discuss access and the next action steps. Currently, the A&A team is working to schedule meetings with Davis Street, John Muir and UCSF to go over access data. Stanford has been harder to outreach too, but A&A will work with the top five trending providers to help improve their compliance/response rates. Currently in 2025 we have already met with the following providers: Tiburcio Vasquez Health Center, Axis Community Health, Alta Bates Perinatal Center, CHCN, La Loma, and Lifelong Medical Care.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		The A&A team is currently finalizing a time to meet with Davis Street Primary, Asian Health, UCSF, and CFMG. If anyone would like to attend the meetings or would like us to disseminate information, please let the A&A team know. Questions: K. Ebido asked who from UCSF do we speak with, since there are many different clinics under the UCSF umbrella. - F. Quan replied the three main contacts at UCSF are Guy, Eve, and Diana and they usually are the ones responding to all our questions and CAPs. Recently, for Ancillary provider type they added a new contact, but majority of the questions referred to the three main contacts we have. K. Ebido asked to join the UCSF meeting once scheduled. - F. Quan confirmed will follow-up with K. Ebido once scheduled. Summary and Next Steps for Access and Availability: L. Tran -Improvement in scores for MY 2024 PAAS was noted for Psychiatrist. Both NPMH and Psychiatrist provider types meet the compliance goal of 75% for MY2024 PAAS. As for member assessment survey (CG-CAHPS) improvement was also noted for In-Office Wait Time, BH Non-Life-Threatening emergency appointment, and non-urgent appointment metrics in Q1 – Q4, 2024. For the next steps: • A&A continues with the provider engagement: ongoing provider education via virtual or onsite training, share survey data and trends. • Send out non-compliant or non-responsive corrective action plans to any providers who did not meet compliance rate threshold. Also, to increase providers' response rate, A&A disseminate survey information and reminders during quarterly provider packet. • Setting up meetings with Q-Metrics to discuss and learn more about data extractions for the upcoming PAAS. Data extraction process would alleviate the emails and phone calls to provider offices and hopefully increase response rate. More to come on data extraction. • We continue to promote best practice, provider incentives, and encourage provider to consider open access scheduling. In which some providers did adopt the open access	K. Ebido would like to join the UCSF meeting once scheduled.	

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		scheduling which allows them to block out a portion of their schedule for urgent and follow-up care appointments. - Urgent and non-urgent appointments continue to be part of the pay for performance. QI team is offering incentives for providers who are interested in extending their office hours, provider recruitment and retention to help maintain or improve appointment availability. Even so, many providers still express staffing shortages, competition for recruitment, and space availability. Focus areas: - Tracking and trending the top five non-compliant providers and schedule meetings to identify opportunities for improvements. - Members facing documents-create alternative access documents focusing on decreasing ER Utilization and member assessment survey focusing on increasing member's response rate. - Provider Recruitment-collaboration with Provider Services and Network Contracting by sharing Geo-Access data and survey responses regarding providing updates with Network and contracting team for Network Road Map planning. - Improve survey responses and lower ineligible providers. Often when meeting with provider offices, due to staff turnover, a lot of contact information we have is not up to date, the A&A team is working internally and externally to improve provider contact information which can benefit the quality of our future surveys and refine our corrective action plan, process, and actions taken in collaboration with other departments,		
XI. Provider Network Capacity Report (May)	C. Gomez F. Quan	C. Gomez went over the May Network Capacity report. Reports are used to monitor members to PCP assignments. Providers who are at 80% or more will appear on the list to be monitored. 80% - 90% outreach is done to the provider listed to inform them of where they stand in their capacity. If the provider is at 90% their panel will be closed to auto assignment. If the provider reaches 100%, they will be closed to all assignments. Adrain Lemar James, MD under CHCN network, is an error. It's an error because member assignments are done at the clinic level not at the individual level for CHCN contracted providers. Rhodora Cruz De La Cruz, MD is the only provider who reached above 90%, and her auto assignment has been closed. Confirmed from IT of closure. All other providers are in the 80% - 90% range and have been outreached to inform them of their capacity. Providers		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		who fall under CFMG network, communication goes directly to CFMG and CFMG will inform their providers. Questions: D. Carey asked which provider is no longer able to enroll new members? - C. Gomez answered that currently only auto assignments have been closed. This allows members to still call in to request assignments, but the provider will not have members auto assigned to them. D. Carey asked which provider and what is their specialty? - Dr. Rhodora Cruz De La Cruz is at 97.35% capacity and is a Pediatric PCP provider. B. Juan asked to clarify is the capacity calculated by clinic and not provider? - C. Gomez answered that it was an error in the report. CHCN network providers are not assigned on the individual level but at the clinic level and are monitored in a different way. B. Juan asked because Dr. Suri and Dr. Lopez, are both at the same practice and are both on the capacity report. Both providers have their own 2000-member capacity, correct? - C. Gomez answered, Correct. Only FHQC are assigned at the site level all other providers are assigned at the provider level. F. Quan went over the PQIs received for the providers listed on the Capacity report. Not all providers received PQIs, the following providers who did are listed below: • Amita Sharma, MD – Had 1 PQI for Non-Urgent Appointment and when we conducted the confirmatory survey it was non-compliant. Non-Compliant providers are tracked and trend for three consecutive quarters. • Gautam Pareek, MD – Had 2 PQIs, 1 In-Office Wait Time and Call Return Time both were non-compliant when confirmatory survey was conducted. • Najibulrahman Saifulrahman, MD – Had 2 PQIs both for Time to Answer Call and was non-compliant when confirmatory survey was conducted. • Rejesh Sam Suri, MD – Had 1 PQI for Time to Answer Call and was compliant after confirmatory survey was conducted. • Rhodora Cruz De la Cruz, MD – Had the most PQIs out of all the providers with a total of 4 PQIs all related to Time to Answer Call. In which, 3 were compliant and 1 was not after confirmatory survey was conducted.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		Yahaira Lucia Lopez Arredondo, MD – Had 3 PQIs 2 for Time to Answer Call which was compliant after confirmatory survey and 1 for Urgent Appointment. Urgent appointment was not compliant after confirmatory survey.		
XII. Grievance & Appeals	A. Loza	A. Loza presented on Q1, 2025 Access and Availability Grievances Related Report: IHSS: There were 140 standard grievances related to access in quarter 1. All were closed within the 95% compliance rate. There were no expediated access related grievances this quarter. There were 82 exempted grievances which were also close within the 95% compliance rate. Quarter 1, 2025 had 222 access cases. The total grievance cases for IHSS members this quarter was 430. Standard and expediated grievances related to access are then separated by filed against type which are: Ancillary Provider, Clinic, Delegate, Hospital, Mental Health Facility, Other, Out of Network, PCP, Plan, and Specialist. Standard/Expediated grievances: 52 cases filed against The Plan related to Access to care. 19 related to authorization. 3 for Geographic Access. 4 for out of network, 10 for provider availability, and 16 related to technology/telephone. 44 cases filed against Clinics. There was 1 clinic identified with more than 5 unique grievances for the reporting quarter. Which was for Alameda Health System – Hayward Wellness Center. 14 cases were filed against PCPs but there were no PCPs identified with more than 5 unique grievances. 10 cases were filed against Specialists but there were no Specialists identified with more than 5 unique grievances. Exempt grievances: 29 cases were filed against The Plan and 27 of those were related to Telephone/Technology which consist of ID Card issues, Member portal issues, Other, and Telephone Access. - There were no providers (PCP, Specialist, Clinics) identified with 5 or more grievances for the reporting quarter		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		Medi-Cal: There were 2,647 standard grievances related to Access in Q1. All were closed within the 97.7% compliance rate. There were no expedited Access related grievances. There were 2,219 Exempt Grievances related to Access and they were closed within the 99.5% compliance rate. The total number of Access related cases this quarter is 4,866 and the total number of grievances received this quarter was 11,610. Standard/Expediated grievances: • 465 cases were filed against The Plan. 404 of the cases were related to AAH system Error issues which fell within the category of (291) Other Health Insurance, (61) ID Card Issues, (32) Member Portal Issues, (14) Other, (3) Specific Provider Directory Error, (1) Call Back/phone issues unrelated to different issues type, (1) Other Authorization issues, and (1) Other Care Coordination Issue. • 1,351 cases were filed against Clinics and the clinics below had the highest number of grievances related to Timely Access: - 291 Alameda Health Systems clinics (Newark, Hayward, Highland, and Eastmont Wellness Center) - 248 CHCN Clinics - 15 Davis Street Primary Care - 10 AmCare Medical Group • There were no providers (PCP and Specialist) identified with 5 or more unique grievances for the reporting quarter Exempt grievances: • 900 cases were filed against The Plan, most of them related to technology/telephone: Replacement ID Cards, Accessing Member Portal issues, and Phone/Systems issues • 601 cases were filed against Clinics with the clinics below having the highest number of grievances: - 81 Alameda Health Systems - 161 CHCN Clinics - 11 Davis Street Primary Care • 404 cases were filed against PCPs and 5 providers were listed to have 10 or more unique grievances filed against them: - 10 Dr. Rhodora De La Cruz - 10 Dr. Sylvia Hoang		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		- 10 Dr. Lucia Lopez Arrendondo - 15 Dr. Ranjana Sharma - 12 Dr. Jennifer Tsai • There were no specialist providers who identified with 5 or more unique grievances. L. Tran added that the telephone issue was one of the highest cases filed against. But when you compare data between Q1, 2024 to Q1, 2025 there is improvement quarter after quarter where the number of cases is trending down. The A&A team also notice this trend when meeting with providers such as La Clinica. In Q3 and Q4 they were updating their phone system which caused a lot of incoming call delays and the members' phone calls not being answered. In the most recent meeting with La Clinica the telephone system has been fully upgraded, and telephone issues started to trend down as of Q4, 2024 to Q1, 2025. Questions: M. Broadnax asked if clinics or contracted providers are required to inform the Alliance if they are going through system updates or changes that can affect the member experience? - L. Tran answered there are no regulatory requirements. Usually, the A&A team finds out when conducting reassessments, confirmatory survey or during provider meetings. However, we do encourage providers to inform us if they have a closure, system updates, or issues that might affect their day-to-day business to reach out to the team. For example, Tiburcio Vasquez provided us with monthly updates when they had a site closed to new members. M. Broadnax noted this would be good information to know ahead of time, to better prepare the Member Services team on the possible influx of calls and how to properly mitigate the issue. - L. Tran agrees and states that is why there are monthly meetings with these providers to stay up to date with information. If there are updates, we will disseminate information to all the effected departments.		
XIII. FSR/MRR Updates	K. Ebido	K. Ebido presented on Q1, 2025 FSR/MRR updates. There was a total of 39 different audits conducted this quarter. Along with the audits the FSR team also conducted training and education meetings. There was a total of 7 trainings completed with the following providers: • TVHC		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		• Rabin Khetrapal, MD • B. Ann Parker, MD • Highland Wellness • John Muir • Lifelong – Howard Daniel • Roots Community Health Failed Reviews: There was a total of 4 providers who failed the review. Some of the doctors that failed the review were Dr. Kishore Narra, Dr. Rajiv Ahuja, and Dr. Zulfiqar Ali which all reside in the Fremont area. Dr. Ali had failed both the site and medical record review. Membership Hold: When a provider fails or does not compliant with submitting their CAPs, their membership is placed on hold. One of the providers placed on hold was Dr. Khetrapal because he could not close his CAP within the timeframe. The following providers had membership holds: • Rabin Khetrapal, MD • Kishore Narra, MD • Rajiv Ahuja, MD • Zulfiqar Ali, MD Corrective Action Plan (CAP) – PCP: The goal for the FSR team is to receive the CAP within 30 days from the report and not exceed the 90 days mark. In Q1, 2025 there were a total of 24 CAPs issued. 88% of those CAPs were closed within the 30 days mark. There are currently no CAPs open outside the 120 days. The providers currently who still have open CAPs but have no exceeded the 90 days are: • Highland Wellness • Asian Health Services • California Cardiovascular • Newark Wellness • Washington Township • Mowry		

ACCESS AND AVAILABILITY SUBCOMMITTEE

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Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		Critical Element (CE) CAPs: Critical elements CAPs have a weight of two points and need to be corrected within 10 business days. All CAPs with critical elements are closed. Most of them are criteria regarding emergency equipment like ambu-pag, and non-safety needles onsite are the most seen. Audit of Initial Health Appointment (IHA) via FSR 2025: In Q1, there were 12 eligible provider sites to be reviewed for IHA. The look back period for IHA is 3 years. When sampling charts, the FSR team can also see if new members were assigned. About 67% of the IHA reviewed were non-compliant. The FSR team will continue to work with the providers, commonly providers do the assessment within 120 days, but it's not fully completed, or they miss the risk assessment that is also required. SNF Quality Monitoring: Another quality related monitoring where the team looks at the star rating for SNF. 9 sites have a 1-star rating and 10 sites have a 2-star rating. Even though we have 9 sites that have a 1-start rating only 5 of those sites have Alliance members at them. For example, there are currently no members reported at Atherton and Menlo Park care centers. The FSR team also monitor if incoming PQIs for the listed facilities come in as level C3. When reviewing 2024 data there were no C3 leveled PQIs except for one on the 2-star facility list which had 1 C3 PQI. FSR team will continue to monitor the data and at the next meeting will include updates from PQIs received in Q1, 2025. Questions: M. Stott noticed the report showed addresses that are out of the Alliance services area like Cupertino and Stockton. - K. Ebido answered that the facilities are received from the analytics team report. From there the FSR team will go on the CDPH website to obtain the Star Rating. M. Stott asked Allison Lam if she had any insight into some of these sites that are outside the service area and if there were any precautions taken for members there. - A. Lam noted members this can be due to the transition when the Alliance inherited members who were already in those areas but outside of the Alliance area, and to bring those members back in house has posted a challenge since most of them reside in those settings for a while.		

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
XIV. Member Services Telephone Wait Time & Call Center Dashboard	J. Rosas	J. Rosas presented on the Member Services Call Center Dashboard for Q1, 2025 for both Medical and GroupCare line of business. Target goal is to answer 80% or more of the incoming calls within 30 seconds or less and have an abandonment rate of 5% or less. In Q1, 2025 there were 57, 291 calls and 54,710 calls were answered. The abandon rate was 4%. On average the calls were answered in 13 seconds. Calls answered in 40 seconds or less were 94% and the average talk time was 7 minutes and 31 seconds. The goal to answer calls within 10 minutes was met with 100% in Q1, 2025. In Q1, 2025 there was a 16% increase in calls compared to Q4, 2024. The top reasons for calls this quarter were PCP change, eligibility and enrollment, grievances and appeals, benefits and provider network information. While there was a slight decrease in benefits and PCP change related calls there was an increase in calls related to eligibility enrollment and grievances and appeals. Volume for provider network related calls remains the same.		
XV. Q&A	All			
XVI. Meeting Adjourn	L. Tran	Next Meeting: September 10, 2025		

Meeting Minutes submitted by: Fiona Quan, Quality Improvement Project Specialist Date: 07/10/2025

Cultural and Linguistic Services Subcommittee (CLSS) Meeting
April 23, 2025

Committee Member Name	Title	Present
Linda Ayala, MPH	Director, Population Health and Equity	X
Farashta Zainal, MBA, PHP	Quality Improvement Manager	X
Tran Loc	Manager, Access to Care	X
Donna Carey, MD	Chief Medical Officer	
Darryl Crowder	Director, Provider Services	
Gia DeGrano	Director, Member Services	
Carlos Lopez	Quality Assurance and Regulatory Reporting Manager	X
Cecilia Gomez	Sr. Manager, Provider Services	
Beverly Juan, MD	Medical Director, Medical Services	
Jennifer Karmelich	Director, Quality Assurance	
Michelle Lewis, MPH	Manager, Communications and Outreach	
Alma Pena	Manager, Grievances and Appeals Manager	X
Mao Moua, MPA	Manager, Cultural and Linguistic Services	X
Gil Duran, MPH	Manager, Population Health and Equity	X
Lao Paul Vang	Chief Health Equity Officer	
Michelle Stott, MSN	Senior Director of Quality	
Anastacia Swift	Chief Human Resource Officer	
Allison Lam	Senior Director, Health Care Services	
Andrea DeRochi	Behavioral Health Manager	
Lisha Reamer-Robinson	Manager, Compliance Audits, and Investigations	X
Marie Broadnax	Manager, Regulatory Affairs & Compliance	X
Yen Ang	Director Health Equity	X
Shatae Jones	Director Housing & Community Services Program	X

Staff Member Name	Title	Present
Yemaya Teague	Senior Analyst of Health Equity	X
Cindy Brazil	Interpreter Services Coordinator	X
Sylvia Guzman	Interpreter Services Coordinator	X
Mara Macabinguil	Interpreter Services Coordinator	X
Berenice Sanchez	Lead Interpreter Services	X
Mandy Gutierrez	Senior Communications & Media Specialist	X
Rosa Carrodus	Disease Management Health Educator	X
Robert Smith	Regulatory Compliance Specialist	X

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
1. Call to Order/Introductions	M. Moua	M. Moua called the meeting to order.	
2. Minutes from 1/22/2025 Meeting	M. Moua	Mao asked participants to review the minutes from the January meeting, attached to the meeting invite, and to raise any questions or changes.	
3. Agenda Review	M. Moua	M. Moua reviewed the agenda.	
4. Follow-up items from 1/22/2025	M. Moua	M. Moua reported on the follow-up items from the last meeting. - Review Cultural and Linguistic Services Subcommittee (CLSS) Charter. - Charter will be reviewed during today's meeting (Completed). - Share disparity survey results with Dr. Yen Ang (Completed). - Bring up the next steps for the removal of Tagalog as a threshold language with Senior Leadership Team (SLT). Regulatory Affairs will provide an update during today's meeting (Completed). ➤ <i>Comment-M. Broadnax: We've determined that there's no compliance reason why we need to continue translating documents into Tagalog. If there's an operational need, we can work with the COO or anybody on the Operations team.</i> - Provide a final list of Alliance threshold languages. - Regulatory Affairs will provide an update during today's meeting (Completed). ➤ <i>Comment-M. Moua: Thank you so much, Marie. The next item also falls within your scope as well, providing a final list of the aligned threshold languages.</i> ➤ <i>Response-M. Broadnax: I will talk about that during my presentation.</i> - Follow-up with vendor, Hanna on Farsi interpreter qualifications and dialects spoken. - Confirmed Farsi interpreter qualifications with Hanna, including whether they are fluent in Dari and which dialects they specialize in. - Hanna scheduling team will coordinate requests based on this information to ensure accurate matching (Completed).	

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5. CLS Workplan Q1 Update	M. Moua	M. Moua provided an update on the Q1 CLS Work Plan for 2025, highlighting new initiatives and goals, including assessing member and cultural linguistic needs, language assistance services fulfillment, and increasing the use of on-demand interpreting services. • Member Cultural and Linguistic Assessment: Completed assessment at the CLSS meeting on 01/22/2025 (Goal met). • Language Assistance Services (Interpreter Services): Achieved an average fulfillment rate of 99% across all modalities (in-person, video, and telephonic interpreter services) (Goal met). • Increase monthly use of on-demand vs in-person services by 2 percentage through improvements to on-demand access (Planned implementation in Q2). • Language Assistance Services (Behavioral Health Services Tracking): Met with the vendor to re-evaluate the call prompt categories. Vendor confirmed they would review call flow data points to explore alternative methods for accurately identifying BH calls (In-progress). • Provider Language Capacity (Member Satisfaction): Based on the Member CG-CAHPS Survey results, goal met for Q4 2024 for both adult and child. Q1 2025 results are not yet available, planned implementation for Q2 2025 and will share results at the next CLSS meeting (Q4 2025: Goal met, Q1 2025: Planned implementation for Q2 2025). • Language Assistance Services (Member Satisfaction): Based on the Timely Access Requirement (TAR) Survey, the survey was dropped in the mail on 03/11/2025 and the results will be reported at the next CLSS meeting (In-progress). • Provider Language Capacity and Race and/or Ethnicity (Provider Network): The team completed data gathering and started drafting the report, with key findings and focus areas to be presented. (In-progress). • Community Advisory Committee (CAC): Connected and presented information about the CAC as part of membership recruitment with the following organizations:	

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		○ Greater New Beginnings on 01/17/2025 and received two (2) CAC candidate applications. ○ Asthma Start Program, ACPHD on 1/29/2025. ○ Oakland Catholic Worker on 3/13/2025 ○ Conducted initial outreach and provided information to Native American Health Center and Asian Health Services via email (Ongoing) ● Potential Quality Issues-Quality of Language (PQI-QOL): Achieved a 95% closure rate for Q1, despite the high volume of requests (Goal met).	
6. CLS Charter Review	M. Moua	M. Moua reviewed the Cultural Linguistics Services Subcommittee (CLSS) Charter, making minor grammar updates and adding the Behavioral Health representation to the list of CLSS committee members.	
7. 2024 DHCS Audit Finding Update	M. Moua	M. Moua discussed the 2024 DHCS audit findings related to monitoring the linguistic performance of vendors providing interpreting services with the following actions taken. ● Updated P&P CLS-011: CLS Program Monitoring to include additional language on monitoring information collected and reporting by 04/30/2025. (Completed. P&P Approved by Administrative Oversight Committee (AOC) on 04/16/2025) ● Updated vendor contracts to include reporting requirements for vendor interpreter qualifications and cadence by 04/30/2025. (Ongoing) ● Anticipation of implementation of monthly vendor interpreter qualifications reporting by 1/31/2025. (Completed) ● Anticipation of implementation of a monthly attestation of monthly vendor interpreter qualifications review by 1/31/2025. (Completed) ● Reviewed and addressed concerns with vendor interpreter qualifications at Quarterly Vendor Joint Operations Meeting (JOM) by 04/30/2025. (Completed) ● Reported and addressed concerns with vendor interpreter qualifications at Quarterly Cultural and Linguistic Services Subcommittee (CLSS) meeting by 4/30/2025. (Ongoing)	

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8. CG-CAHPS	M. Moua	M. Moua presented the analysis of the 2024 Clinician and Group Consumer Assessment of Healthcare Providers and System (CG-CAHPS) data, highlighting favorable response rates for adults and children regarding communication with doctors and clinic staff in their preferred language. ○ Favorable Response Rate in 2023: Adult 85.2% and Child 95.4% ○ Favorable Response Rate in 2024: Adult 87.3% and Child 92.5% ○ For Adult, only 3% of responses were non-favorable and 10% of members choose to have a family member or friend as interpreter for their appointments. ○ For Child, only 3% of responses were non-favorable and 4% of members choose to have a family member or friend as interpreter for their appointments. ➤ <i>Comment-L. Ayala: I appreciate the pie graphs and glad to see that the non-favorable responses percentage is super low and we'd love to even see it lower. But in comparison members are really getting the interpreter services they need. And with the family and friends' responses, I think there's always that question of whether it is the member's preference or whether the provider or the Alliance were unable to provide the interpreter? It is good to see that again those percentages have stayed relatively low over the years. Adult responses are always lower than children's responses, which could be attributed to cultural preferences from our members.</i>	
9. Provider Access by Language Report	M. Moua	M. Moua provided an overview of the 2024 Provider Language Capacity report, focusing on member-to-provider ratios by language for PCPs, specialists, and behavioral health providers. The report highlighted areas with the highest ratios and ongoing efforts to address language access gaps. The following data is self-reported, which means that providers can opt out to provide this information. • Medi-Cal: ○ PCP-to-member ratio is highest for the Spanish and Vietnamese languages. ○ Significant membership increase of 6.5% for the Latino ethnicity in 2024.	

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		○ Among Specialists, Spanish and Vietnamese languages have the highest ratio per member. ○ For Behavioral Health providers, Chinese and Vietnamese languages have the highest ratio per member. ● Group Care: ○ Member population remained stable, with a slight decrease in English-speaking members. ○ Chinese and Vietnamese languages have the highest PCP-to-member ratio. ○ Chinese and Vietnamese languages hold the highest Specialist-to-member ratio. ○ For Behavioral Health providers, Chinese and Vietnamese languages have the highest ratio per member. ● Provider Language Capacity Report for Applied Behavior Analysis (ABA) providers has been redesigned by our analytics team to only include child members in the calculations and will be reviewed at a future meeting.	
10. Compliance Updates	M. Broadnax R. Smith L. Reamer-Robinson	M. Broadnax discussed compliance updates, including the implementation of a new threshold language (Farsi) and updates to non-discrimination templates and Notices of availability. ● Background on Alliance Letters and Enclosures: The Plan has had multiple findings over the years regarding the letters and enclosures. ● New DHCS APL 25-005-Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Access Services, and Alternative Formats. ○ Farsi is a new threshold language for Alameda County and will be replacing Tagalog. ○ Chinese, English, Spanish, and Vietnamese continue to be our other threshold languages. Other revised templates include: ▪ Notice of Nondiscrimination Template ▪ Notice of Availability Template ▪ Statement of Nondiscrimination for Small Sized Notices Template	R. Smith to reach out to CLSS members if necessary.

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		➤ Question-M. Moua: I know that the taglines were renamed, did you want to talk about the Notice of Availability Template? ➤ Response-M. Broadnax: Robert is an expert on that. ➤ Response-R. Smith: Yes, the Notice of Availability Template is a new name, but it's still what we consider the taglines. ➤ Question- M. Broadnax: Are there any substantive changes on the template related to language change? ➤ Response-R. Smith: No, there are no language changes. They just changed the title of the template from the taglines to the Notice of Availability, but there was no subsequent change within the template at all. ➤ Question-L. Ayala: Mandy feel free to jump in as well. Does the Alliance translate into traditional Chinese? ➤ Response-M. Gutierrez: Yes, that's correct, Linda. To date, I haven't received any requests for simplified Chinese, at least not to my knowledge. ➤ Comment-M. Broadnax: My understanding is that the Plan has a large Taiwanese population and those prefer traditional rather than simplified Chinese. ➤ Question-Y. Ang: I want to add a little context here because the simplified Chinese versus the traditional Chinese is presentations in terms of character. But in terms of oral or pronunciations, Taiwanese speak the same as the Chinese all over the world. Would that make a difference in our translation services? ➤ Response-M. Broadnax: So, translation is written, interpretation is oral. If we're putting it on paper, it's going to be a translation. In Alameda County, the DHCS preference is simplified. Does that make sense? ➤ Response-Y. Ang: I see. ➤ Comment-L. Ayala: The reality is we can see usually whether it's Cantonese or Mandarin in the files, sometimes it's a little more difficult to see some of the other languages, but when a provider asks for an interpreter, we try to get as specific as possible to make sure they can understand.	

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		➤ Question-Y. Ang: Are you saying that the Alliance provides dialect translation in addition to official language? ➤ Response-L. Ayala: The Alliance provides interpretation which is oral. ➤ Response-M. Broadnax: Originally, DHCS required everything to be translated into traditional, but lately, as of last year they opted to make simplified the official version. They asked the plans to translate into simplified Chinese. However, in our county, it's more required or more needed. ➤ Comment-Y. Ang: I just want to share that there is a lot of political influence on the simplified versus traditional. I guess it has to do with the changing political climate that we have. China aims for simplified Chinese when the Taiwanese people and the rest of the world is for traditional. I grew up learning traditional then I had to switch to simplified because of the influence of China. L. Reamer-Robinson provided an update on the 2025 DHCS CAP finding 4.2.1, which states that the Plan did not assess the performance of its vendor's staff that provided linguistic services such as interpreter services. • Completed Actions: ○ The Plan implemented monthly reporting for vendor interpreter qualifications. Documents for April 2025 include: ▪ 4.2.1_PropioILA_3.25 ▪ 4.2.1_CyraCmILA_3.25 ▪ 4.2.1_HannaILA_3.25 ○ Monthly attestation process for reviewing vendor interpreter qualifications established. April 2025 attestation document: ▪ 4.2.1_IntRwAtt_3.25 • Pending Deliverables (On Track): ○ Updates to vendor contracts to include reporting requirements for interpreter qualifications and reporting cadence will be implemented by 04/30/2025. ○ Contract amendments have been submitted to vendors; signatures from CyraCom and Propio are pending receipt. • Other Deliverables:	

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		○ Vendor JOMs have been completed, and meeting minutes have been submitted. ○ Propio's JOM was scheduled for 4/16/2025. These meeting minutes will be submitted with the next update on 5/2/2025. ○ CLS Subcommittee meeting minutes for 4/23/2025 will be provided in the next update. ➤ <i>Question-M. Moua: Due to timing, we received our monthly reports from our vendors on the 10th of each month, and I do see that the next one is due on May 2nd so there may be a delay. Would it be possible to send those after that date?</i> ➤ <i>Response-L. Reamer-Robinson: If we don't have the reports, then we may update the delivery date. We would just state that those reports will be available on X date and then we will submit them.</i> ➤ <i>Comment-M. Moua: Perfect. Thank you so much. I greatly appreciate you and your team's guidance and support throughout this whole CAP process.</i> ➤ <i>Comment- L. Reamer-Robinson: You are very welcome.</i>	
11. 2024 NCQA Net 1A Report	M. Moua	M. Moua presented the key findings and focus areas of the 2024 NCQA Net 1A report, including member demographics, provider capacity, language use trends, and grievances and discrimination cases. • Report Purpose: to assess the cultural, ethnic, racial, and linguistic needs of the Plan's members. Adjust the availability of practitioners within the Plan's network if necessary. • Language Trends: ○ Medi-Cal: ▪ Spanish-speaking members had an increase of 6.55% and English-speaking members had a decreased of 5.25% in 2024. ○ Group Care: ▪ Membership is predominantly English and Spanish-speaking where English speakers had a decreased of 0.53% in 2024. • Provider by Race/Ethnicity Comparison Report:	M. Moua to share the findings on provider and member race and ethnicity with the Behavioral Health team for further analysis and action.

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		○ The greatest difference showed for Hispanic (Latinx) race/ethnicity, with 33% of members and only 3% of specialists. ● Provider Capacity: ○ Provider-to-member ratios were calculated quarterly with a third quartile benchmark (75% of data falls below this point) to reflect potential language access gaps for those values above the third quartile (Q3). ○ Member to PCP by Threshold Language: ▪ Medi-Cal: Spanish > Q3 benchmark in all quarters ▪ Group Care: Vietnamese and Chinese languages were near/exceeded Q3 benchmark ▪ Tagalog showed lowest ratios (strongest access) across both lines of business (Medi-Cal and Group Care) ○ Member to Specialists by Threshold Language: ▪ Medi-Cal: Spanish and Vietnamese > Q3 benchmark in Quarters 1 and 2. Improved by Quarter 4. ▪ Group Care: Vietnamese and Chinese languages > Q3 benchmark in Quarters 1 and 2. Improved by Quarter 4. ○ Member to Behavioral Health Providers by Threshold Language: ▪ Medi-Cal and Group Care: Vietnamese and Chinese languages consistently > Q3 benchmark. ▪ Medi-Cal: Chinese improved in Quarter 4. ▪ Medi-Cal and Group Care: Spanish improved. ▪ Tagalog showed lowest ratios (strongest access) across both lines of business (Medi-Cal and Group Care) ➤ <i>Comment-L. Ayala: Our Group Care membership has access to almost our entire network and that is probably why the numbers are very low. Which is wonderful access whether above that third quartile. Even for Medi-Cal membership, we're not seeing huge discrepancies and</i>	

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		<i>variations in those ratios across the different languages. But the 3rd Quartile line does help us to look at this in a different way than we had before.</i> ➤ <i>Comment-M. Broadnax: When we look at Medi-Cal and Group Care separately, you don't see that because Group Care members are still going to see the same providers. Most likely the Group Care membership is experiencing the same capacity as the Medi-Cal membership.</i> ➤ <i>Comment-M. Broadnax: We could look at it separately, but it's the same provider network.</i> ➤ <i>Question-Y. Ang: It looks like the Hispanic ethnicity has the lowest representations in terms of PCPs 6%, where they make up 30% of our membership. Are these members of the Hispanic community?</i> ➤ <i>Response-M. Moua: Yes, that is correct.</i> ➤ <i>Question-Y. Ang: I'm just curious if this misrepresentation of the Hispanic community translates into Members' dissatisfaction in terms of translation or interpretation services?</i> ➤ <i>Response-M. Moua: I'd say yes and no. This is not really a true representation of our provider network's race and ethnicity. This data is self-reported, and we do have a lot of providers that do not report it out. One of our actions is to encourage providers to report on this to ensure that we do have accurate information. But to answer your question, it could potentially lead to dissatisfaction. I have seen members' language preferences, where they want their PCP to speak their preferred language.</i> ➤ <i>Comment- M. Broadnax: Might be more needed depending on the type of service they're offering, because it's helpful to be able to speak to your therapist in your own language as an interpreter doesn't always interpreter what's going on with you, such as experiencing depression.</i> ➤ <i>Comment-L. Ayala: I appreciate that comment, Marie. I do think 20% for Behavioral Health is encouraging. I guess there are two (2) other things that we've noted in our overall analysis: one is recognizing there probably are fewer providers who are of that race/ethnicity in the provider pool as there are so many assistants or other individuals who</i>	

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		<i>are working in healthcare where the provider doesn't speak the member's language, but we've got these three (3) other staff in the clinic who does. That might not be ideal, but it helps with some of that cultural navigation. I think that's an important piece to put out here.</i> ➤ <i>Question-G. Duran: You said this is self-reported data so are we as the Alliance trying to increase the number of self-reported data among our providers network?</i> ➤ <i>Response-M. Moua: That's a great question. One of our recommended actions is to work towards that. We would like to work hand by hand with the Provider Services team -Ceci, Darryl, and Melissa's team- to really see how we can support them in ensuring and encouraging our providers to report their race and ethnicity.</i> ➤ <i>Comment-L. Ayala: That's a good idea, too. We might be able to do something with provider communication and/or educate the Provider Relations (PR) representatives about the importance of having this information, and how it helps us make sure to meet the members' needs. It's a great take away.</i> ➤ <i>Comment-A. Yen: One more observation is that statistically in Behavioral Health (BH), those minorities have a hard time and face more challenges in receiving BH services. If there are providers who can speak the members' preferred language, it would be very important to encourage them to report out their spoken languages. Also, I just wanted to note that there is some discrepancy in terms of representations around Behavioral Health, because that is the area that is that we know is very problematic for certain ethnic minorities.</i> ➤ <i>Question-L. Ayala: Agreed. That's important to note. Do we have anyone from the Behavioral Health team here?</i> ➤ <i>Response-M. Moua: I thought I saw Dr. Currie, but maybe not.</i> ➤ <i>Comment-L. Ayala: I think it's also an important thing for us to continue to talk about. I know we've just in the past couple of years really worked hard to make sure we're putting the data in view. We do have something to look at and to say, hey, these are the concerns. So,</i>	

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		<i>let's make sure as a takeaway that we circle back with this information for the Behavioral Health team and share it with them.</i> ➤ <i>Comment-A. Yeng: I also noticed that Pacific Islanders BH providers has zero (0) representation even though our members with that ethnicity only make up a very small segment of our population (7%), that's alarming.</i> ➤ <i>Comment-L. Ayala: If providers are not identified, it makes it harder for us to do matches too, right? So, we can look at the population level, but also at the individual level. If our Member Services teams are trying to help match folks, they don't have the information they need to know what a good match might be. Thank you.</i> ➤ <i>Comment-M. Moua: Those are great observations and more than happy to take this offline and share our findings with Dr. Currie and his team.</i> • Language use trends: ○ Interpreter Services utilization had a 70% increase since 2023. ○ Telephonic interpreter services: Highest increase in Spanish, Mandarin, and Mam languages ○ In-person interpreter services: Highest increase in Spanish, Mandarin, Cantonese languages ○ Video interpreter services: Highest increase in Spanish ○ Use of Family and friends still common among Chinese adults due to cultural preferences • Grievance and Discrimination cases: ○ Grievances: ▪ Medi-Cal: 503 cases related to language access services which represents an increase of 73% compared with 2023 cases. ▪ Group Care: 16 cases related to language access services in 2024. ○ Most common grievances:	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		▪ PCP change request (member's preferred spoken language). ▪ Providers not scheduling interpreting services. ▪ Quality of interpreter services ○ Discrimination Cases: ▪ 109 cases (substantiated and non-substantiated) with a decrease of 41% from the previous year. ▪ Only one (1) case was found to be substantiated. ○ No patterns of provider issues. • Next steps: ○ Share final report at the next Quality Improvement Health Equity Committee (QIHEC) meeting for review and approval on May 9, 2025. ○ Share final report/changes at the next CLS Subcommittee meeting on July 23, 2025. • Open discussion and Input: ○ How might we better support recruitment or training of providers in high-need language groups? ➤ <i>Question-M. Broadnax: Are there any community reinvestment programs that are working on trying to train new providers? And if we could leverage that?</i> ➤ <i>Response-M. Mouda: Thank you, Marie. That's a good idea.</i> ○ How can we better promote interpreter services, especially in communities still relying on family/friends? ➤ <i>Question-A. Yen: Could you please clarify why it is recommended to not use friends and family as interpreters? Does it have to do something with compliance?</i> ➤ <i>Response-M. Broadnax: Yes, there is. Sometimes, the members may not feel comfortable telling the provider exactly what's going on with them because they are in the same room as a family member. Especially in situations where the person interpreting is an abusive</i>	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		<i>spouse, or somebody who is an abuser, we would like for the member to be able to communicate with their provider freely.</i> ➤ <i>Question-A. Yen: I hear what you say, Marie, but I think that could work both ways. Don't you think?</i> ➤ <i>Response-M. Broadnax: Yes, it can certainly work both ways.</i> ➤ <i>Question-A. Yen: I am sharing this because that's my experience with my own mom. Perhaps there are also situations where a member might feel more comfortable with their own daughter or spouse interpreting for them. In that case, does the Alliance allow it?</i> ➤ <i>Response-M. Broadnax: Sure. It's the member's choice who's going to be their interpreter. The other issue is that the family members may not have sufficient medical terminology and may not interpret properly. So those are the two (2) concerns that went into the thought when this regulation was written. But I got it when my mom needed to go to the doctor, I was there with her to help advocate for her even when we both speak English. It wouldn't hurt to have a friend or family member and an interpreter to ensure that the medical terminology is conveyed properly.</i> ➤ <i>Question-A. Yen: I see. I guess my question was: does the law prohibit for a friend or family member to interpret?</i> ➤ <i>Response-M. Broadnax: Is does not prohibit it.</i> ➤ <i>Question-A. Yen: Does the Alliance have flexibility to allow the patient to choose their own interpreter?</i> ➤ <i>Response-M. Broadnax: Of course.</i> ➤ <i>Response-L. Ayala: I must admit it is a little bit of a challenge with some providers as they would not offer qualified interpreter services when they know that the member is showing up to their appointments with a friend or family member who is interpreting for them. What we would like to see is for providers to be open to making arrangements to have a qualified interpreter and if they decline saying I prefer to have my adult daughter do it, that is fine. I think it is how we educate our providers to make sure that they are always offering a qualified interpreter as the first case scenario and not as a backup scenario.</i> ➤ <i>Response-M. Moua: I think also informing our members of their right to have qualified interpreters, so they don't have to rely on friends and</i>	

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		<i>family. I think the biggest concern there is that medical terminology is always so challenging and evolving. Depending on the complexity of each language, sometimes there's no right word that nicely translates into English, so it requires an explanation in more detail. I want to make sure that our communities understand they have the right to request for interpreters, rather than relying on family and friends as interpreters. Many depend on their children to interpret or take them to appointments and sometimes their kids are working and may not have time to take them to the doctor's office. Therefore, they're waiting for their kids to take them.</i> ➤ <i>Comment-M. Broadnax: It could be sometimes their minor children, where a 10-year-old child cannot properly interpreted.</i> ➤ <i>Comment-L. Ayala: That is prohibited unless it is an emergency.</i> ➤ <i>Comment-M. Broadnax: That is an issue.</i> ➤ <i>Comment-M. Moua: I've been interpreting for my grandparents since I was 6-years-old at the doctor's office. It relates to what we just talked about it, my family preferred someone they know to interpret for them even though I was very young and could not understand everything.</i> ➤ <i>Question-A. Pena: What do you do right now to promote interpreter services besides to the EOC?</i> ➤ <i>Response-M. Moua: Members can call in to inquire about interpreting services and the Member Services team always does a wonderful job to let them know about the availability of interpreting services. We also have articles within the member newsletters. Additionally, we do facility site reviews to ensure that our providers know that there is the Point-To-Your-Language sign that they can post up in front of their office for patients to let the clinic staff know the language they speak and that there are interpreting services available for them when they go to their appointments.</i> ➤ <i>Response-L. Ayala: Also, there is the Notice of Availability, previously known as the Taglines, which goes out with all member letters and communications. The notice is available in 15 languages and informs that the Alliance offers 24/7 free interpreter services.</i>	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		➤ <i>Question-A. Pena: It looks to me that you've hit all the points and places where members can be reached. Does the Alliance have commercials or anything else where this information can be added to?</i> ➤ <i>Response-M. Moua: I think that is worth considering. Last year, during one of our CAC meetings, we received feedback from our CAC members on how the Alliance can market or better communicate to our membership within the different outlets. I believe there are a few billboards. I think tailoring communication to the specific communities that we are serving can be helpful.</i> ➤ <i>Comment-A. Yen: I really appreciate all this input, but I'd like to point out that this is a very delicate dance here. Communicating widely to our members that the Alliance offers interpreting services will be beneficial to anyone who needs them. On the other hand, honoring the patient's choice to use friends and family members as interpreters due to privacy concerns. If a member is going to receive mental counseling services, they may not want anybody to hear what they have to say, not even the medical students. So, my point is that the patient's choice is always loud and clear as first choice.</i> ➤ <i>Comment-M. Moua: Definitely. I think I'd speak for everyone here when I say that is something we focus on, which is ensuring the members' safety and comfortability in terms of when they're communicating. But those are great points and that's our goal to make sure that we meet the members' language needs, whether it's ensuring that we give them interpreting services at their appointments or that they choose friends or family members.</i> ➤ <i>Comment-M. Moua: I am going to be mindful of time so let's just skip the next two questions. If someone has feedback or ideas, please let us know and that's something we can report back in July.</i> ▷ Are there other actions that we should consider adding to the report? ▷ From our actions, which priorities should we focus on over the year?	
12. Q1 Language Access Monitoring and Reporting			

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
12a. Grievance and Appeals Report	A. Pena	A. Pena reported on grievance and appeals cases related to language access and discrimination for Q1. The report included the number of cases, types of grievances, and actions taken to address the issues. For Medi-Cal membership, the Plan received the following cases in Q1 2025: • 171 grievance cases (including shadow cases) with 0.10 per 1000 members. • Grievance Types: ○ Access to Care: 131 cases ○ Quality of Service: 40 cases • 129 unique grievance cases resolved pertaining to lack of language access and discrimination. • 40 grievances were related to discrimination and were forwarded to the Compliance Department for further investigation. Providers or vendors with 3 or more grievances filed against them: • AAH Plan: There were (25) complaints against the Plan regarding Language Access. These consisted of: ○ Not receiving correspondence in their preferred language ○ Dissatisfaction with the interpreter process ○ Reaching representatives who speak their preferred language. • PCP/Clinic: The complaints filed against the following clinics are because the members experienced language barriers with the staff. ○ (5) AmCare Medical Group, Inc ○ (4) Eastmont Wellness Center ○ (4) Newark Health Center ○ (4) Tiburcio Vasquez Health Center – Hayward ○ (3) Dr. Floyd Huen ○ (3) Dr. Htay Win • Vendor: ○ (5) Complaints against ModivCare. These consisted of: ▪ Members faced language barriers when calling to make reservations for rides because they do not have staff members who speak their preferred languages. ▪ Members experienced language barriers with the drivers	

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		▪ These grievances were resolved by helping the members call ModivCare with interpreters to schedule rides. ○ (3) Complaints against Hanna. These consisted of: ▪ Hanna did not fulfill interpreter requests for members, such as the vendor did not process their interpreter requests and the interpreter not staying for the entire appointment time. ○ (2) Complaints against CHME. These consisted of: ▪ Members experienced difficulties reaching a staff member that speaks their preferred languages. For IHSS (Group Care) membership, the Plan received the following cases in Q1 2025: • 2 grievance cases with 0.23 per 1000 members. • 1 grievance related to discrimination • 1 grievance related to lack of language access. • All cases related to discrimination were forwarded to the Compliance Department for further investigation. • PCP: 1 grievance against Tiburcio Vazquez Health Center. ○ The clinic does not have providers who speak Spanish. • Vendors: Grievances filed against our Delegates/Vendors are reported to the groups during our quarterly Joint Operation Meetings.	
12.b. Quality of Language-PQI Report	M. Moua	M. Moua presented the PQI report for Q1. • Most cases are related to clinic sites, followed by ancillary providers, and then vendors. • The Plan received the following cases related to Quality of Language: ○ (28) January ○ (30) February ○ (29) March • Plan/Provider/Vendor List (with 2 or more consecutive QOL-PQIs): ○ AAH: 9 cases in 2024 Q4 and 5 cases in 2025 Q1 ○ Rhodora De La Cruz, MD: 2 cases in 2024 Q4 and 2 cases in 2025 Q1 ○ Hanna: 2 cases in 2024 Q4 and 3 cases in 2025 Q1 • AAH:	

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		○ Complaint: Member received call from AAH in non-preferred spoken language. ▪ Resolution/Outcome: The member was provided information regarding the call and was mailed a new survey. ○ Complaint: Dissatisfaction with AAH's phone tree language capacity (Spanish). ▪ Resolution/Outcome: The member was educated on which option to select for Spanish when calling Member Services. ○ Complaint: Member was sent a letter from AAH in non-preferred written language. ▪ Resolution/Outcome: The member was provided with information on the survey sent as well as where to change their language preference. An alert in Alliance data systems was created to indicate member's preferred language. ○ Complaint: Member is dissatisfied with the language capacity of the AAH provider network (Russian or Ukrainian). ▪ Resolution/Outcome: The member was provided with a list of in-network providers. The member made a change to a PCP that meets the member's language needs. ○ Complaint: Members were sent correspondences from AAH in non-preferred written language. ▪ Resolution/Outcome: Member's preferred language was noted correctly in the Alliance data systems/systems of records. Member's most recent correspondences were related to G&A and member was sent both English and Spanish letters. ● Provider Rhodora De la Cruz, MD: ○ Complaint: Provider did not provide interpreter services: Provider was educated over the phone on how to access Alliance interpreter services. Provider confirmed that they have Spanish-speaking staff and know how to access Alliance interpreter services.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		▪ Resolution/Outcome: No CAP issued; Provider office has received education, and we see utilization/interpreter services requests submitted. • Vendor: ○ Complaint: Quality of Interpreter Services Provided (Dari): Dari Interpreter disconnected due to audible technical issues. ▪ Resolution/Outcome: Interpreter equipment was tested and determined line was working. ○ Complaint: Interpreter left early from appointment (PQI Case 1): ▪ Interpreter was only assigned for one appointment at the provider office and stayed for the duration of the time requested. No request was submitted for the 2nd appointment. ○ Complaint: Interpreter left early from appointment (PQI Case 2): Interpreter arrived early and was informed member had rescheduled as well as dismissed. ▪ No CAP issued; Vendor office has received education.	
12.c. Membership Reports	M. Macabinguil	M. Macabinguil presented on Member Demographic information for threshold languages. • Farsi language has been added as a threshold language for Alameda County and will be replacing Tagalog. • The Alliance is preparing for full implementation of Farsi as threshold language by August 2025 • See CLSS Full Report (attached to the meeting invite) for more details on Members' Ethnicity, Gender & Age.	
12.d. Utilization of Interpreter Services	M. Macabinguil	M. Macabinguil provided an overview of interpreter services utilization for Q1, highlighting a 99% fulfillment rate and the top languages requested for interpreter services. The report also included the top utilizers of on-demand and scheduled interpreter. • Fulfillment rate: The Alliance achieved an average fulfillment rate of 99% overall. All vendors met the 95% metric goal for fulfillment rate. • Utilization by Modality: Phone (74%), Video (1%), and On-Demand make up to 75% of interpreter services.	

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		• 25% of Scheduled interpreter services are provided for complex appointments such as ABA services, BH assessments, Physical Therapy and American Sign Language (ASL) • The top ten (10) languages requested were: Spanish (43%), followed by Cantonese (16%), Vietnamese (12%), Mandarin (7%), Mam (4%), Arabic (3%), Dari (2%), Farsi (1%), Khmer (1%), and Punjabi (1%) • Community Health Center Network (CHCN) is the highest utilizer for On-Demand services and Tri-City Physical Therapy is the highest utilizer for Prescheduled services followed by Alameda Health Systems.	
12.e. Vendor Interpreter Quality Monitoring Report	M. Moua	M. Moua reviewed the Interpreter Linguistic Assessments Reports for vendors, Hanna, CyraCom, and Propio, highlighting the completion rates and actions taken to address any issues. The reports were submitted to the Department of Health Care Services (DHCS) as part of the CAP process. • Hanna: Total number of interpreters reviewed in Q1 2025. ○ January: 212 ○ February: 23 ○ March: 233 ○ All Hanna interpreters completed an Interpreter Linguistic Assessment with a “Pass”. ○ Alliance submitted both January and February reports to the DHCS. • CyraCom: ○ All CyraCom interpreters completed an Interpreter Linguistic Assessment with a “Pass.” ○ Alliance inquired clarification regarding how often the interpreters are tested and what actions are taken to address those that receive a “Fail.” CyraCom Response: ▪ Candidates undergo a three-step qualification assessment based on the Interagency Language Roundtable (ILR) scale and must score at least a “3 - Professional Working Proficiency” to become qualified interpreters.	

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		▪ Throughout their employment, interpreters are monitored up to eight times per month and evaluated as Meets/Exceeds Expectations or Needs Improvement. ▪ For those receiving a "fail" grade, additional coaching is provided, and corrective action may be taken based on the reason for the failed session. ▪ Interpreters do not handle calls unless they pass the interpreter qualification assessment and complete CyraCom's training. ○ Alliance submitted both January and February reports to the Department of Health Care Services (DHCS). ○ Pending March data to be received by April 10, 2025 • Propio: ○ 95% of Propio's interpreters achieved a "Pass" on the Interpreter Linguistic Assessment. ○ January Report: Alliance inquired clarification regarding the percentage range of assessment/evaluation grading for interpreters to understand which percentage is a pass or fail. Additionally, which actions are taken to address those that receive a failing grade. Propio's Response: ▪ A score of 80% and above is considered a "Pass". ▪ If the interpreters score below 80%, they receive coaching from the Quality Department and their evaluations are shared in areas to improve on. ▪ If improvements have not been made, their contract is terminated. ▪ Propio interpreters' evaluation scores are averagely above 80% and interpreters receive feedback monthly. ▪ For those receiving a "Fail" grade, additional coaching is provided, and corrective action may be taken based on the reason for the failed session.	
12.f. Utilization of Translation Services Report	M. Gutierrez	M. Gutierrez provided an overview of translation services for written materials in Q1, including the number of documents translated by each team and the	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		top languages requested. The report also included a visual representation of language utilization. Translated Documents in Q1: - G&A holds the largest number for all threshold languages. (948) Spanish (249) Chinese (73) Vietnamese (18) Tagalog - Top languages translated into: Spanish (42%), followed by English (25%), and Chinese (15%). - A detailed translation services report available on the C&O intranet page: http://allianceconnect/Intranet/Main.aspx?tid=248&mtid=224	
12.g. Member Services Representative-Multilingual Staff Report	C. Lopez	C. Lopez reported on the multilingual staff and call monitoring for Q1, highlighting the number of qualified multilingual staff members and the distribution of staff by language. The report also included a finding related to the use of formal pronouns in Vietnamese. - Member Services Multilingual Staff in Q1: - Spanish: 28 - Vietnamese: 5 - Cantonese: 5 - Mandarin: 4 - Tagalog: 4 - Open Positions: (1) MSR I-Bilingual Spanish (2) MSR I-Bilingual Vietnamese (1) MSR I-Bilingual Cantonese (1) MSR I-Bilingual Mandarin - Linguistic issues reported in Q1 during call monitoring: a Vietnamese-speaking agent used informal pronouns with callers in Vietnamese. The agent has been coached on this by our assessed, Vietnamese-speaking Supervisor and will continue to support the agent.	
Adjournment	M. Moua	Next meeting on July 23, 2025.	

Approved By: Mao Moua, Manager, Cultural Linguistic Services

Date: 07/03/2025

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INTERNAL QUALITY IMPROVEMENT COMMITTEE

7/16/2025, 1:00pm-2:30pm
Remote

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Name	Title	Name	Title
Michelle Stott, RN, MSN	Senior Director of Quality	Dr. Donna Carey	Chief Medical Officer
Allison Lam	Director, Health Care Services	Dr. Beverly Juan	Medical Director, Utilization Management
Lilly Hunter	Director, Social Determinants of Health	Darryl Crowder	Director, Provider Relations & Provider Contracting
Jennifer Karmelich	Director of Quality Assurance	Cecilia Gomez	Sr. Manager, Provider Services
Alma Pena	Manager, Grievances & Appeals	Tiffany Cheang	Chief Analytics Officer, Healthcare Analytics
Linda Ayala	Director, Population Health	Farashta Zainal	Manager, Quality Improvement Team
Loc Tran	Manager, Access to Care	Christine Rattray	Supervisor, Quality Improvement (PQI)
Gil Duran	Manager, Population Health and Equity	Mao Moua	Manager, Cultural and Linguistic Services

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7/16/2025, 1:00pm-2:30pm
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Agenda Item	Responsible Person(s)	Discussion	Follow-Up Person(s)/Action/Due By
Call to Order/Roll Call			
I. Review agenda for 7/16/25	L. Ayala	The agenda was reviewed by Linda.	
II. Staffing Updates	L. Ayala	Linda Introduced the D-SNP team to the IQIC Meeting attendees	
III. IQIC Charter Update	L. Ayala	- Linda reviewed updates to the IQIC charter, highlighting integration of DSNP (Dual Special Needs Plan) references and inclusion of CMS requirements. - Added Medicare leadership team representatives as committee members. - Incorporated population health work into the charter objectives, including oversight of NCQA accreditation compliance for population health management. - The committee's role now includes reviewing and informing health education, population needs assessment, and population health management activities and effectiveness.	
IV. Policies & Procedures	L. Ayala	The following Policies were reviewed and will move to QIHEC in April. - BH-001: Behavioral Health Services - BH-005: Care Coordination- Behavioral Health - BH-008: Behavioral Health Services (Group Care/IHSS) - QI-124: Initial Health Appointment (IHA) and Initial Preventive physical Exam (IPPE) - QI-107: Appointment Access and Availability Standards - HED-001: Health Education Program - HED-002: Health Education Materials - HED-006: SABIRT Services - HED-007: Tobacco Cessation	

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		- HED-009: Diabetes Prevention Program - HED-010: Doula Services - PH-001: Population Health Management Program - PH-002: Basic Population Health Management - PH-003: Risk Stratification and Segmentation - PH-005: Population Assessment	
V. Meeting Minutes - IQIC 3/19/25	L. Ayala	Meeting Minutes submitted for review. Minutes Approved 4/6/2025.	
VI. Grievances & Appeals Report	A. Loza	- The Q2 2025 Medi-Cal grievance and appeals report details 12,377 total cases with an overall compliance rate of 96.9%, including 6,980 standard grievances at 94.7% compliance and 183 standard appeals at 96.7%. - The overturn rate for grievances and appeals was 28.7%, exceeding the 25% internal benchmark, with plan appeals overturn rate notably higher at 32.3%. - Access to care issues, particularly related to technology and telephone problems, were the most common complaints against the plan, while mode of care complaints focused on service quality. - IHSS cases totaled 613 with 96.7% compliance and a 54.54% overturn rate, meeting benchmarks, and no ancillary providers or clinics reached high grievance volumes within IHSS.	
VII. Population Health Updates	G. Duran	2025 Population Health Management (PHM) strategy developed and presented, focusing on three pillars: closing primary care gaps, supporting members with health conditions, and connecting members to whole person care.	

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		- Alliance is contributing resources, staffing, and data to Alameda County and City of Berkeley for community health assessments and improvement programs, including collaboration with Kaiser Permanente. - PHM monitoring goal achieved: implemented a population-based framework and dashboard prototypes with consultant ideas⁴², aiming to track outcomes, experience, and equity. - Dashboard framework includes alliance inputs, outputs (metrics/indicators), and outcomes, with equity and social determinants lenses. - Ongoing work to refine dashboard content, functionality, and adoption, with close collaboration with analytics and internal teams. - Risk segmentation and stratification analysis underway, preparing for statewide Medi-Cal Connect RSS; focus on using new tools to connect members to appropriate care and prevent bias. - Collaborative goal: aligning emergency department (ED) visit definitions and data sources across teams, mapping interventions before, during, and after ED visits, and integrating ED utilization into various Alliance programs (community supports, case management, P4P, etc.).	
VIII. HEDIS Updates	J. Burke	2024: Most measures met or exceeded thresholds; only three did not (AMR, controlling high blood pressure, topical fluoride). 2025: Current performance—some measures above minimum performance level (MPL), others below (notably behavioral health ED follow-up, cervical and colorectal cancer screenings, controlling high blood pressure, A1C, and some well-child visit measures). - Well-child visits and topical fluoride remain challenging due to data dependencies and visit requirements.	

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		- Ongoing projects: member outreach calls, mailers, provider education on coding and documentation, chronic disease and cancer screening gap closure, HPV self-swab kits, and collaboration with community organizations (e.g., First 5). - Noted ramp-up in well-child visits expected in the fall (back-to-school period). - Focus on closing gaps through direct member engagement, provider support, and targeted incentives.	
IX. QI Engagement & Member Feedback	J. Burke	Preventative Health Management - The preventative health engagement program began in September 2024, with two full-time staff dedicated to member outreach for preventative screenings tied to quality metrics (e.g., mammograms, well-child visits, cervical cancer screening, high blood pressure, A1C, and behavioral health ED follow-up). - Since launch, 32 campaigns have been conducted, reaching over 6,800 unique members, with an average 20% successful contact rate per campaign. - Key barriers identified include lack of transportation, limited provider office hours, scheduling delays (especially for pap smears and mammograms), unclear screening locations, and members being unaware of their assigned PCP or how to change it. - Additional challenges: members living outside the county (e.g., college students), lack of awareness about benefits and screening frequency, and misconceptions about costs. - Education gaps persist, especially regarding the importance and frequency of screenings, and cultural, religious, or personal discomfort with certain exams (e.g., pelvic exams for pap smears).	

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		- Interventions include direct education during outreach, collaboration with providers to improve PCP assignment processes, and development of simple instructions for demographic or PCP changes. - The program collaborates with other teams (e.g., Member Services, Case Management) to address member needs and make findings actionable.	
X. PQI Updates	C. Rattray	- The PQI dashboard tracks 2,000–2,600 cases per quarter, with most issues related to quality of service, followed by case management, access, language, and quality of care. Quality of care cases are reviewed by RNs and finalized by a medical director, with most found to have no quality issue, but some require corrective action. - Corrective action plans (CAPs) are mainly issued to hospitals and transportation providers, often for missed rides (especially for dialysis) or injuries during transport. Some CAPs are issued even if the final review downgrades the severity after provider input. - There was a temporary decrease in case reviews due to a medical director vacancy, with Dr. Juan providing interim support. - Exempt grievance audits show high compliance in identifying and referring potential quality issues, with most cases resolved quickly by Member Services. A new referral guide was implemented to further improve accuracy. - Quality of service PQIs are regularly audited for timeliness and accuracy, with compliance rates above 98% and no retraining needed.	
XI. Behavioral Health Updates	C. Currie	- Behavioral health utilization is steadily increasing for both mental health and ABA (autism) services, reflecting improved access and ongoing efforts to remove barriers. - Care coordination is provided by mental health clinicians, psychiatric nurses, and navigators, with all ABA cases requiring coordination due to	

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7/16/2025, 1:00pm-2:30pm
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		complexity. Many cases remain open as members transition to new providers. - Utilization management (UM) activity remains steady, with a denial rate around 1.1%, meeting internal criteria. - DHCS behavioral health screening tools are used to determine appropriate system entry (county specialty vs. mild/moderate), and referrals are coordinated under the "no wrong door" policy. The Alliance receives more referrals from the county than it sends. - The team ensures members are transitioned smoothly between systems, handling referrals directly rather than requiring members to navigate the process themselves. - No major technical or operational issues were reported in the update.	
Adjournment	L. Ayala	Next meeting: 10/15/2025	

Meeting Minutes submitted by: Ashley Asejo Date: 7/29/2025

Approved by: Farashta Zainal Date: 7/29/2025



Utilization Management Committee Meeting Minutes

May 30, 2025, 1:30 PM – 3:00 PM

Teams

Member Name and Title	Present	Member Name and Title	Present
Donna Carey, Chief Medical Officer		Karen Marin, Manager, Long Term Care	
Richard Golfin, Chief Compliance Officer		Katherine Goodwin, Supervisor, Health Plan Audits	X
Tiffany Cheang, Chief Analytics Officer	X	Kimberly Glasby, Director, Long Term Services & Supports	X
Allison Lam, Senior Director, Health Care Services	X	Kisha Gerena, Manager, Grievances & Appeals	
Alma Pena, Sr. Manager, G&A		Laura Grossman-Hicks, Sr. Director, Behavioral Health Services	X
Amani Sattar, Executive Assistant		Lily Hunter, Director, Social Determinants of Health	X
Andrea DeRochi, Manager, Behavioral Health	X	Linda Ayala, Director, Population Health & Equity	X
Annie Lam, Manager, Provider Services Call Center		Lisha Reamer-Robinson, Manager, Compliance Audits & Investigation	X
Benita Ochoa, Lead Pharmacy Tech		Loc Tran, Manager, Access to Care	
Beverly Juan, Medical Director, Community Health	X	Luke Lim, Sr. Director, Pharmacy	X
Brittany Nielsen, Executive Assistant		Marie Broadnax, Manager, Regulatory Affairs & Compliance	
Carla Healy-London, Manager, Inpatient UM	X	Michelle Findlater, Director, Utilization Management	X
Cecilia Gomez, Sr. Manager, Provider Services		Michelle Stott, Senior Director, Quality	X
Corinne Casey-Jones, Manager, Community Supports	X	Nancy Pun, Sr. Director, Analytics	
Darryl Crowder, Director, Provider Relations and Contracting		Nora Tomassian, Director, Pharmacy	
Daphne Lo, Medical Director, LTSS	X	Oscar Macias, Manager, Housing Program	
Farashta Zainal, Manager, Quality Improvement		Peter Currie, Senior Director, Behavioral Health	
Gia Degrano, Senior Director, Member Services		Rahel Negash, Pharmacy Supervisor	
Gil Duran, Manager, Population Health & Equity		Ramon Tran Tang, Clinical Pharmacist	
Heather Wanket, Clinical Manager, ECM	X	Sanya Grewal, Healthcare Services Specialist	
Hope Desrochers, Manager, Outpatient UM	X	Sharma Parag, Medical Director	
Jeffrey Bencini, Clinical Pharmacist		Shatae Jones, Director, Housing & Community Services Program	X
Jennifer Karmelich, Director, Quality Assurance		Stephen Smythe, Director, Compliance & Special Investigations	X
Jorge Rosales, Manager, Case & Disease Management	X	Stephen Williams, Supervisor, OP UM	
Judy Rosas, Sr. Manager, Member Services		Timothy Tong, Lead Clinical Pharmacist	X

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Utilization Management Committee Meeting Minutes

May 30, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
I. Call to Order/ Introductions	A. Lam	The meeting was called to order by Allison Lam at 1:32 pm		
II. Review and Approval of minutes	A. Lam	The UM Committee Minutes from April 25, 2025 were approved electronically by a quorum of the committee prior to the meeting.	 UMC_Meeting Minutes_4.25.25.pdf	Approved via e- vote: 5/1/25 – 5/4/25
III. Policies and Procedures	All	• CS-002 • CS-003 • CS-004 • CS-007 • CS-008 • CS-009 • CS-010 • CS-011 • CS-012 • UM-016	 PP Summary of Changes.pdf	Vote to Approve: None opposed: The policies will be finalized as approved and moved forward to QIHEC
IV. Program Scope & Structure A. G&A Report	A. Loza	• Appeals Overview: There were 132 medical appeals, with a compliance rate below the 95% target. The overturn rate for standard appeals was 21.2%, expedited appeals 50%, and overall 22%. • Appeals Breakdown: 57 inpatient appeals, 64 out-of-network appeals, and 11 non-covered benefit appeals. The overturn rates were 16.7% for CHCN and 22.8% for the plan.	 GA Report_IHSS.pdf	

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Utilization Management Committee Meeting Minutes

May 30, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		○ Top Providers and Services: 24 Hour Home Care and Crown Bay Rehab Center. The top appealed services were long-term care and outpatient services. ○ Behavioral Health Inclusion: It has been confirmed that behavioral health appeals should be included under outpatient appeals.	 GA Report_MCAL.pdf	
B. Behavioral Health	V. Eang Kim	● Prior Authorization Rules: All behavioral health treatments and applied behavioral analysis require prior authorization, while non-specialty mental health services do not, with some exceptions like neuropsychological testing and transcranial magnetic treatments. ● Case Volumes: There is an average of 175 mental health cases and 248 ABA cases for quarter one of 2025. The higher volume for ABA cases is due to opening cases for each step of the continuum of care. ● Case Closure Reasons: 54% of mental health cases were closed due to completed services, while 14.6% were closed due to losing contact with the member. For ABA cases, 25% were closed after FBA completion, and 15.8% after CDE assessment completion.	 Behavioral Health Report.pdf	
V. CM Program Effectiveness A. Community Supports	K. Glasby	● Utilization Comparison: A comparison of quarter three and quarter one data, shows a decrease in authorizations and claims due to new criteria implemented in December 2024. The criteria aimed to reach the most vulnerable population and ensure a return on investment by reducing ER and inpatient utilization. ● Turn Around Times: There are improvements in turnaround times, with December at 85.4%, January at 92%, and March at 93.6%. The implementation of a UM process in December 2024 contributed to these improvements.	 CS Metrics.pdf	

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Utilization Management Committee Meeting Minutes

May 30, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		Pre-Post Service Analysis: The pre-post service analysis shows a 63% decrease in admissions per 1000 and a 13.2% decrease in average length of stay for quarter one of 2025, compared to 39% and 12.4% respectively in quarter four of 2024.		
B. LTC Metrics	K. Glasby	Membership Trends: There was a slight decrease in long-term care membership from quarter four to quarter one, with an average membership of 2545 in quarter one. Note that membership fluctuates as members are discharged and new members fill the beds. Turn Around Times: Improvements in turnaround times, maintaining a 99% rate across the board for quarter one, after addressing staffing shortages and hiring a full-time nurse. Admissions and ER Visits: Data shows a decrease in admissions, length of stay, and ER visits from quarter four to quarter one. In-Network Transition: Efforts to transition members to in-network facilities resulted in a decrease from 180 out-of-network members in October to 85 in March. Collaboration with contracting teams and social workers facilitated these transitions.	 LTC Metrics.pdf	
C. CM Program	J. Rosales	Transportation Update: On-site visits to Motive Care's office, updates on call center staff, software upgrades, and provider portal updates. There are monthly meetings with providers and quarterly audits at dialysis centers to ensure timely and quality transportation services. EPSDT Referrals: Ongoing refreshers are provided to outpatient staff to refer EPSDT cases to the case management team. Referrals are tracked monthly, ensuring they are correctly labeled in the system.	 Case Management Report.pdf	

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Utilization Management Committee Meeting Minutes

May 30, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• Case Volumes: There is a significant increase in transitional care cases due to new state requirements. • Internal Audits: Quarterly audits of complex cases showed a decline in performance due to one nurse. Training and timely feedback were provided to address the issues and improve audit results. • HRA/HIFMET Processing: Processing of HRAs and HIFMETs had a spike in January due to the Anthem transition. Efforts to improve return rates include stratification and outreach by HRA coordinators. A vendor will assist with HRA processing for both DSNP and medical members.		
D. Community Advisory Committee (CAC) Report	L. Ayala	• CAC Feedback: Feedback from the Community Advisory Committee (CAC) meetings, including concerns about staff diversity, ABA services, public health assessments, mental health outreach, and housing.	 CAC Presentation.pdf	
E. PA Code Changes	M. Findlater	• PA Code Changes: Proposed changes to the PA code list, recommending the removal of codes that do not require prior authorization according to DHCS regulations. The committee approved the changes, which will be sent to the Clinical Committee for final approval.	 Review of Changes to PA Rules.pdf	
VI. Adjournment	A. Lam	The meeting was adjourned at 3:00 pm		Next Meeting: June 27, 2025 at 1:30 PM

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Utilization Management Committee Meeting Minutes

May 30, 2025, 1:30 PM – 3:00 PM

Teams

Meeting Minutes submitted by:

DocuSigned by:

Amani Sattar

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Amani Sattar,
EA to the CMO

07/03/2025 | 1:38 PM PDT

Date: _____

Approved by:

DocuSigned by:

Allison Lam

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Allison Lam,
Sr. Director, Health Care Services

07/03/2025 | 2:06 PM PDT

Date: _____

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Utilization Management Committee Meeting Minutes

June 27, 2025, 1:30 PM – 3:00 PM

Teams

Member Name and Title	Present	Member Name and Title	Present
Donna Carey, Chief Medical Officer	X	Karen Marin, Manager, Long Term Care	X
Richard Golfin, Chief Compliance Officer		Katherine Goodwin, Supervisor, Health Plan Audits	X
Tiffany Cheang, Chief Analytics Officer		Kimberly Glasby, Director, Long Term Services & Supports	X
Allison Lam, Senior Director, Health Care Services		Kisha Gerena, Manager, Grievances & Appeals	
Alma Pena, Sr. Manager, G&A		Laura Grossman-Hicks, Sr. Director, Behavioral Health Services	X
Amani Sattar, Executive Assistant	X	Lily Hunter, Director, Social Determinants of Health	X
Andrea DeRochi, Manager, Behavioral Health	X	Linda Ayala, Director, Population Health & Equity	X
Annie Lam, Manager, Provider Services Call Center		Lisha Reamer-Robinson, Manager, Compliance Audits & Investigation	X
Benita Ochoa, Lead Pharmacy Tech		Loc Tran, Manager, Access to Care	
Beverly Juan, Medical Director, Community Health	X	Luke Lim, Sr. Director, Pharmacy	X
Brittany Nielsen, Executive Assistant		Marie Broadnax, Manager, Regulatory Affairs & Compliance	
Carla Healy-London, Manager, Inpatient UM	X	Michelle Findlater, Director, Utilization Management	X
Cecilia Gomez, Sr. Manager, Provider Services		Michelle Stott, Senior Director, Quality	
Corinne Casey-Jones, Manager, Community Supports	X	Nancy Pun, Sr. Director, Analytics	
Darryl Crowder, Director, Provider Relations and Contracting		Nora Tomassian, Director, Pharmacy	
Daphne Lo, Medical Director, LTSS	X	Oscar Macias, Manager, Housing Program	X
Farashta Zainal, Manager, Quality Improvement		Parag Sharma, Medical Director	X
Gia Degrano, Senior Director, Member Services	X	Peter Currie, Senior Director, Behavioral Health	X
Gil Duran, Manager, Population Health & Equity	X	Rahel Negash, Pharmacy Supervisor	
Heather Wanket, Clinical Manager, ECM	X	Ramon Tran Tang, Clinical Pharmacist	
Hope Desrochers, Manager, Outpatient UM	X	Sanya Grewal, Healthcare Services Specialist	
Jeffrey Bencini, Clinical Pharmacist		Shatae Jones, Director, Housing & Community Services Program	X
Jennifer Karmelich, Director, Quality Assurance		Stephen Smythe, Director, Compliance & Special Investigations	X
Jorge Rosales, Manager, Case & Disease Management		Stephen Williams, Supervisor, OP UM	X
Judy Rosas, Sr. Manager, Member Services		Timothy Tong, Lead Clinical Pharmacist	X

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Utilization Management Committee Meeting Minutes

June 27, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
I. Call to Order/ Introductions	A. Lam	The meeting was called to order by Allison Lam at 1:30 pm		
II. Policies and Procedures	All	• CM-001 • CM-002 • CM-003 • CM-004 • CM-006 • CM-008 • CM-009 • CM-011 • CM-018 • CM-034 • CM-041	 PP Summary of Changes.pdf	Vote to Approve: None opposed: The policies will be finalized as approved and moved forward to QIHEC
III. Review of Changes to PA Rules	T. Tong	• Requested UMC approval for the DSNP prior authorization list, which had already been approved by the Pharmacy and Therapeutics Committee.	 Review of Changes to PA Rules.pdf	• Notify providers about the new prior authorization

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Utilization Management Committee Meeting Minutes

June 27, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		- DHCS announcement regarding the reimbursement of drugs for Casgevy and Lyfgenia for the treatment of sickle cell disease under the fee-for-service medical benefit. The therapies will be carved out of managed care plan contracts and reimbursed by DHCS. Reimbursement Details: DHCS will reimburse the cost of Casgevy and Lyfgenia for sickle cell disease treatment under the fee-for-service medical benefit, effective July 1, 2025. These drugs will be carved out of managed care plan contracts. Implementation Plan: Pharmacy processes and configurations will be aligned with the DHCS announcement, and the two impacted HCPC codes will be updated accordingly. Coordination with delegates will be necessary to implement these changes.		rules for physician-administered drugs. (Timothy) - Update the PA list for the team once the new prior authorization rules are approved. (Timothy) - Coordinate with delegates regarding the changes in the carve-out process for cell and gene therapy drugs. (Allison, Timothy)

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Utilization Management Committee Meeting Minutes

June 27, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
IV. CalAIM ECM	H. Wanket	Enrollment Trends: Growth in ECM program enrollment from January 2024 to March 2025, with a notable increase in completed cases with a slight decline in outreach efforts. Denial Reasons: The reasons for ECM program denials include ineligibility, duplicate services, and lack of Medi-Cal coverage with an expected increase in denials due to more thorough reauthorization reviews. Outreach Efforts: The outreach process requires at least five attempts over 60 days and can include both successful and unsuccessful attempts, and providers may have different approaches to outreach.	 CalAIM ECM.pdf	Ensure ECM providers are aware of the prioritized MIF and encourage them to focus outreach on high-utilization members. (Heather)
V. Carved-Out Services	H. Desrochers	Referral Statistics: Out of 1334 total referrals for Q1, 385 were submitted to CCS, with about two-thirds approved and one-third denied. Denials were due to non-CCS diagnoses, medical ineligibility, or non-paneled providers. Diagnosis Breakdown: A breakdown of diagnoses for inpatient and outpatient cases include perinatal conditions being the most common for inpatients and congenital abnormalities for outpatients. Provider Analysis: The top rendering providers include Children's, UCSF, GenDex, and Highland. Also note the importance of screening for EPSDT and CM referrals, with 12 EPSDT and one CM referral from denied cases.	 Carveout Services CCS Q1 2025- 6.27.25	Pull the tracker and diagnosis for Highland CCS cases to determine if they are NICU or trauma-related. (Hope)
VI. Over/Under Utilization	M. Findlater	ED Utilization: Alliance had the highest ED visits, followed by CHCN and CFMG. Highland Hospital was the most frequently visited facility, and respiratory issues were the most common diagnosis.	 Over Under Utilization UMC 6.27.25	

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Utilization Management Committee Meeting Minutes

June 27, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• Acute Admissions: There is a decrease in acute admissions, average length of stay, and days per thousand compared to the previous year. SPD duals had the highest admission rates, and children had the lowest. • Readmission Rates: There are high readmission rates, with the current rate at 21% and there is a need for better follow-up appointments and collaboration between UM and CM teams to reduce readmissions. • Denial Rates: There was a peak in February for inpatient denials. Full denials were more common than partial denials. • Specialty Services: Specialty services include acupuncture, chiropractic, podiatry, transplant evaluations, and palliative care. Reasons for denials, include medical necessity and retroactive requests.		
VII. Adjournment	A. Lam	The meeting was adjourned at 2:34 pm		Next Meeting: July 25, 2025 at 1:30 PM

Meeting Minutes submitted by:

DocuSigned by:

Amani Sattar

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Amani Sattar,
EA to the CMO

07/03/2025 | 1:40 PM PDT

Date: _____

Approved by:

DocuSigned by:

Allison Lam

8E7713C4669F403...

Allison Lam,
Sr. Director, Health Care Services

07/03/2025 | 2:06 PM PDT

Date: _____

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Utilization Management Committee Meeting Minutes

July 25, 2025, 1:30 PM – 3:00 PM

Teams

Member Name and Title	Present	Member Name and Title	Present
Donna Carey, Chief Medical Officer		Karen Marin, Manager, Long Term Care	
Richard Golfin, Chief Compliance Officer		Katherine Goodwin, Supervisor, Health Plan Audits	X
Tiffany Cheang, Chief Analytics Officer		Kimberly Glasby, Director, Long Term Services & Supports	X
Allison Lam, Senior Director, Health Care Services	X	Kisha Gerena, Manager, Grievances & Appeals	
Alma Pena, Sr. Manager, G&A		Laura Grossman-Hicks, Sr. Director, Behavioral Health Services	X
Amani Sattar, Executive Assistant	X	Lily Hunter, Director, Social Determinants of Health	X
Andrea DeRochi, Manager, Behavioral Health	X	Linda Ayala, Director, Population Health & Equity	
Annie Lam, Manager, Provider Services Call Center		Lisha Reamer-Robinson, Manager, Compliance Audits & Investigation	X
Benita Ochoa, Lead Pharmacy Tech		Loc Tran, Manager, Access to Care	
Beverly Juan, Medical Director, Community Health	X	Luke Lim, Sr. Director, Pharmacy	X
Brittany Nielsen, Executive Assistant		Marie Broadnax, Manager, Regulatory Affairs & Compliance	
Carla Healy-London, Manager, Inpatient UM	X	Michelle Findlater, Director, Utilization Management	X
Cecilia Gomez, Sr. Manager, Provider Services		Michelle Stott, Senior Director, Quality	
Corinne Casey-Jones, Manager, Community Supports		Nancy Pun, Sr. Director, Analytics	
Darryl Crowder, Director, Provider Relations and Contracting		Nora Tomassian, Director, Pharmacy	
Daphne Lo, Medical Director, LTSS	X	Oscar Macias, Manager, Housing Program	X
Farashta Zainal, Manager, Quality Improvement		Parag Sharma, Medical Director	X
Gia Degrano, Senior Director, Member Services		Peter Currie, Senior Director, Behavioral Health	
Gil Duran, Manager, Population Health & Equity	X	Rahel Negash, Pharmacy Supervisor	
Heather Wanket, Clinical Manager, ECM		Ramon Tran Tang, Clinical Pharmacist	
Hope Desrochers, Manager, Outpatient UM	X	Sanya Grewal, Healthcare Services Specialist	X
Jeffrey Bencini, Clinical Pharmacist		Shatae Jones, Director, Housing & Community Services Program	X
Jennifer Karmelich, Director, Quality Assurance		Stephen Smythe, Director, Compliance & Special Investigations	
Jorge Rosales, Manager, Case & Disease Management	X	Stephen Williams, Supervisor, OP UM	
Judy Rosas, Sr. Manager, Member Services		Timothy Tong, Lead Clinical Pharmacist	X

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Utilization Management Committee Meeting Minutes

July 25, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
I. Call to Order/ Introductions	A. Lam	The meeting was called to order by Allison Lam at 1:30 pm		
II. Review and Approval of minutes	A. Lam	The UM Committee Minutes from June 27, 2025 were approved electronically by a quorum of the committee prior to the meeting.	 UMC_Meeting Minutes_6.27.25.doc	Approved via e- vote: 7/3/25 – 7/10/25
III. Policies and Procedures	All	See attached	 UMC PP Summary of Changes_7.25.25	Vote to Approve: None opposed: The policies will be finalized as approved and moved forward to QIHEC
IV. UM Program Effectiveness A. IP, OP	H. Desrochers C. Healy- London	Operational Metrics – Inpatient Authorization Volume: Steady decrease in authorization volume from quarter one to quarter two, with a 17% overall decrease, noting that winter months typically have higher inpatient authorizations.	 IP Operational Utilization Reviewpd  OP Operational Utilization Reviewpd	

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Utilization Management Committee Meeting Minutes

July 25, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		○ Turnaround Time: Consistent turnaround times, with overall turnaround time at 97% for quarter one and 96% for quarter two, meeting the benchmark of 95%. ○ Denial Rates: Low denial rates for inpatient services, with full denials ranging from 1.2% to 1.6% and partial denials driven by admin days. ○ NOAA Compliance: High NOAA compliance, with overall audit scores of 99% for quarter one and 98% for quarter two, noting improvements in timeliness and file review scores. • Operational Metrics – Outpatient ○ The overall average TAT was 100% in Q2 2025, demonstrating sustained high performance ○ Full denial rates remained relatively stable, starting at 4.1% in January, dipping slightly to 4.0% in February, and increasing to a peak of 4.9% in April and May before easing to 4.3% by June. ○ Partial denial rates stayed low and stable throughout the period, starting at 0.5% in January, dipping to 0.2% in March, and rising slightly to 0.6% by June ○ Total denial rates for all types showed an upward trend in the first half of the year, beginning at 4.6% in January, peaking at 5.3% in April, and gradually declining to 4.9% in June.		

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Utilization Management Committee Meeting Minutes

July 25, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
B. NOA Compliance	H. Desrochers	Overall score including Timeliness, Review Elements and NOA is at 100%	 OP Q2 2025 Internal NOA Audit.pdf	
C. CBAS Measures	H. Desrochers	CBAS for Q2, including requests and assessments, IPC renewals, and emergency remote services. There is a significant decrease in ERS services and the team's efforts to support members returning to centers or receiving support at home.	 CBAS.pdf	
D. DUR Report	A. Lam	Deferred	 DUR Report.pdf	Deferred
E. Behavioral Health	P. Currie	Behavioral health report, covering authorization volume, UM timeliness, denial rates, NOAA compliance, quality audit, and BH utilization. There is an increase in pre-service requests, low denial rates, and the team's efforts to improve NOAA compliance.	 BH Services.pdf	
V. Delegation Oversight (UM / CM) A. CHCN	M. Findlater	CHCN HICE - Both outpatient and inpatient services saw very low denial rates in Q1 2025. The percentage of denied authorizations ranged from 0.22%-0.25% from 2024 YTD –Q1 2025. Over & Under Utilization Metrics– Analysis Referral Metrics - Both outpatient and inpatient services saw very low denial rates from 0.22%-0.25% from 2024 YTD –Q1 2025. UM TAT Metrics	 Delegation Oversight_CHCN.pdf	

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Utilization Management Committee Meeting Minutes

July 25, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		- Medi-Cal had Decision TAT and Notification TAT of 99% for urgent, non-urgent, and post-service requests - Commercial had a Decision TAT at 99%-100% compliance for urgent, non-urgent, and post-service requests		
B. CFMG	M. Findlater	CFMG HICE - Both outpatient and inpatient services saw very low denial rates in Q1 2025. The percentage of denied authorizations increased slightly from 0.0% in 2024 to 0.3% in Q1 2025 Referral Metrics - Outpatient and inpatient services saw very low denial rates at 0.3% from Q1 2025. UM TAT Metrics - All TAT metrics for decision and notification in urgent, routine, and post-service categories were 100% compliant in Q1 2025, meeting all required timeframes.	 Delegation Oversight_CFMG.pdf	
C. Auto Auths	M. Findlater	Removal of auto authorization for certain MRI and MRA codes to ensure proper review and approval, addressing concerns about out-of-network approvals.	 Review of Changes to AutoAuth Rules.pc	Approved
D. Regulatory Audit Findings (DHCS / DMHC)	A. Lam	- Successful closure of the 2024 DHCS audit, with all corrective actions accepted by DHCS. - As of 6/10/2025: DHCS has accepted all CAP responses - Oversight & Monitoring Activities will continue as part of standing quality assurance procedures, to ensure sustained compliance Monthly Operational Audits	 DHCS Audit_UM Findings.pdf	

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Utilization Management Committee Meeting Minutes

July 25, 2025, 1:30 PM – 3:00 PM

Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
VI. Adjournment	A. Lam	The meeting was adjourned at 2:21 pm		Next Meeting: August 29, 2025 at 1:30 PM

DocuSigned by:

Amani Sattar

07/29/2025 | 2:35 PM PDT

Meeting Minutes submitted by:

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Date: _____

Amani Sattar,
EA to the CMO

DocuSigned by:

Allison Lam

07/29/2025 | 2:37 PM PDT

Approved by:

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Date: _____

Allison Lam,
Sr. Director, Health Care Services

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Provider Manual

Alameda Alliance for Health
Medi-Cal, ~~& Alliance~~ Group Care, ~~Medi-~~
~~Cal,~~ and ~~and~~ Medicare Advantage Dual
Eligible Special Needs Plan (D-SNP)

~~October~~ June ~~October~~ 2025

Table of Contents

Part 1. Alliance Services	8
Section 1: Introduction.....	8
Welcome to Alameda Alliance for Health (Alliance)	8
The Provider Manual	9
Getting Involved	9
Section 2: Alliance Resources.....	17
Alliance Provider Services Department.....	17
Alliance Member Services Department	17
Section 3: Eligibility and PCP Choice	22
Identifying Alliance Members	22
Verifying Member Eligibility	23
Provider Portal Instructions	25
Selecting a PCP	25
Changing PCPs.....	26
Section 4: Provider Compliance	28
Travel Time and Distance Standards	28
Hours of Operation	28
Alliance Marketing Materials	28
Approved Medi-Cal Marketing Methods	28
Discharging Members	29
Provider Directory Changes	30
Provider Data Requirements (274).....	30
Part 2. Providing Services.....	32
Section 5: Primary Care Provider (PCP) Roles and Responsibilities	32
PCP Services	32
Providing Capitated Services to Alliance Group Care Members	41
Non-Capitated Services	41
PCP Role in Supervision of Mid-Level Clinicians	43
Section 6: Utilization Management.....	47
Overview	47

Questions? Call the Alliance Provider Services Department, Monday – Friday,
 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Outpatient (Ambulatory) Services	49
Biomarkers for Cancer	50
Standing Referrals	50
Authorizations Requirements	52
Continuity of Care (CoC)	60
Doula Services	64
Enteral Nutrition Formulas for Medi-Cal Members	66
Continuous Glucose Monitor (CGM) Devices for Medi-Cal Members	66
Palliative Care Services	66
Delegation of UM to Medical Groups	70
Provider-to-Provider Communication	72
Transplant Services, including Major Organ Transplants (MOT).....	73
Minor Consent Services	75
Vision Care Services	76
Hospice Services (Medi-Cal).....	77
Hospice Services (D-SNP).....	78
Long-Term Care (LTC) (Medi-Cal Only).....	78
Community-Based Adult Services (CBAS).....	79
Community-Based Adult Services (CBAS) Emergency Remote Services (ERS)...	81
Transgender Services	83
Tertiary and Quaternary (TQ) Services	86
Second Opinions	87
Coordination of Care	87
Coordination of Services	88
Coordination of Care – California Children’s Services (CCS).....	92
Section 7: Behavioral Health Services	94
Medi-Cal Mental Health Services	94
Medi-Cal: Specialty Mental Health Services (SMHS).....	94
Medi-Cal: Non-Specialty Mental Health Services (NSMHS).....	95
Group Care Members: Mental Health	96
Substance Use Treatment Services.....	97

Behavioral Health Evaluation and Treatment for Autism for Members Under Age 21 years	99
Section 8: D-SNP Supplemental Benefits.....	105
Supplemental Benefits Overview	105
Section 9: Claims	107
Claims Overview	107
Submitting a Claim	107
Claims Receipt and Determinations	113
COORDINATION OF BENEFITS (COB).....	116
Service Specific Information	119
Code Sets	123
Electronic Visit Verification (EVV) (MEDI-CAL ONLY)	125
Section 10: Provider Dispute Resolutions (PDR)	126
Section 11: Telehealth (Medi-Cal and Group Care Only)	132
Telehealth Requirements for Medi-Cal and Group Care	132
<i>VIDEO AND AUDIO REQUIREMENTS</i>	132
<i>MODEL LANGUAGE FOR TELEHEALTH PATIENT CONSENT</i>	132
<i>REQUIREMENTS TO PROVIDE TELEHEALTH SERVICES</i>	133
<i>REIMBURSABLE TELEHEALTH SERVICES</i>	133
<i>TELEHEALTH BILLING - PLACE OF SERVICE CODES AND MODIFIERS</i>	135
<i>TELEHEALTH RESOURCES</i>	135
Telehealth Requirements for Alameda Alliance Wellness (D-SNP)	136
Section 12: Service and Referrals for Adults – Adult Clinical Preventive Services	138
OB/GYN Services	138
Cancer Screening	138
Documentation	138
Immunizations	139
Alliance Wellness (D-SNP).....	139
Family Planning Services	139
Confidential Human Immunodeficiency Virus (HIV) Testing.....	142
Abortion Services	144
Sterilization Services	144

Questions? Call the Alliance Provider Services Department, Monday – Friday,
 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)	145
Tobacco Cessation	148
Section 13: Services and Referrals for Newborns, Children, and Adolescents	150
Newborn Services	150
Clinical Preventive Services for Children – Periodic Health Assessments	151
Cognitive Health Assessments.....	152
Immunizations	153
Medi-Cal for Kids & Teens (Early Periodic Screening Diagnosis and Treatment (EPSDT) (Medi-Cal Only).....	156
Women, Infants & Children (WIC)	159
Early Intervention Services.....	159
Section 14: Perinatal Services.....	162
Perinatal Services	162
Reimbursement and Documentation of OB Services (Medi-Cal and Group Care Only)	166
Section 15: Community Supports (CS).....	168
Section 16: Out-of-Plan Services	169
California Children Services (CCS)	169
Dental Screening – Medi-Cal	172
Tuberculosis (TB) Control Services.....	173
Medi-Cal Rx – Outpatient Pharmacy Benefit (Medi-Cal Only).....	176
Section 17: Health Education	177
Health Education Services	177
Section 18: Serving Our Diverse Population	178
Documenting Staff Language Proficiency	179
Signage for Interpreter Services.....	179
Requesting Interpreter Services.....	179
Cultural and Linguistic Provider Training and Development.....	183
Monitoring Alliance Cultural and Linguistic Services Program	185
Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training ..	185
Section 19: Transportation Services.....	189
Transportation Benefits	189

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Transportation Liaison.....	193
Section 20: Formulary and Pharmacy Services.....	194
Formulary.....	194
Pharmacy Prior Authorizations and Exceptions	197
Pharmacy Network.....	200
Injectables	201
Section 21: Clinical Laboratory Services	204
Outpatient Laboratory Services.....	204
Laboratory Procedures in the PCP Office	204
Part 3. Care Management	206
Section 22: Care Management.....	206
Measuring and Improving Plan Performance (HEDIS®)	206
Measuring and Improving Plan Performance (CAHPS and HOS).....	206
Alliance Measures of Provider Performance	209
Care Management Programs.....	210
Basic Population Health Management	211
Care Coordination	212
Complex Case Management (CCM)	212
Community Health Worker (CHW) Services.....	213
Enhanced Care Management (ECM).....	213
California Integrated Care Management (CICM).....	214
Disease Management	215
Diabetes Prevention Program (DPP)	217
Medicare Diabetes Prevention Program (MDPP).....	219
Transitional Care Services	220
Infertility Services	221
Reconstructive Surgery	221
Reporting Provider-Preventable Conditions (PPCs).....	222
Section 23: Grievance and Appeals	224
Deadlines for a fast appeal at Level 2	232
Deadlines for a standard appeal at Level 2	232
ALJ - Administrative Law Judge (Level 3)	234

Questions? Call the Alliance Provider Services Department, Monday – Friday,
 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

MAC – Medicare Appeals Council (Level 4).....	235
Section 24: Credentialing	236
Credentialing Process	236
Credentialing Criteria and Basic Qualifications	238
Re-Credentialing	240
Section 25: Facility Site Review (FSR).....	242
FSR Overview	242
FSR Preparation	242
FSR Tool.....	245
MRR Tool.....	246
Help and Resources.....	247
Provider Initial Review and Fair Hearing Process	247
Requesting an Appeal.....	248
Requirements for Mid-Level Clinicians.....	249
Organizational Providers.....	250
Part 4. Member Rights and Compliance.....	251
Section 26: Member Rights and Responsibilities	251
Alliance Member Rights	251
Alliance Member Responsibilities.....	252
What Can You and Your Office Do to Protect Member Privacy?	253
How to Protect the Protected Health Information (PHI) of Your Patients	253
Section 27: Fraud, Waste, and Abuse (FWA) and Protected Health Information (PHI).....	256
Overview of Fraud, Waste, and Abuse (FWA)	256
FWA Definitions	256
Examples of FWA	256
How to Report Potential FWA	257
Health Insurance Portability and Accountability Act (HIPAA)	258
Safeguarding PHI.....	258
Uses and Disclosures of Member PHI	260
Member Access to PHI	260
Reporting of Privacy Incidents and Breaches to the Alliance	260

Part 1. Alliance Services

Section 1: Introduction

Welcome to Alameda Alliance for Health (Alliance)

Thank you for joining the Alameda Alliance for Health (Alliance) provider network! This manual is intended to provide you with the information and requirements to navigate our health plan and to assist you with offering the best possible care to our Alliance members.

ABOUT THE ALLIANCE

The Alliance is a public, not-for-profit health plan offering high-quality managed care to one (1) out of every four (4) Alameda County residents through We offer three (3) lines of business coverage programs: Group Care (Alliance Group Care), Medi-Cal (Alliance Medi-Cal), and the Medicare Advantage (MA) Health Maintenance Organization (HMO) Dual Special Needs Plan (D-SNP) (Alameda Alliance Wellness).

~~and the In-Home Supportive Services (IHSS) Alameda Alliance Wellness program, also known as Alliance Group Care, and starting January 1, 2026, Medicare Dual Special Needs Plan (D-SNP) for members who have both Medicare and Medi-Cal and enroll in D-SNP~~ **Alliance Health Care Coverage Programs**

<u>Alliance Group Care</u>	<u>Provides coverage for health care benefits and services to In-Home Supportive Services (IHSS) workers in Alameda County.</u>	 Alliance ALAMEDA FOR HEALTH Alliance Group Care
<u>Alliance Medi-Cal</u>	<u>Provides coverage for health care benefits and services to Medi-Cal members in Alameda County.</u>	 Alliance ALAMEDA FOR HEALTH Alliance Medi-Cal
<u>Alameda Alliance Wellness</u>	<u>Provides coverage for health care benefits and services to members who have both Medicare and Medi-Cal and enroll in a D-SNP.</u>	 Alliance ALAMEDA FOR HEALTH Alliance Wellness

OUR MISSION, VISION, AND VALUES

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality, and accessible services.

Vision

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

The vision of the Alliance is that all residents of Alameda County will achieve optimal health and well-being at every stage of life.

Values (TRACK)

- **Teamwork:** We participate actively, support each other, develop local talent, and interact as one team.
- **Respect:** We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people's health and well-being.
- **Accountability:** We work to create and maintain efficient processes and systems that minimize barriers, maximize access and sustain high quality.
- **Commitment & Compassion:** We are empathic and care for the communities we serve including our members, providers, community partners and staff.
- **Knowledge & Innovation:** We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.

The Provider Manual

This Provider Manual describes your responsibilities to our members as a provider and is intended as a resource to help you provide them with the best possible care.

The Alliance requires that contracted practitioners, medical groups, providers, hospitals, ancillary providers, and other non-hospital facilities, together referred to as "Provider" or "Providers," fulfill the relevant specified responsibilities described in this Provider Manual and their contract.

The Alliance Provider Manual is regularly updated and reviewed at least annually and made available to in-network and out-of-network providers on the Alliance website at www.alamedaalliance.org.

Starting in 2024, the Alliance Provider Manual will be presented for review to the Alliance Community Advisory Committee (CAC) and Quality Improvement Health Equity Committee (QIHEC).

If you have any questions about the Alliance, our practices, or our members, please call our Alliance Provider Services Department at **1.510.747.4510**.

Getting Involved

Provider involvement helps us improve services for our members and providers.

WAYS TO PARTICIPATE:

Quality Improvement Health Equity Committee (QIHEC): The QIHEC meets at least quarterly. The Alliance Providers are encouraged to participate in the QIHEC and its peer sub-committees. QIHEC and other subcommittee members are paid a stipend. For

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.



more information, please call the Alliance ~~Peer Review and Credentialing Provider~~
Services Department at **1.510.747.4510**.

Credentialing Committee (CC): The CC meets monthly to review new provider applications, re-credentialing information. For more information, please call the Alliance Peer Review and Credentialing Department at **1.510.747.4522**.

Peer Review Committee (PRC): The PRC reviews quality issues on contracted providers on an as needed basis. For more information, please call the Alliance Peer Review and Credentialing Department at **1.510.747.4522**.

Pharmacy & Therapeutics (P&T) Committee: The P&T Committee meets quarterly to review the drug formulary and make changes to the authorization review criteria. For more information, please call the Alliance Pharmacy Services Department at **1.510.747.4541**.

The Alliance Provider Manual: The Alliance communicates with providers through this manual and periodic provider updates. Provider suggestions have been incorporated into this manual. Feedback is always helpful in keeping the manual as up to date as possible. To share any ideas or comments, please call the Alliance Provider Services Department at **1.510.747.4510**.

The Alliance Provider Updates Bulletin: The Alliance periodically distributes provider letters, newsletters, memos, and updates with additional information to keep you informed. If you haven't received these provider communications, or if you have ideas for topics that you would like to see covered, please call the Alliance Provider Services Department at **1.510.747.4510**.

Provider Training Sessions: The Alliance conducts training sessions throughout the year for providers and their staff. If you or your staff are interested, please call the Alliance Provider Services Department at **1.510.747.4510**.

~~**Pharmacy & Therapeutics (P&T) Committee:** The P&T Committee meets quarterly to review the drug formulary and make changes to the authorization review criteria. For more information, please call the Alliance Pharmacy Services Department at **1.510.747.4541**.~~

DEPARTMENTResource	Phone Number	Address	Website
Alameda Alliance for Health	Phone Number: 1.510.747.4500 Toll-Free: 1.877.371.2222	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Behavioral Health Care Services:	Toll-Free: 1.855.856.0577	1240 South Loop Rd Alameda, CA 94502,	www.alamedaalliance.org
Alliance Case & Disease Management (CMDM)	Toll-Free: 1.877.251.9612	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Compliance Hotline	Toll-Free: 1.844.587.0810	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Automated Eligibility Line	Phone Number: 1.510.747.4505	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Grievance and Appeals (G&A) Department	Phone Number: 1.510.747.4567 Fax: 1.855.891.7258	1240 South Loop Road Alameda, CA 94502	To file a grievance online, please visit: www.alamedaalliance.org
Alliance Health Education Program	Phone Number: 1.510.747.4577 Fax: 1.877.813.5151	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org/live-healthy Email: livehealthy@alamedaalliance.org
Alliance Long-Term Care (LTC) Department	Phone Number: 1.510.747.4516 Fax: 1.510.747.4191	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org Email: LTCHCS@Alamedaalliance.org

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

DEPARTMENTResource	Phone Number	Address	Website
Alliance Member Services Department (Medi-Cal and Group Care)	Phone Number: 1.510.747.4567 Toll-Free: 1.877.932.2738 <u>People with hearing and speaking impairments</u> <u>If you cannot hear or speak well</u> (CRS/TTY): 711/1.800.735.2929	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org/contact-us Email: memberservices@alamedaalliance.org
Alameda Alliance Wellness Customer Services (D-SNP)	Toll-Free: 1.888.882.3767 (1-888-88A-DSNP) <u>If you cannot hear or speak well</u> (CRS/TTY): 711/1.800.735.2929	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org Email: AAWMemberSupport@alamedaalliance.org
Alameda Alliance Wellness Sales (D-SNP)	Toll-Free: 1.877.972.5373 (1-877-WSales3)	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Pharmacy Services Department	Phone Number: 1.510.747.4541 24-Hour Service: 1.855.508.1713	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Provider Services Department	Phone Number: 1.510.747.4510 Fax: 1.855.891.7257	1240 South Loop Road Alameda, CA 94502	www.alamedalliance.org/providers Email: providerservices@alamedaalliance.org

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

DEPARTMENTResource e	Phone Number	Address	Website
Alliance Utilization Management (UM) & and Authorizations	Phone Number: 1.510.747.4540 Prior Authorization Fax: 1.855.891.7174 Concurrent Review: Admission Fax: 1.855.313.6306 Clinical Information Fax: 1.855.891.7409	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Cultural and Linguistic Services	24-Hour Interpreter Hotline (for interpreters by phone*) 1.510.809.3986		www.alamedaalliance.org/providers/provider-resources/language-access Email: interpreters@alamedaalliance.org
ACCESS Program Alameda County Behavioral Health Care Services (Medi-Cal)	Toll-Free: 1.800.491.9099	2000 Embarcadero Cove, Suite 400 Oakland, CA 94606	www.acbhcs.org
Advice Nurse Line	Medi-Cal and D-SNP Members: 1.888.433.1876 Group Care Members: 1.855.383.7873		
Clinical Laboratory Outpatient Services:	Toll-Free: 1.800.288.8008		www.questdiagnostics.com

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

<u>DEPARTMENT Resource</u>	Phone Number	Address	Website
Quest Diagnostics			
Dental Services (Group Care): Public Authority	Phone Number: 1.510.577.3551		www.acgov.org

Dental Services (Medi-Cal): Medi-Cal Dental Program	Toll-Free: 1.800.322.6384 People with speaking impairments (TTY): 1.800.735.2922		https://dental.dhcs.ca.gov/
<u>Dental Services (D-SNP): Liberty Dental Plan</u>	<u>Toll-Free:</u> <u>1.888.704.9838</u> <u>Dental providers LIBERTY Provider Relations Toll-Free:</u> <u>1.888.273.2997</u>	<u>P.O. Box 26110,</u> <u>Santa Ana, CA 92799</u>	To find a dental provider: https://www.libertydentalplan.com/Find-a-Dentist/Find-a-Dentist.aspx
Durable Medical Equipment Provider: California Home Medical Equipment (CHME)	Toll-Free: 1.800.906.0626		www.chme.org Email: aaquestions@chme.org
<u>Flex Card Supplemental Services (D-SNP): Nations</u>	<u>Toll-Free:</u> <u>1.877.408.7542</u>		www.Alliancewellness.nationsbenefits.com
<u>Hearing Supplemental Services (D-SNP): Nations</u>	<u>Toll-Free:</u> <u>1.877.408.7542</u>		www.Alliancewellness.nationsbenefits.com/hearing
Medi-Cal Rx	Toll-Free:		www.medi-calrx.dhcs.ca.gov

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

DEPARTMENTResource e	Phone Number	Address	Website
administered by <u>MagellanPrime</u> <u>Therapeutics</u>	1.800.977.2273 TDD: 711		
Teladoc Telehealth Provider	Toll-Free: 1.800.TELADOC (1.800.835.2362)		www.alamedaalliance.org/members/teladoc
Transportation Services	Toll-Free: 1.866.791.4158		www.alamedaalliance.org
Vision Services (Group Care): Public Authority	Phone Number: 1.510.577.3551		www.alamedacountyca.gov
Vision Services <u>up to</u> <u>12/31/2025</u> (Medi-Cal): MARCH Vision	Toll-Free: 1.844.336.2724		www.marchvisioncare.com
<u>Vision Services starting</u> <u>1/1/2026</u> (D-SNP): <u>Vision Service Plan</u>	<u>Toll-Free:</u> <u>1.855.492.9028</u>		<u>D-SNP Provider Directory:</u> <u>www.vsp.com/advantageonly</u>
<u>Vision Services starting</u> <u>1/1/2026</u> (Medi-Cal): <u>Vision Service Plan</u>	<u>Toll-Free:</u> <u>1.800.877.7195</u>		<u>Medi-Cal Provider Directory:</u> <u>www.vsp.com/medicaid</u>

*In-person interpreters are available for ASL and complex or highly sensitive appointments. For more information, please see “Requesting Interpreter Services” in Section 14: Serving Your Diverse Population.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

Section 2: Alliance Resources

Alliance Provider Services Department (PS)

The Alliance Provider Services Department is your primary link to the Alliance. A quick phone call to an Alliance Provider Relations representative can answer many of your questions about our policies and procedures.

The Alliance Provider Services Department provides information and support to all Alliance network providers about:

- Access
- Alliance promotional materials
- Authorization status training
- Benefits
- Claims/billing status
- Contract issues
- Interpreter services
- Member eligibility
- Office address, and provider directory changes
- PCP assignment
- Peer review
- ~~Provider billing accounts~~
- Provider bulletins
- Provider credentialing, and re-credentialing
- Provider discharges
- Provider network inquiries
- Provider portal access
- Site reviews
- Transportation services

Alliance Member Services Department (MS)

The Alliance Member Services Department helps manage member needs and concerns. The Alliance Member Services Department Call Center is specifically for members and member-related issues.

If a [Medi-Cal or Group Care](#) member has a question about their care or coverage, please encourage them to call:

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

[If you cannot hear or speak well](#) ~~People with hearing and speaking impairments~~

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

(CRS/TTY): 711/1.800.735.2929

If an Alliance Wellness (HMO-~~DSNPD-SNP~~) member has a question about their care or coverage, please encourage them to call:

AllianceAlameda Alliance Wellness Member Services Department—~~DSNPD-SNP Unit~~

Monday – Sunday (seven (7) days a week), 8 am – 8 pm

Toll-Free: 1.888.882.3767

If you cannot hear or speak well, use TTY or call 1.800.735.2929

The Alliance Member Services Department can assist members with:

- Changing a member's assigned primary care provider (PCP)
- Checking the status of a claim
- Checking the status of a prior authorization (PA) request
- Finding an in-network PCP, specialist, or behavioral health care provider
- Finding the location of an in-network pharmacy (For Alliance Group Care and DSNPD-SNP members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- Health education materials and resources
- Interpreter services
- Learning more about plan benefits and services
- Mail order pharmacy information (For Alliance Group Care and DSNPD-SNP members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- Reporting an issue or filing a grievance/appeal
- Requesting information on community resources
- Requesting a reimbursement for covered drugs or services (For Alliance Group Care and DSNPD-SNP members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- Requesting a replacement Alliance member ID card
- Scheduling transportation for covered services
- Updating a member's contact information (permanent contact information changes should be reported to the member's local social services agency by visiting **www.mybenefitscalwin.org**)
- Verifying a member's eligibility

The Alliance Member Services Department provides printed materials upon request for members, such as our Combinedthe Member Handbook or Evidence of Coverage (EOC) and health education resourcesand Provider Directory. Members can also learn more about our services and their coverage on our website at **www.alamedaalliance.org**.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.



The Alliance Member Services Department can also help facilitate communication between members and providers.



For after-hours eligibility verification, please call the Alliance Eligibility Verification Line at **1.510.747.4505**, 24 hours a day, 7 days a week, or use the Online Provider Portal located on our website at **www.alamedaalliance.org**.

Section 3: Eligibility and PCP Choice

Identifying Alliance Members (C&O/MS)

Each Alliance member is issued an Alliance member identification (ID) card with a 9-digit member number. Providers can also use the member's Medi-Cal Client Identification Number (CIN) to identify members who are Medi-Cal beneficiaries.

ALLIANCE MEDI-CAL MEMBER ID CARD

MEMBER ID CARD	[First Name] [Last Name] Member ID: [Member ID] CIN: [CIN] Provider Group/Name: [Provider Group/Name] Primary Care Provider: [PCP Name] Phone Number: [Phone Number] Effective Date: [Effective Date] Group: [Group] Copays: MCAL OV \$0 ER \$0 RX \$0  www.alamedaalliance.org BIN: [xxxxxxxx] PCN: [xxxxxxxx]	MEMBER ID CARD
	In case of emergency, call 911 or go to the nearest hospital Emergency Room (ER). Members may seek Emergency services from Out-of-Network Providers. Emergency services are covered without prior authorization, and at no cost to the member. Member Services and Behavioral Health Care: 1.510.747.4567, toll-free 1.877.932.2738 (CRS/TTY: 711/1.800.735.2929) 24-Hour Advice Nurse Line: 1.888.433.1876 Medi-Cal Rx Pharmacy Benefit Call Center: 1.800.977.2273 This card does not guarantee eligibility.	
	Provider Inquiries: 1.510.747.4510 Claims: PO Box 2460, Alameda, CA 94501	

ALLIANCE GROUP CARE MEMBER ID CARD

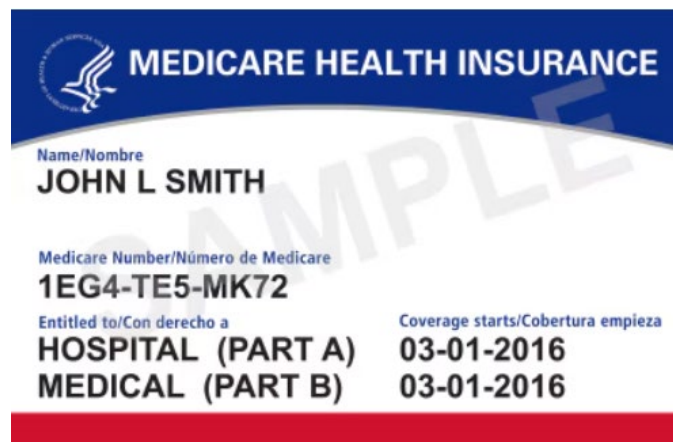
MEMBER ID CARD	[First Name] [Last Name] Member ID: [Member ID] CIN: [CIN] Provider Group/Name: [Provider Group/Name] Primary Care Provider: [PCP Name] Phone Number: [Phone Number] Effective Date: [Effective Date] Group: [Group] Copays: GC OV \$10 ER \$35 RX \$10/G \$15/B INPT \$100 ACU \$5 CHIRO \$10  www.alamedaalliance.org BIN: [xxxxxxxx] PCN: [xxxxxxxx]	MEMBER ID CARD
	In case of emergency, call 911 or go to the nearest hospital Emergency Room (ER). Members may seek Emergency services from Out-of-Network Providers. Emergency services are covered without prior authorization, and at no cost to the member. Member Services and Behavioral Health Care: 1.510.747.4567, toll-free 1.877.932.2738 (CRS/TTY: 711/1.800.735.2929) 24-Hour Advice Nurse Line: 1.888.433.1876 This card does not guarantee eligibility.	
	Provider Inquiries: 1.510.747.4510 Claims: PO Box 2460, Alameda, CA 94501	

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

MEDI-CAL BENEFITS IDENTIFICATION CARD (BIC)



MEDICARE BENEFITS IDENTIFICATION CARD



Verifying Member Eligibility (PS)

Your office is responsible for verifying member eligibility and authorization at the time of service. We encourage you to save a copy of the eligibility results for your reference.

There are several ways to verify a member's eligibility:

- State's Automated Eligibility Verification System (AEVS) – For Alliance Medi-Cal members only):
Toll-Free: 1.800.456.2387
www.medi-cal.ca.gov/eligibility/Eligibility.aspx
- Alliance Provider Services Department – For all Alliance members (Medi-Cal, and Group Care, and D-SNP):
Monday – Friday, 7:30 am – 5 pm

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Phone Number: **1.510.747.4510**

- Alliance Automated Eligibility Verification Line:
24 hours a day, 7 days a week

Phone Number: 1.510.747.4505

Please have your National Provider Identifier (NPI) or Taxpayer Identification Number (TIN) available.

- Alliance Provider Portal:
• Accessed through **www.alamedaalliance.org**

•

Provider Portal Instructions (PS)

ONLINE PROVIDER PORTAL

The Alliance offers contracted and non-contracted providers access to our interactive website.

Through this website, you can:

- Check claims status and remittance advice statements
- Submit/check authorization status
- Submit a Provider Dispute Request (PDR)
- Submit a behavioral health care treatment report and care coordination forms (for mental health and applied behavioral analysis)
- Submit a request for interpreter services that need scheduled in advance
- Submit an Enhanced Care Management (ECM) Referral Form
- Submit professional claims electronically (including secondary claims)
- Verify member eligibility
- Verify and validate your provider directory data
- View the Alliance medication formulary (For Group Care and Alameda Alliance Wellness members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- View the Alliance Provider Directory
- View your gap-~~in~~and-care reports (PCP only)
- View your roster with assigned members (PCP only)

Information on the website is updated every 24 hours directly from our internal system.

To use the online provider portal, you must first obtain a provider account:

- Visit the Alliance website at **www.alamedaalliance.org**, select the Provider Portal link located at the top right banner, then select the “Create Account” link on the Provider Portal landing page.
- The Provider Portal Instructions Manual is available on the home page of the Provider Portal and once logged into the Provider Portal.
- For assistance, please contact:

Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
Email: **providerservices@alamedaalliance.org**

Selecting a PCP (PS)

The Alliance encourages members to participate in their health care by selecting a PCP from the provider network. Members can find a list of PCPs in their Alliance Provider

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Directories or online at **www.alamedaalliance.org**.

Members can choose a physician who is taking new members from the list of internal medicine, general medicine, family practice, pediatrics, and OB-GYNs (women can choose an OB-GYN as their PCP). An Alliance Member Services representative can help members find a PCP who knows their language or culture, or who is close to where they live or work.

Members can also choose a county or community clinic that is part of the Alliance network as their PCP. All Federally Qualified Health Centers (FQHC) in Alameda County are part of the Alliance Network. Members can go to any FQHC for medical care even if it is not part of the Alliance network.

The Alliance will mail members a new ID card with their PCP's name and phone number within **10 business days** to confirm their PCP selection (automatic or voluntary).

Members may change their PCP by calling:

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well ~~People with hearing and speaking impairments~~
(CRS/TTY): **711/1.800.735.2929**

When a member does not select a PCP in their first month of enrollment, the Alliance will assign a PCP based on member age, language, geographic location, and PCP capacity. A member's choice overrides automatic selection, and a member who has been automatically assigned will be prompted to call the Alliance Member Services Department if they prefer to be assigned to a different PCP. If the member is in a long-term care (LTC) facility and/or have Medicare (not enrolled with the Alliance D-SNP) as their primary insurance ~~enrolled in both Medi-Cal and Medicare~~, they do not have to select a PCP.

Changing PCPs (PS)

The Alliance values member empowerment and encourages members to find an in-network provider accepting new patients with whom they can build a rewarding primary care relationship. Members can change their PCP for any reason and at any time by calling the Alliance Member Services Department at **1.510.747.4567**.



Changes will be effective on the first of the following month when the request is made. In some cases, a member may be added to a practice if the Alliance receives the assignment request before the **5th of the month**. If you have questions about a member's eligibility or assignment, please call the Alliance Provider Services Department at **1.510.747.4510**.

The Alliance Member Service Department will confirm the PCP reassignment and the effective date by sending a confirmation letter and a new Alliance member ID card with the new PCP's name and phone number to the member within **10 business days**.

If a PCP leaves their practice or is no longer able to see patients for any reason, the Alliance Member Services Department will notify any affected members as soon as possible and assist them in selecting another PCP.

Section 4: Provider Compliance (PS)

The California Department of Health Care Services (DHCS), ~~and~~ Department of Managed Health Care (DMHC), ~~and Centers for Medicare & Medicaid Services (CMS)~~ have established guidelines for the Medi-Cal managed care program, ~~and~~ Group Care, ~~and D-SNP~~ members. Providers should familiarize themselves with these guidelines to avoid sanctions, fines, or suspension of membership.

Travel Time and Distance Standards (PS)

DHCS established Network Adequacy Standards to ensure adequate availability and accessibility of services to members. These standards include time and distance standards based on county population density.

For Alameda County, the following standards have been established based on provider type:

- **10 miles** or **30 minutes** from the member's residence for adult and pediatric PCPs, OB/GYN primary care, and pharmacies.
- **15 miles** or **30 minutes** from the member's residence for adult and pediatric specialty care, hospitals, and adult and pediatric mental health providers.

Alternative access standards may be approved by DHCS.

Hours of Operation (PS)

Alliance contracted providers are required to ensure the office hours of operation are equally accessible to all patients. This includes all Alliance members as well as Medi-Cal fee-for-service (FFS) beneficiaries.

Alliance Marketing Materials (C&O)

PROMOTIONAL MATERIALS

If you are interested in obtaining brochures, newsletters, or promotional materials, please call the Alliance Provider Services Department at **1.510.747.4510**.

Approved Medi-Cal Marketing Methods (C&O)

As a health care provider, you may:

- Actively encourage your Medi-Cal patients to seek out and receive information and enrollment materials that will help them select a Medi-Cal health care plan for themselves and their families.
- Provide patients with the phone number of the outreach and enrollment or Member Services Departments of the plan(s) with which you are affiliated.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Provide patients with the toll-free phone number of the DHCS, Health Care Options (HCO) enrollment contractor (toll-free: **1.800.430.4263**) and inform them of locations and times when they may receive individual or group assistance about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information, activities, presentations, and problem-resolution functions.
- Tell your Medi-Cal patients the name of the health plan or plans with which you are affiliated.

Discharging Members (PS)

The Alliance allows PCPs and specialists to request the discharge of assigned members. The Alliance will work with the member to choose another PCP or specialist who can best meet the member's needs.

HOW TO DISCHARGE A MEMBER

1. Determine the reason for the proposed discharge. Under the Medical Services Agreement, PCPs may only request the discharge of a member if medical services can no longer be successfully provided for reasons other than medical conditions. Some acceptable reasons for discharge include unruly behavior, threatening remarks, frequently missed appointments, fraud, etc. Document the reason(s) for discharge in the member's medical record. Requests to discharge a member due to medical conditions, frequent visits, or high cost of care will be denied.
2. Contact the Alliance Provider Services Department (or your Provider Relations representative) in writing to request a discharge. On the practice letterhead, please provide complete documentation regarding the nature of the problem(s) and reason(s) for the discharge. The Alliance Provider Services Department will review the request.
3. When a discharge request is granted, the Alliance Member Services Department will notify the member regarding the change in status and will work with the member to find a new PCP or specialist.
4. The PCP or specialist must maintain responsibility for the member's care until reassignment is complete. This responsibility includes giving the patient a **30-day** written notice of the discharge.

The member discharge notice must state the following:

- That the PCP will be available for emergencies and prescriptions for **30 days** or until a new PCP or specialist assignment is effective;
- That the member should contact the Alliance Member Services Department for assistance with selecting a new PCP or specialist; and
- That the PCP or specialist will make available the member's medical records to the member's new PCP or specialist upon request.

Additionally, a copy of the member discharge letter must be sent to the Alliance Provider Services Department to ensure appropriate follow-up and member assistance.

If the PCP, specialist, or member is dissatisfied with the decision, the PCP, specialist, or member may file a grievance for further review.

Provider Directory Changes (PS)

Keeping your information up-to-date and accurate is important to ensure our provider directory information is correct and that we maintain accurate information about your demographics.

Changes that should be reported include, but are not limited to, the following:

- Site name
- Site location (including suite numbers and floors)
- Phone and fax number(s)
- Hours of operation
- Accepting member status
- Member age limitations
- Languages spoken by office staff and providers
- Gender affirming care that may be offered
- Providers additions and terminations
- Telehealth or in-person availability

The Alliance requests that you notify us immediately of any updates that need to be made to the Alliance Provider Directory by calling the Alliance Provider Services Department at **1.510.747.4510**.

Provider Data Requirements (274) (PS)

The Alliance is required to report multiple provider data elements for all contracted providers to DHCS monthly. The report is called 274 and is a comprehensive and standardized file layout and protocol used by all Medi-Cal plans to submit provider network data to DHCS. The data will be used by DHCS for network assessments, data analytics, and other federal and state reporting requirements.

The preferred method to submit to the Alliance is through a file format called a Flat File. The Alliance can provide you with a Flat File template and help get you set up with how to send files electronically to allow providers to report required changes.

The required information includes, but is not limited to:

- Provider full name
- NPI

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- Gender
- Date of birth
- Specialty
- Languages
- Provider license number
- DEA number
- Board certification
- Site NPI and tax ID of where the providers practice
- Site location of where the providers practice
- Hospital privileges
- Provider additions and terminations

Part 2. Providing Services

Section 5: Primary Care Provider (PCP) Roles and Responsibilities **(PS)**

It is the primary care provider (PCP) who acts as the primary case manager to all assigned members. This means the PCP must follow case management protocols as set forth in this section.

PCP Services **(PS)**

CARE MANAGEMENT PROTOCOL

As a PCP in the Alliance network, we ask that you follow care management protocols as set forth in this manual for the following areas:

- Check the rosters posted on the provider portal monthly to know which members are assigned to you as their PCP
- Coordinate and direct appropriate care for members by means of an initial diagnosis and treatment and obtain second opinions and consultation(s) with contracting specialists, as necessary
- Coordinate member discharge planning and referral to long-term care (LTC) or other services with the hospital and the Alliance
- Establish procedures to contact members when they miss appointments, require rescheduling for additional visits, or confirm referrals to a specialist for care
- Follow up on referrals made to specialists to assess the results of the care medication regimen, and special treatment, and ensure continuous care
- Provide a medical history and physical examination as appropriate:
- For new members: Provide an Initial Health Appointment (IHA) within **120 calendar days** of the member's effective date of enrollment
- Provide the specified scope of services to members
- Refer, as necessary, certain medically necessary non-emergency hospital specialty services, and diagnostic testing

OVERALL GOALS OF CARE MANAGEMENT

The Alliance will assist our PCPs in achieving these overall case management goals:

- Coordinate care of members to achieve positive care results
- Discourage inappropriate use of pharmacy and drug benefits
- Facilitate patient understanding and use of disease prevention practices and

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early diagnostic services

- Provide a structure for physicians to manage services by providing performance data on utilization, cost, and quality
- Provide National Committee for Quality Assurance (NCQA)-compliant Case and Disease Management for members
- Reduce, where appropriate, the use of emergency services as a source of nonemergency care

TIMELY ACCESS STANDARDS FOR PROVIDERS

Please see below for a table detailing the required DHCS, DMHC, NCQA, and Alliance required response times:

Appointment Wait Times	
Appointment Type:	Appointment Within:
Urgent Appointment that <i>does not</i> require PA	48 Hours of the Request
Urgent Appointment that <i>requires</i> PA	96 Hours of the Request
Non-Urgent Primary Care Appointment	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent Appointment with a Specialist Physician	15 Business Days of the Request
Non-Urgent Appointment with a Behavioral Health Provider	10 Business Days of the Request
Non-Urgent Appointment with Ancillary Services for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request
<u>Appointments Wait Time (D-SNP)</u>	
<u>Appointment Type:</u>	<u>Appointment Within:</u>
<u>Urgently needed services or emergency that does not require PA</u>	<u>Immediately</u>
<u>Non-Urgent Primary Care Appointment</u>	<u>7 Business Days of Request</u>
<u>Routine or preventive care</u>	<u>30 Business Days of Request</u>

All Provider Wait Time/Telephone/Language Practices	
<u>Standard Appointment Type:</u>	<u>Appointment Within:</u>
In-office wait time	60 minutes
Call return time	1 business day
Time to answer call	10 minutes
Telephone access – Provide coverage 24 hours a day, 7 days a week.	
Telephone triage and screening – Wait time not to exceed 30 minutes.	
Emergency instructions – Ensure proper emergency instructions.	
Language services – Provide interpreter services 24 hours a day, 7 days a week.	

LTSS Timely Access Network Standards

—The Alliance’s Utilization Management Department monitors our LTSS facility **against** against —the following timely access network standards.

<u>LTSS Timely Access Network Standards</u>	
<u>Provider Type:</u>	<u>Standard:</u>
<u>Skill Nursing Facility</u>	<u>Within 5 business days of request</u>
<u>Intermediate Care Facility/ Developmentally Disabled (ICF-DD)</u>	<u>Within 5 business days of request</u>
<u>Community Based Adult Services (CBAS)</u>	
<u>Initial</u>	<u>Within 5 business days acknowledge receipt of request from CBAS center</u>
<u>F2F Eligibility Assessment</u>	<u>Completed within 30 days</u>
<u>IPC by CBAS Center</u>	<u>Within 90 days</u>
<u>Reassessment</u>	<u>6 months</u>

*The DMHC Timely Access Standard for an appointment with psychiatrist is **15 business days**; however, to comply with the CMS and NCQA accreditation standards of **10 business days**, the Alliance uses the more stringent standards.

PA – Prior Authorization

Urgent Care: Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care: Routine appointments for non-urgent conditions.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Triage or Screening: The assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage and determine the urgency of the member's need for care.

Shortening or Extending Appointment Timeframes: The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

Department of Health Care Services (DHCS) Timely Access Survey

About the Survey: Quarterly, the California Department of Health Care Services (DHCS) requires Medi-Cal managed care plans (MCPs) to monitor timely access to **Urgent and Non-Urgent Appointments Availability** in providers office.

Methodology: Utilizes a third party; DHCS selects and surveys a randomized sample of Alliance network providers on a quarterly basis every year. DHCS will make 3 attempts to each provider's office to conduct the survey.

Questions: The survey solicits answers about the next available appointment date and time for Urgent and Non-urgent appointments (please see table above for appointment wait time).

Minimum Performance Levels: Effective January 1, 2025 (MY2025), timely access MPLs is required for appointment wait times. Please see the table below detailing the requirements for DHCS.

<u>Timely Access Category</u>	<u>MPL Effective Wednesday, January 1, 2025 to Thursday, December 31, 2026</u>	<u>MPL Effective Friday, January 1, 2027</u>	<u>MPL Effective Saturday, January 1, 2028</u>
<u>Urgent Adult PCP Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Urgent Pediatric PCP Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Adult PCP Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Pediatric PCP Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Urgent Adult Specialist Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Urgent Pediatric Specialist Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Adult Specialist Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Pediatric Specialist Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Non-Physician Mental Health Care or SUD Provider Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Urgent Non-Physician Mental Health Care or SUD Provider Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Non-Physician Mental Health Care or SUD Provider Follow-Up Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Ancillary Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Non-Physician Mental Health Care or SUD Provider Follow-Up Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>
<u>Non-Urgent Ancillary Appointment</u>	<u>70%</u>	<u>80%</u>	<u>90%</u>

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

INITIAL HEALTH APPOINTMENT (IHA)

All new Alliance members must receive an Initial Health Appointment (IHA). The IHA consists of a history, a review of systems, a physical exam, and preventive services. For Medi-Cal members, this must be completed within **120 days** of enrollment or provider assignment. During site audits, a PCP's compliance with this standard will be assessed. On a regular basis, the Alliance's Quality Improvement Department conducts random audits to determine if all components of the IHA have been completed and whether the completion followed the guidelines.

The IHA should consist of an evaluation sufficient to enable the PCP to assess the acute, chronic, and preventive health needs of the member and assume responsibility for effective management of the member's health care service needs.

For children, the IHA must consist of the elements found in the most recent periodicity schedule recommended by the Bright Futures Guidelines/American Academy of Pediatrics (AAP). PCPs must provide preventive health visits for all members under **21 years of age** for Early and Periodic Screening, Diagnostics, and Treatment services at times specified by the most recent AAP periodicity schedule. The IHA must bring members up to date with all currently recommended preventive services for the lower age nearest to the current age of the child.

Codes that qualify for IHA:

PROVIDER TYPE		CPT CODES	Z-CODES	DESCRIPTION
PROVIDER TYPE	CPT CODES	Z-CODES		DESCRIPTION
Behavioral Health	96156			Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
OB/Gyn	59400 59425 59426 59430 59510 59610 59618	Z1000 Z1008 Z1020 Z1032 Z1034 Z1036 Z1038		Under vaginal delivery, antepartum and postpartum care procedures, under cesarean delivery procedures, under delivery procedures after previous cesarean delivery, under delivery procedures after previous cesarean delivery
PCP	99202- 99205 99461	Z1016		Office or other outpatient visit for the evaluation and management of new patient
PCP	99211- 99215	Z00.01 Z00.110 Z00.114		Office or other outpatient visit for the evaluation and management of an established patient with PCP but new to the Alliance

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

PROVIDER TYPE		CPT CODES	Z-CODES	DESCRIPTION
PROVIDER TYPE	CPT CODES	Z-CODES		DESCRIPTION
		Z00.8		
		Z02.4		
		Z02.3		
		Z02.5		
PCP	99381-99387			Comprehensive preventive visit and management of a new patient
PCP	99391-99397			Comprehensive preventive visit and management of an established patient with PCP but new to the Alliance

<u>Provider</u>	<u>Codes</u>	<u>Description</u>
<u>Behavioral Health</u>	<u>96156</u>	<u>Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making).</u>
<u>OB/Gyn</u>	<u>59400, 59425, 59426, 59430, 59510, 59610, 59618</u> <u>Z1000, Z1008, Z1020, Z1032, Z1034, Z1036, Z1038</u>	<u>Under vaginal delivery, antepartum and postpartum care procedures, under cesarean delivery procedures, under delivery procedures after previous cesarean delivery, and under delivery procedures after previous cesarean delivery.</u>
<u>PCP (new patient)</u>	<u>99202-99205, 99461</u> <u>Z1016</u> <u>99381-99387</u>	<u>Office or other outpatient visit for the evaluation and management of new patient.</u> <u>Comprehensive preventive visit and management of a new patient.</u>
<u>PCP (established patient)</u>	<u>99211-99215</u> <u>Z00.01, Z00.110, Z00.111, Z00.8, Z02.1, Z02.3, Z02.5</u> <u>99391-99397</u>	<u>Office or other outpatient visit for the evaluation and management of an established patient with PCP but new to the Alliance.</u> <u>Comprehensive preventive visit and management of an established patient with PCP but new to the Alliance.</u>

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

INITIAL PREVENTIVE PHYSICAL EXAM (IPPE)

The Medicare IPPE, also known as the "Welcome to Medicare" Visit, is a one-time preventive service that should be completed within the first twelve months of a beneficiary's enrollment in Part B coverage. This visit focuses on a member's medical history, social history, and preventive education needs. Electrocardiograms are not mandatory for an IPPE but are a covered service that may be provided during the visit.

<u>Codes</u>	<u>Description</u>
<u>G0402,</u> <u>G0468</u>	<u>The IPPE is a face-to-face visit with covered services limited to new beneficiaries during the first 12 months of Medicare enrollment</u> <u>Federally qualified health center (FQHC) IPPEs or AWVs include the standard bundle of Medicare-covered provided during those visits</u>
<u>G0403,</u> <u>G0404,</u> <u>G0405</u>	<u>Electrocardiogram with 12 leads; performed as a screening for the IPPE with interpretation and report</u> <u>Electrocardiogram 12 leads; tracing only, performed as a screening for the IPPE</u> <u>without interpretation and report</u> <u>Electrocardiogram with 12 leads; interpretation and report only, performed as a screening for the IPPE</u>

ANNUAL WELLNESS VISIT (AWV)

The Medicare AWV is an annual visit for Medicare beneficiaries with Part B coverage. The visit is a conversation between a patient and provider to develop or modify personalized prevention and disease management plans based on history reviews, clinical screenings, and an updated health risk assessment. Advance care planning (ACP) is not mandatory but is a highly recommended element of the AWV

<u>Codes</u>	<u>Description</u>
<u>G0438</u>	<u>The Initial AWV includes a personalized prevention plan and can only be billed once per lifetime after the first 12 months of enrollment in Medicare Part B</u>
<u>G0439</u> <u>G0468</u>	<u>Subsequent AWVs includes a personalized prevention plan of service and can</u> <u>Federally qualified health center (FQHC) IPPEs or AWVs include the standard bundle of Medicare-covered provided during those visits</u>
<u>G0439</u>	<u>Subsequent AWVs includes a personalized prevention plan of</u>

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	<u>service and can, informed by their updated health risk assessment, functional status, and screenings results</u>
<u>G0468</u>	<u>Federally qualified health center (FQHC) IPPEs or AWPVs include the standard bundle of Medicare-covered provided during those visits</u>
<u>99497</u>	<u>Sixteen to thirty minutes of face-to-face advance care planning which includes the review and discussion of advanced directives with the member</u>
<u>99498</u>	<u>Each additional thirty minutes of ACP</u>
<u>99498</u>	<u>Each additional thirty minutes of ACP</u>

Providing Capitated Services to Alliance Group Care Members (PS)

SUBMISSION OF CAPITATED SERVICE ENCOUNTERS

PCPs are capitated for their Alliance Group Care members. Capitated services are the PCP's contractual responsibility. These services are covered by the monthly capitation payment. Capitated services do not require prior authorization.

PCPs must submit capitated services as claims/encounters to the Alliance with the usual and customary billed charges listed. Reported capitated services will appear along with non-capitated services (fee-for-service (FFS) claims) in a Remittance Advice to the PCP, although no payment will be associated with such services.

CAPITATED SERVICES TO A NON-ASSIGNED MEMBER

FFS billing of capitated services is limited to certain situations.

Providers who perform a capitated service for an Alliance member who is not assigned to that provider will only be paid for that service on an FFS basis during the following circumstances:

- Annual gynecological examination
- Diagnosis and treatment of a sexually transmitted disease
- Family planning services
- HIV testing and counseling
- Minor consent services
- Prenatal care (a global fee is paid for this type of care, except for specific procedures)
- The member is not assigned to any PCP
- Vaccination serum, except those covered by the Vaccines for Children (VFC) program

Non-Capitated Services (PS)

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.



PCPs may provide services within their scope of practice that are not included in the capitation contract for their assigned members. These services are paid on an FFS basis.

Among the non-capitated services that PCPs can provide to their members on an FFS basis are preventive health care visits and inpatient care services.

All prior authorization may be submitted via the Alliance Provider Portal with supporting clinical documentation.

PCP Role in Supervision of Mid-Level Clinicians (PS)

REQUIREMENTS FOR MID-LEVEL CLINICIANS

PCPs who employ or contract with mid-level clinicians in their practices are responsible for making sure that the mid-level clinicians meet the standards set forth by the clinician's licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. They must meet certain qualifications and standards to be credentialed by the Alliance. This helps ensure quality care for members.

SCOPE OF PRACTICE

A supervising physician must define the scope of practice for each mid-level clinician working in the practice. The scope of practice may vary depending on the skills of the individual clinician, but in all cases must comply with applicable state laws.

CREDENTIALING

Any mid-level clinician who provides care to Alliance members must be credentialed by the Alliance. The effective date of a credentialed provider is the first day of the month following the month they were credentialed.

DEFINITIONS OF MID-LEVEL CLINICIANS

Mid-level clinicians are non-physician medical practitioners, including:

- Certified nurse-midwives
- Nurse practitioners
- Physician assistants

Continuing Education: All mid-level clinicians must maintain skills in their field of practice through continuing medical education programs, following the guidelines of their respective certifications. The supervising physician should monitor this process.

Supervision: All mid-level clinicians must practice under the supervision of a licensed physician and follow medical policies and protocols established by the physician.

CHARTS

Whenever care is provided by the mid-level clinician, the medical record must be reviewed and co-signed by the supervising physician in accordance with the requirements set forth by the clinician's licensing board. The Alliance will audit for compliance with this standard.

PCP/MID-LEVEL CLINICIAN RATIOS AND MEMBER CAPACITY

The number of non-physician medical practitioners who may be supervised by a single PCP is limited to the following:

- Four (4) nurse practitioners
- Four (4) nurse-midwives
- Four (4) physician assistants; or
- Four (4) of the above individuals in any combination

The ratio is based on each physician at any one-time/shift regardless of full-time equivalent status. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits.

The ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits.

AFTER-HOURS SERVICE

Mid-level clinicians may participate in the after-hours call network; however, the supervising physician must also be available for consultation when the mid-level is on-call.

The provider may also refer members to the toll-free Advice Nurse Line, accessible 24 hours a day, 7 days a week:

Medi-Cal Members (Including Alliance Wellness when dually eligible for Medi-Cal): 1.888.433.1876

Group Care Members: **1.855.383.7873**

DISCLOSURE

Members must be informed when a practitioner is a mid-level clinician and must have the opportunity to request a physician if they wish.

QUALITY AND UTILIZATION MANAGEMENT

Contracted organizations are responsible for adherence to contractual obligations and Alliance quality standards for utilization management and quality improvement. The Alliance maintains responsibility for the overall adherence to quality and utilization standards for Alliance members.

Provider responsibilities include the following:

- Completion of corrective action plans as required to improve performance
- Prompt response to plan requests for medical records, corrective action plans, or additional information

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Participation in provider and member satisfaction and timely access surveys
- Cooperation with Alliance annual audits such as CMS, DHCS, DMHC, NCQA, and ad hoc state and other regulatory audits
- Development, enactment, and monitoring of a utilization management and/or quality improvement plan that meets contractual requirements and Alliance standards
- Provide a representative to the Alliance Quality Improvement Health Equity Committee (QIHEC)
- Provision of encounter information and access to medical records for Alliance members
- Submission of quarterly reports, annual evaluations, and work plans
- Submission of utilization management reports based on the delegation agreement

FACILITY SITE REVIEWS (FSR) - MONITORING FSR (QI)

Facility Site Reviews (FSR) are the application of prescribed standards by the California Department of Health Care Services (DHCS)/Medi-Cal Managed Care Division (MMCD), and Centers for Medicare and Medicaid Services (CMS) for all primary care provider (PCP) sites.

All network PCP sites receive the following:

- An Initial FSR as part of the credentialing process
 - New PCP sites must pass their Initial FSR and, as applicable, correct all deficiencies to close the Corrective Action Plan (CAP) before being added to the network and receiving Alliance member assignments
- A Medical Record Review (MRR) survey is performed at the time of the FSR if Medi-Cal patient records are available; otherwise, the Alliance must complete the initial MRR of the new PCP site within **90 calendar days** of the date that the Alliance first assigns members
- A Periodic Full Scope FSR and MRR conducted every **three (3) years** thereafter
- An Interim Monitoring Review is conducted between each Periodic Full Scope FSR and MRR via an attestation form or on-site review
- A focused review (targeted review of one (1) or more specific areas of FSR or MRR) may be conducted to investigate problems identified through monitoring activities or to follow up on corrective actions
- The FSR and MRR are conducted by DHCS-certified nurse reviewers and scored with standardized DHCS guidelines and audit tools
The purpose of the reviews is to ensure that:
 - Appropriate primary health care services are provided
 - Processes that support continuity and coordination of care are consistent
 - Patient safety standards and practices are maintained; and
 - Clinics operate in compliance with applicable local, state, and federal laws and regulations

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Regulatory agencies may conduct periodic oversight audits of the Alliance's facility site review process. It is the expectation of the Alliance that selected providers will participate in this process.

Each delegate's contract addresses the responsibility for facility site reviews. If the delegated entity is responsible for the review of their provider sites, summary reports must be provided to the plan that includes the number of sites reviewed, deficiencies, and any corrective action plans.

POTENTIAL QUALITY ISSUE (PQI) ~~(QI)~~

A potential quality issue (PQI) is an individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.

The PQI review, evaluation, and monitoring process applies to all providers rendering services to Alliance members/enrollees on the plan's behalf, within all care settings. The Alliance Quality Improvement (QI) Department has the responsibility for ensuring and maintaining a timely PQI review process from the receipt of all PQI through investigation, appropriate intervention, and resolution. Providers are expected to participate in the PQI process, including submitting medical records or responding to corrective plans to complete the investigation. The Alliance considers this system process a critical component of the QI HE Program.

Section 6: Utilization Management

Overview (HCS)

The Alliance Utilization Management (UM) Department helps ensure the delivery of high-quality, safe, equitable, necessary cost-effective health care for our members to improve health outcomes.

The Alliance UM Department serves to accomplish the following goals:

- Ensure that members receive the appropriate quantity and quality of health care service(s)
- Ensure that service(s) is delivered at the appropriate time
- Ensure that the care setting in which the service(s) is delivered is consistent with the medical needs of the member

The Alliance UM Department decisions are based only on the existence of coverage and appropriateness of care and service. The Alliance does not reward or incentivize practitioners or other individuals for issuing denials of coverage, service, or care. There are no financial incentives for the Alliance UM Department to make decisions that would result in underutilization.

SCOPE OF UM REVIEWS

The Alliance UM Department includes appropriately licensed health care professionals to make decisions on provider requests for authorization of services. Authorization decisions are based on eligibility, evidence of coverage, and medical necessity. The Alliance only allows a licensed physician to deny or modify requests for authorization of health care services for reasons of medical necessity. The Alliance uses a variety of sources to assist in making determinations for care.

The Alliance applies the following policies and/or guidelines, [in the following hierarchy of review](#):

- [Regulatory and contractual requirements](#)
 - [Regulatory requirements include WPATH guidelines for Transgender Care](#)
 - [Regulatory requirements include LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders.](#)
 - [National Coverage Determinations \(NCD\)](#)
 - [Local Coverage Determinations \(LCD\)](#)
- [Evidence based guidelines.](#)
- [Alliance specific guidelines](#)
- [National medical associate consensus](#)
- [Independent Medical Review](#)
- [Medical necessity/medical judgment](#)

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- ~~Alameda Alliance Policy and Procedures for Utilization Management review~~
- ~~Evidenced-based clinical guidelines~~
- ~~External specialist review~~
- ~~MCG[®] clinical guidelines~~
- ~~Medi-Cal Policy Guidelines and All Plan Letters~~
- ~~CMS Managed Care Manual and Title 42 Code of Federal Regulations~~
- ~~Medicare Local Coverage Determinations and National Coverage Determinations~~
- ~~Member's Evidence of Coverage (benefit coverage)~~

The Non-Profit guidelines for Group Care members including the American Society of Addiction Medicine (ASAM), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), Early Childhood Service Intensity Instrument (ESCI) and World Professional Association for Transgender Health (WPATH). Criteria are applied in conjunction with considering individual needs such as age, co-morbidities, complications, progress of treatment, psychosocial situations and home environment.

COMMUNICATION AND AVAILABILITY OF UM STAFF TO MEMBERS AND PRACTITIONERS

Peer-to-Peer Discussions

During the course of a utilization review, Alliance Medical Directors are available for peer-to-peer discussions with physicians to support evidence-based care for our members. Providers may contact Alliance Medical Directors for a peer-to-peer call using the Medical Directors' phone number listed on the Notice of Action.

Please Note: An adverse medical necessity determination cannot be overturned as a result of a peer-to-peer discussion. Providers may file an appeal on behalf of a member, after obtaining member consent, if they do not agree with an adverse medical necessity determination.

Outpatient (Ambulatory) Services (HCS)

The Alliance provides covered medical benefits for outpatient (ambulatory) services.

These services include, but are not limited to:

- Chiropractic
- Podiatry
- Rehabilitative and habilitative (therapy) services and devices:
 - Acupuncture
 - Audiology
 - Occupational therapy
 - Speech therapy

For a list of services and authorization requirements, please refer to the Alliance Referral and Prior Authorization (PA) Grid for Medical Benefits for Directly Contracted Providers at **www.alamedaalliance.org**. Sensitive services, such as abortion, family planning, sterilization, sexually transmitted diseases, and HIV testing and counseling, do not require prior authorization.

Biomarkers for Cancer (HCS)

Biomarker testing for members with advanced or metastatic stage 3 or 4 cancer does not require prior authorization. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment and expedite care.

WHAT DOES THIS MEAN FOR OUR PROVIDERS?

No prior authorization will be required for:

- Advanced or metastatic stage 3 or 4 cancer.
- Cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4 cancer.
- Biomarker testing associated with the U.S. Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
- Cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6.

Standing Referrals (HCS)

The Alliance is required to provide standing referrals to specialists or Specialty Care Centers (SCC) for enrollees who require continuing specialized medical care over a prolonged period of time as part of ongoing ambulatory care or due to a life-threatening, degenerative, or disabling condition. A standing referral allows a member to see a specialist without needing a new referral for each visit when the condition may need an extended period of treatment. Standing referrals may be granted up to a maximum of **12 months**. The PCP or specialist will decide when a member meets the guidelines for a standing referral.

Services shall be authorized as a medically necessary proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and consistent with benefit coverage.

Requests can be made by a member, PCP, specialist, or SCC. A member may request a standing referral through their PCP or specialist. A standing referral made by the PCP is for more than one (1) visit to a specialist or specialty care center as indicated in an approved treatment plan for a particular diagnosis in consultation with the specialist prior to submission of the request. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the Alliance, a contracted provider, or a provider group. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the member's PCP, subject to the terms of the treatment plan.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Potential conditions for which you may want to consider a request for a standing referral when accessing out-of-network services include, but are not limited to:

- Asthma requiring specialty management
- Cancer
- Chronic obstructive pulmonary disease
- Chronic wound care
- Cystic fibrosis
- Diabetes requiring endocrinologist management
- Gastrointestinal conditions such as severe peptic ulcer, chronic pancreatitis
- Hepatitis C
- HIV/AIDS
- Lupus
- Neurological conditions such as multiple sclerosis, uncontrolled seizures
- Rehab for major trauma, extensive surgery
- Renal failure
- Significant cardiovascular disease

Potential conditions to consider for a standing referral when accessing in-network services include, but are not limited to:

- Burn care
- Chronic wound care
- Professional services that require prior authorization
- Tertiary services

Please include the following information with your request:

- Anticipated length of treatment
- Diagnosis
- Frequency of visits
- Plan of care
- Specify that you are requesting a Standing Referral

How to submit a request for a standing referral:

- Complete the Alliance Prior Authorization (PA) Request Form
- Submit the request by fax as indicated on the form or through the Alliance Provider Portal.

The turnaround time for standing referrals is **three (3) business days** from the date of receipt.

Authorizations Requirements (HCS)

The Alliance requires contracted providers to obtain authorization before ~~rendering~~ ~~of rendering~~ ~~the certain following~~ services, including but not limited to:

- All out-of-network services
- Certain radiology, nuclear medicine, and outpatient services and procedures
- Elective inpatient admissions
- Emergency inpatient admissions
- Skilled nursing/rehabilitation admissions

A complete list of service types and procedures requiring authorizations is available at **www.alamedaalliance.org**.

Claims may not be reimbursed if a rendering provider does not receive authorization approval from the Alliance or one of our delegated partners before rendering services.

The Alliance will only accept a PA Request Form from the treating provider who determined the medical necessity for the requested services or procedure.

The treating provider is defined as the facility, PCP, behavioral health, or specialty clinician who is currently providing care to the member. This includes attending clinicians at a hospital or skilled nursing facility responsible for the member's discharge planning.

For services that do not require prior authorization but are associated with a service that requires prior authorization, there must be an approved authorization on file for the primary service requiring authorization for the associated code(s) to be paid. Associated service codes will not be paid separately if the primary service is denied.

NOTIFICATION REQUIREMENTS FOR ACUTE INPATIENT CARE

Contracted facilities must notify the Alliance within **24 hours** of an acute admission. Non-contracted facilities must notify the Alliance as soon as the member's medical condition has been stabilized per California Health and Safety Code Section 1262.8.

All facilities contracted and non-contracted must notify the Alliance within **24 hours** of a change in the level of care or discharge from the facility (including skilled nursing facilities).

Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.

Admission notifications for Acute Inpatient Admissions can be made using The Alliance Inpatient Authorization Request Form on the provider portal, ~~or~~ by fax, -or by sending the Admission Facesheet and supporting clinicals to the Alliance UM Department. -For Facesheet Admission notifications fax to the Alliance UM Department at **1.855.313.6306**. Clinical information can be faxed to **1.855.891.7409**.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Hospitals and SNFs with electronic health records are required to comply with the Interoperability and Patient Access Final Rule (CMS-9115-F) and the California Health and Human Services Data Exchange Framework (Health and Safety section 130290), as specified in the Population Health Management Policy Guide, and provide admission, discharge, and transfer (ADT) feeds. We encourage facilities to contact the Alliance Provider Services at telephone number **1.510.747.4510** for any questions about how to ~~setup~~ set up an ADT feed.

~~For Facesheet Admission notifications should be faxed to the Alliance UM Department at 1.855.313.6306. Clinical information can be faxed to 1.855.891.7409.~~

Notifications and clinical notes received outside of the above time frames may result in a denial of the authorization for service and payments.

For D-SNP members, hospitals, facilities and/or other ancillary providers are required to issue members the appropriate notices as specified here on the CMS website at <https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative>.

PROCESS FOR REQUESTING AUTHORIZATION

Unless otherwise indicated, the information provided in this section applies to both contracted and non-contracted providers providing care for an Alliance member assigned to a PCP. Providers are expected to adhere to the process below.

ELECTRONIC SUBMISSION OF PRIOR AUTHORIZATION REQUESTS

Providers can complete and submit an electronic submission of outpatient or IP elective authorization requests by using the Alliance Provider Portal.

Log in to the Alliance Provider Portal using Google Chrome and follow these steps:

- Step 1. Click 'Submit Authorizations' under the Authorization quick link.
- Step 2. Click 'Select a form' and choose from the appropriate drop-down selection:
 - ~~Inpatient Authorization (elective procedures only)~~
 - ~~Outpatient Authorization~~
 - ~~Prior Authorization~~
 - Home Health
- Step 3. Enter all required fields as directed in this section.
- Step 4. Attach medical records to avoid further delays of the review or possible denial of services.
- Step 5. Click 'Submit request' once you are ready to submit.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

FAX SUBMISSION OF PRIOR AUTHORIZATION REQUESTS

Providers can obtain an [PA Request Form/ Home Health Request Form Authorization Request Form](#) -from the Alliance through any of the following:

- Alliance Provider Services Department: **1.510.747.4510**
- Alliance UM Department: **1.510.747.4540**
- Alliance Provider Portal: Visit **www.alamedaalliance.org** and click on the 'Provider Portal' link located at the top right banner. After you sign in, you will be able to view and download the form.
- Alliance Website: **www.alamedaalliance.org/providers/provider-forms**

IMPORTANT REMINDERS WHEN SUBMITTING AUTHORIZATION REQUESTS

1. Confirm member eligibility with the Alliance:
 - Alliance Automated Eligibility Verification System: **1.510.747.4505**
 - Online: www.alamedaalliance.org
 - Select 'Provider Portal – check member eligibility.'
 - Select an Alliance participating provider.
 - Online: www.alamedaalliance.org
 - Select 'Provider Portal – check the provider directory.'
2. Complete all required items on the [PA Authorization Request Forms/ Home Health Form](#), or as indicated on the Alliance Provider Portal, for the requested service.

~~Follow separate processes for Home Health, durable medical equipment (DME) and prescription drug prior authorization (PA) requests. Please see below for additional instructions on submitting authorizations for these other services.~~

To ensure timely processing, please ~~indicate~~ choose the appropriate level of urgency on each authorization request. The time frames for review are listed on the forms, associated with the appropriate level of urgency. whether the request for MediCal/ Group Care is "Routine", "Urgent," "Routine," or "Retro," "Standing Referral" on the PA Request Form. For D-SNP there are also options available for Part D Prescription Drugs.

- When requesting an urgent review timeframe (~~within~~ within 72 hours ~~24 hours for Part D Prescription Drugs or within 72 hours for all other types of urgent requests~~), the urgency for the service being requested must be necessary due to an imminent and serious threat to the member's health, including, but not limited to, the potential loss of life, limb, or other major bodily function.
- If there is a concern raised by the UM Reviewer that aAny # PA authorization requests marked as urgent does not meet the definition of "urgent", the request will be reviewed by an Alliance Medical Director (physician) to make a final determination as to whether to determine if the supporting documentation for the request meets the definition of an urgent/expedited request, as outlined above. If it does not, the request will be modified to a routine timeframe (**five (5) business days**) from the date of receipt. Providers will be notified of this change.

You may submit the PA Request Form to the Alliance UM Department electronically, by fax, or by mail:

Mail: Alameda Alliance for Health
Health Care Services Department
1240 South Loop Road
Alameda, CA 94502

Fax: **1.855.891.7174**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.



Providers may call the UM Department by phone at 1.510.747.4540 for any questions or assistance with the authorization forms or process.

Please Note: Always retain a copy of the completed [PA-Authorization](#) Request Form in the patient's medical record.

CONCURRENT AUTHORIZATION SUBMISSION

Confirm member eligibility with the Alliance:

- Phone Number: **1.510.747.4505**
- Online: **www.alamedaalliance.org**
 - Select 'Provider Portal' and log in to check member eligibility.

Fax initial admission hospital face sheet, census report, and all relevant clinical information to **1.855.313.6306**.

Fax changes to the level of care and daily updated clinical information to **1.855.891.7409** or utilize the Provider Portal Form/ PDF version of the Inpatient Authorization Request form to indicate when a member has changed levels of care.

SKILLED NURSING AUTHORIZATION SUBMISSION

Confirm member eligibility with the Alliance:

- Phone Number: **1.510.747.4505**
- Online: **www.alamedaalliance.org**
 - Select 'Provider Portal' and log in to check member eligibility.

Use the Provider Portal/PDF version of the Post Acute Authorization Request Form.

Fax initial admission face sheet, census report, and all relevant clinical information to **1.855.313.6306**.

Fax changes to the level of care and daily updated clinical information to **1.855.891.7409** or utilize the Provider Portal Form/ PDF version of the Post Acute Authorization Request form to indicate when a member has changed levels of care.

AUTHORIZATION NOTIFICATION OF DETERMINATION DECISIONS

An authorization number, along with any quantity and date limits, will be given for all authorizations, regardless of the determination status.

Notification to members and providers/facilities are provided within **24 hours** of the review determination.

Providers are notified electronically. Members receive notifications via mail.

Medi-Cal and Group Care mMembers with questions about their notification, or who need language assistance, may call:

Alliance Member Services Department

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well, use People with hearing and speaking impairments (CRS/TTY): 711/ or call 1.800.735.2929

Alameda Alliance Wellness members with questions about their notification, or who need language assistance, may call:

Alameda Alliance Wellness Customer Services Department

Toll-Free: 1.888.882.3767 (1-.888-.88A-.DSNP)

If you cannot hear or speak well, use (CRS/TTY): 711/ or call 1.800.735.2929

To request a copy of the criteria used in the review, providers may contact:

Alliance Authorization Department

Phone Number: **1.510.747.4540**

Provider confidentiality will be maintained regarding releasing criteria related to a specific case.

AUTHORIZATION REVIEW TIMELINESS STANDARDS

The Alliance processes authorization requests in a timely manner and in accordance with regulatory requirements.

The Alliance will make a determination within the following time frames:

Request Type	Medi-Cal	Group Care	Wellness ~~DSNP~~ -SNP
Urgent	72 hours	72 hours	72 hours
Routine	5 business days	5 business days	7 calendar days
Concurrent	72 hours	72 hours	72 hours
Retrospective/Post Service	30 calendar days	30 calendar days	30 calendar days
Standing Referral	3 business days	3 business days	N/A
Major Organ Transplant	72 hours	72 hours	72 hours
Urgent Medical Drug	24 hours	72 hours	24 hours
Urgent Prescription Drug	Submit to Medi-Cal Rx	24 hours	24 hours
Routine Medical Drug	24 hours	5 business days	72 hours
Routine Prescription	Submit to Medi-Cal	24 hours	72 hours

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Drug	Rx		

REQUEST TYPE	MEDI-CAL	GROUP CARE	WELLNESS-DSNPD-SNP
Urgent	72 hours	72 hours	72 hours
Routine	5 business days	5 business days	7 calendar days
Concurrent	72 hours	72 hours	72 hours
Retrospective/Post Service	30 calendar days	30 calendar days	30 calendar days
Standing Referral	3 business days	3 business days	
Major Organ Transplant	72 hours	72 hours	72 hours
Urgent Medical Drug	24 hours	72 hours	24 hours
Urgent Prescription Drug	Submit to Medi-Cal Rx	24 hours	24 hours
Routine Medical Drug	24 hours	5 business days	72 hours
Routine Prescription Drug	Submit to Medi-Cal Rx	24 hours	72 hours

When there is insufficient information to support a determination decision, the request will be deferred for up to **14 calendar days** from the initial date the authorization request was received, while additional information is gathered from the requesting provider. The Alliance will notify the provider and the enrollee, in writing, that a decision cannot be made within the required time frame, and specify the information needed. The Alliance will specify the anticipated date on which a decision may be rendered in accordance with regulatory timeframes. If the provider has not submitted the requested medical information by the stated deadline, the request may be denied.

A request for an elective (non-urgent) surgery or treatment submitted urgently due to the imminent date of service is not considered to be urgent. Urgent is defined by DHCS as an imminent and serious threat to the member's health, including, but not limited to the potential loss of life, limb, or other major bodily function. Therefore, requests should only be made when care is needed within **24-72 hours**, or the member is at risk of serious harm should care be delayed. Inappropriate use of the "urgent" category will be monitored.

Retrospective/Post-Service Process

Retrospective/post-service review is the process in which utilization review is used to determine medical necessity or coverage under the health plan benefit **after** health care services or supplies have been provided to a member and a prior authorization was not obtained.

The Alliance does not require prior authorization for emergency or urgent services.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Reminder: To obtain prior authorization for non-emergency or non-urgent services, the Alliance offers access to submit requests through the Alliance UM Department, 24 hours a day, 7 days a week.

Providers may contact:

Alliance Utilization Management (UM) Department

Phone Number: **1.510.747.4540**

To submit a request via E-Fax line: **1.855.891.7174**

The Alliance maintains and publishes a list of services that require prior authorization. The list is accessible at **www.alamedaalliance.org/providers/authorizations**.

Retrospective requests submitted within **90 calendar days** of the date of service will be reviewed by the Alliance UM Department for medical necessity. Determinations on retrospective requests are made within 30 calendar days of receipt of the request, per regulatory guidelines.

There are two (2) exceptions under which a retrospective request beyond **90 days** from the date of service may be considered (documentation is required):

1. Member eligibility – Incorrect eligibility was given or unable to validate eligibility with the Alliance at the time of service.
2. Inpatient services – The facility is unable to confirm enrollment with the Alliance.

Please Note: Retrospective/post-service requests are not considered urgent, and will not be processed as such. Requests for services that do not meet the criteria above are subject to denial, as no authorization has been obtained.

TRACKING AND MONITORING OF SERVICES AUTHORIZED

The Alliance tracks and monitors services authorized to specialists, including open or unused approved authorizations. This process is in place to ensure that authorized services are utilized within the authorized time duration. A monitoring report will be reviewed to evaluate whether there are access constraints for certain providers and specialties, as well as to identify any members who continuously do not utilize approved authorizations for possible referral to case management to help coordinate their care.

Continuity of Care (CoC) (HCS)

Beneficiaries who are mandated to transition from Medi-Cal fee-for-service (FFS) and enroll as members in a managed care plan (MCP), transition from MCPs with contracts expiring, or have providers who terminate contracts with the MCP, have the right to request continuity of care (CoC) with an out-of-network Provider for a covered benefit if a verifiable pre-existing relationship exists with that Provider and the member saw the out-of-network Provider at least once for a nonemergency visit during the 12 months before the date of their initial enrollment in our plan.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

CoC protections extend to the following providers:

- Primary Care Providers
- Specialists
- Select Ancillary Providers:
 - Physical Therapy
 - Occupational Therapy
 - Respiratory Therapy
 - Behavioral Health Treatment (BHT)
 - Speech Therapy
- Durable medical equipment (allowable for at least 90 days until a new assessment/authorization is completed)
- Prenatal services
- Surgery pre-approved within 180 days of transition

CoC protections do not extend to the following providers:

- Radiology
- Laboratory
- Dialysis Centers
- Non-Emergency Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Other Ancillary Services
- Non-enrolled Medi-Cal Providers

Members, authorized representatives (AOR), or providers may request **up to 12 months** of CoC with a provider, unless other timelines specified below. CoC requirements include:

- The Alliance determines the Member has a pre-existing relationship with the provider (a pre-existing relationship means the member has seen the OON provider for a non-emergency visit, at least once during the 12 months prior to the date of their initial enrollment in the MCP)
- The provider is willing to continue to see the member
- The provider is willing to accept the Alliance's contract rates or Medi-Cal FFS rates
- The provider meets the Alliance's applicable professional standards and has no disqualifying quality of care issues; and
- The provider is a California State Plan approved provider (a list of suspended or ineligible Providers is available at <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/sandi>)

12-month CoC Period Restart:

- After a mandatory transition into the Alliance, if a member changes MCPs by choice following the initial enrollment with the Alliance during the 12-month CoC period, the

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12-month CoC period for a pre-existing provider **may start over one time**

Example: If a member enrolls in an MCP on January 1, 2023, but then later changes MCPs by choice on April 1, 2023, then the 12-month Continuity of Care may start over one time and the Member may see the Provider until April of the following year

- After a mandatory transition into the Alliance, if a member loses and then later regains MCP eligibility during the 12-month CoC period, then the 12-month CoC period for a pre-existing provider **may start over one time**
- If the Member changes MCPs or loses and then later regains MCP eligibility a second time (or more), the CoC period **does not start over** and the member does not have the right to a new 12 months of CoC
- If the member returns to Medi-Cal FFS (if applicable) and later re-enrolls in an MCP, the CoC period **does not start over**

Additionally, if a member has one of the conditions listed below in the Health and Safety Code (HSC) section 1373.96, CoC is provided for the completion of a course of treatment for that specific condition by a terminated or out-of-network provider, at the member's request.

Health condition	Time period
Acute conditions (a medical issue that needs fast attention)	For as long as your acute condition lasts
Serious chronic physical and behavioral conditions (a serious health care issue you have had for a long time)	For an amount of time required to finish your course of treatment and to safely move you to a new doctor in the Alliance network
Pregnancy and postpartum (after birth) care	During your pregnancy and up to 12 months after the end of pregnancy
Maternal mental health services	For up to 12 months from the diagnosis or from the end of your pregnancy, whichever is later
Care of a newborn child between birth and 36 months old	For up to 12 months from the start date of the coverage or the date the provider's contract ends with the Alliance
Terminal illness (a life-threatening medical issue)	For as long as the illness lasts. A member may still get services for more than 12 months from the date they enrolled with the Alliance or the time the provider stops working with the Alliance
Performance of a surgery or other medical procedure from an out-of-network provider as long as it is covered, medically necessary, and authorized by the Alliance as part of a documented course of treatment and recommended and documented by the provider	The surgery or other medical procedure must take place within 180 days of the provider's contract termination date or 180 days from the effective date of a member's enrollment with the Alliance

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Please Note: If the Alliance is not able to come to an agreement with the terminated provider or out-of-network provider, or if the member, authorized representative, or provider does not submit a request for the completion of covered services by said provider, the Alliance is not required to continue the provider's services.

CONTINUITY OF CARE FOR COVERED SERVICES AND PRIOR TREATMENT AUTHORIZATIONS

For members who mandatorily transition from Medi-Cal FFS to the Alliance with active prior treatment authorizations for services, those services must be honored for **90 days** from the date of enrollment without a request by the member, authorized representative or provider. Services authorized under the active treatment authorization should be arranged with an **in-network provider**, or **if there is no in-network provider to provide the service, with an OON provider**. ~~Th~~~~After 90 days 6 months, th~~ After **90 days 6 months**, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment, whichever is shorter. A new assessment is considered complete if the member has been seen in-person and/or via synchronous Telehealth by a network provider and this provider has reviewed the member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.

A. Durable Medical Equipment (DME) rentals and medical supplies:

Members who mandatorily transition from Medi-Cal FFS to the Alliance are allowed to keep their existing DME rentals and medical supplies from their **existing** providers under the previous prior authorization for a minimum of **90 days 6 months 90 days** following MCP enrollment and until the MCP can reassess, the new equipment or supplies are in possession of the member, and ready for use. Continuity of DME and medical supplies must be honored without request by the member, authorized representative or provider. After **90 days 6 months**, the Alliance may reassess the member's authorization at any time and require the member to switch to an in-network DME provider.

Please Note: If DME or medical supplies have been arranged for a transitioning member, but the equipment or supplies have not been delivered, the Alliance must allow the delivery and for the member to keep the equipment or supplies for a minimum of **90 days 6 months** following MCP enrollment and until reassessment.

B. Non-Emergency Medical Transportation and Non-Medical Transportation:

Members who mandatorily transition from Medi-Cal FFS to the Alliance must be allowed to keep the **modality** of transportation under the previous prior authorization with an in-network provider until the MCP is able to reassess the member's continued transportation needs.

Additional information on CoC for Medi-Cal members ~~is found here~~ can be found at:
<https://www.dhcs.ca.gov/services/Pages/Continuity-of-Care.aspx#coc>.

CoC for Group Care is available in the following scenarios:

- Acute condition – Completion of covered services shall be provided for the duration of the acute condition
- Pregnancy (including care after the birth) – Completion of covered services shall be provided for the duration of the pregnancy when (1) the pregnancy is high-risk, or (2) the member is in their second or third trimester
- Serious chronic condition – Completion of covered services shall be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the member and the non-participating provider, and consistent with good professional practice
 - a. Completion of covered services shall not exceed **12 months** from the time of enrollment with the Alliance
- Surgeries and/or procedures – Performance of surgeries and/or other procedures that the member's previous plan authorized as part of a documented course of treatment, and that had been recommended and documented by the non-participating provider to occur within **180 days** of the time the member enrolled with the Alliance
- Terminal illness – Completion of covered services shall be provided for the duration of the terminal illness
 - a. Completion of covered services may exceed **12 months** from the time of enrollment with the Alliance

Specific provider requirements for coverage are:

- The provider has had a pre-existing relationship within the last **12 months** for non-urgent services
- The provider is willing to continue to see the member
- The provider is willing to complete a letter of agreement for payment

Doula Services (Q1)

Doulas services are covered for prenatal, perinatal, and post-partum members as preventive services and are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants. Doulas are birth workers who provide person-centered, culturally competent health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doulas are not licensed and do not require supervision. Doulas offer various types of support, including health navigation, lactation support, the development of a birth plan, and linkages to community-based resources.

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7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Services can be provided virtually or in-person with various locations including, but not limited to:

- Homes
- Office visits
- Hospitals
- Alternative birth centers

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure. Doulas are required to enroll as Medi-Cal providers.

The California Department of Health Care Services (DHCS) issued a statewide standing recommendation for doula services. The recommendation covers all Medi-Cal members who are pregnant or have been pregnant within the past year and would benefit from doula services.

Services include:

- One (1) initial visit
- Up to eight (8) additional prenatal and postpartum visits
- Support during labor and delivery (including stillbirth, abortion, or miscarriage)
- Up to two (2) three-hour postpartum visits after the end of a pregnancy

Providers do not need to complete a recommendation form for the initial nine doula visits.

Members may receive up to nine (9) additional postpartum visits with a written recommendation from a physician or other licensed practitioner of the healing arts (LPHA) acting within their scope of practice. The recommending practitioner does not need to be enrolled in Medi-Cal or be a network provider with the Plan.

An LPHA may include any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), or licensed-eligible practitioner working under the supervision of a licensed clinician.

The recommendation for additional doula services can be found [at-on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**](https://www.alamedaalliance.org/providers/provider-forms).

The Alliance will work with network hospital/birthing centers as needed to ensure that doulas will not have any barriers to accessing these providers when accompanying members for delivery, regardless of the outcome.

Alliance members can access doula services by:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Calling the Alliance Member Services Department at **1.510.747.4567**
- Searching the Alliance Provider Directory at www.alamedaalliance.org/help/find-a-doctor/ and contacting a doula directly

Enteral Nutrition Formulas for Medi-Cal Members (RxQI)

Enteral nutrition formula for Medi-Cal members is covered by Medi-Cal Rx as a pharmacy benefit. No changes will occur to how enteral supplies such as pumps, tubing, or general enteral nutrition products are submitted. The Alliance or delegate group will still authorize these supplies.

A list of covered enteral nutrition products can be found on the Medi-Cal Rx Covered Product List <https://medi-calrx.dhcs.ca.gov/provider/forms>. Providers may call Medi-Cal Rx toll-free at **1.800.977.2273**.

Parenteral services will continue under the medical benefit and be reviewed by the Alliance or assigned delegate group.

Enteral nutrition for Group Care will remain with the Alliance or assigned delegate group and follow the general prior authorization processes and form for submission.

Continuous Glucose Monitor (CGM) Devices for Medi-Cal Members (Rx)

Continuous glucose monitors (CGM) for Medi-Cal members are covered by Medi-Cal Rx as a pharmacy benefit.

A list of covered CGM products and coverage criteria can be found on the Medi-Cal Rx Covered Product List at <https://medi-calrx.dhcs.ca.gov/provider/forms>. Providers may call Medi-Cal Rx toll-free at **1.800.977.2273**.

CGM products for Group Care members are covered by the Alliance or assigned delegate group and follow the general prior authorization processes and form for submission.

Palliative Care Services (HCS)

The Alliance authorizes palliative care services to its Medi-Cal members when these services are medically necessary. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the Alliance's contracts and does not affect a member's ability to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302. Palliative care is

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available both within and outside of hospice services.

ELIGIBILITY CRITERIA

Member must meet at least one (1) of the following:

- Member is likely to or has started to use hospital or emergency department to manage their advanced disease (excluding elective procedures)
- Member has advanced illness, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment
- Clinician feels that member's death within a year would not be unexpected based on clinical status
- Member has either received appropriate patient-desired medical therapy or is a member for whom patient-desired medical therapy is no longer effective
- Member is not in reversible acute decompensation
- Member, and if applicable, family/patient designated support person agrees to:
 - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
 - b. Participate in advance care planning discussions

DISEASE-SPECIFIC ELIGIBILITY CRITERIA

The member has one (1) of the following conditions:

- Congestive heart failure (must meet both of the following):
 - New York Heart Association class 3 or higher or at least one (1) hospitalization for heart failure ~~in six (6) months~~ with no further invasive interventions planned; and
 - Ejection Fraction <30% for systolic failure or significant comorbidities
- Chronic obstructive pulmonary disease (COPD) (must meet either of the following):
 - Forced Expiratory Volume (FEV) 1 less than 35% and 24-hour oxygen requirement of less than 3L; or
 - 24-hour oxygen requirement of greater than or equal to 3L per minute
- Advanced cancer (must meet both of the following):
 - Stage 3 or 4 solid organ cancer, lymphoma, or leukemia; and
 - A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy)
- Liver disease (must meet either of the following):
 - Evidence of irreversible liver damage, serum albumin <3 and INR >1.3 and ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
 - Evidence of irreversible liver damage and a Model of End Stage Liver Disease (MELD) score of greater than 19
- Advanced dementia and Alzheimer's dementia (must meet four (4) out of the five (5) criteria indicated below for coverage):
 - Decreased oral intake and/or significant weight loss in the last six (6) months
 - Functional impairment (ADL dependencies)
 - Malnutrition
 - Minimal communication
 - Profound memory deficits
- Other serious and advanced illnesses, as diagnosed by a doctor

Palliative care services may be authorized while the member is also receiving curative care and until the condition improves, stabilizes, or results in death.

The Alliance, as part of its palliative care network development, contracts hospitals, long-term care (LTC) facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals.

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Palliative care services include, at a minimum, the following seven (7) services when medically necessary and reasonable for the management of a qualified serious illness:

- Advance care planning: Advance care planning for beneficiaries enrolled in Medi-Cal palliative care includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally recognized decision-maker
 - a. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST12) forms
- Palliative care assessment and consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations.
 - a. Topics may include, but are not limited to:
 - i. Advance directives, including POLST forms
 - ii. Emotional and social challenges
 - iii. Legally recognized decision maker
- Pain, symptoms, and medicine side effects
 - iv. Patient goals
 - v. Spiritual concerns
 - vi. Treatment plans, including palliative care and curative care
- Plan of care: A plan of care is developed with the engagement of the member and/or their representative(s) in its design
 - a. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion
 - b. A member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care
- Palliative care team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of members and their families and can assist in identifying sources of pain and discomfort of the member
 - a. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc.
 - b. The palliative care team will also address other issues such as medication services and allied health needs
 - c. The team members must provide all authorized palliative care
 - d. DHCS recommends that the palliative care team includes, but is not limited to the following team members, a Doctor of Medicine or osteopathy (PCP if MD or DO), a registered nurse, a licensed vocational nurse or nurse practitioner (PCP if NP), and/or a social worker
- Care coordination: A member of the palliative care team provides coordination of care, ensures continuous assessment of the member's needs and implements the plan of care

- Pain and symptom management: Adequate pain and symptom management is an essential component of palliative care
 - a. Prescription drugs, physical therapy, and other medically necessary services may be needed to address beneficiary pain and other symptoms
 - b. The member's plan of care includes all services authorized for pain and symptom management
- Mental health and medical social services: Counseling and social services are available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process
 - a. Counseling services facilitated by the palliative care team may include, but are not limited to psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate
 - b. The provision of medical social services does not duplicate specialty mental health services (SMHS) provided by county Mental Health Plans (MHPs) and does not change the Alliance's responsibility for referring to and coordinating with county MHPs for Medi-Cal and DSNPD-SNP members.

Delegation of UM to Medical Groups (HCS)

Specifically, for Medi-Cal Members may be assigned to a PCP who is not directly contracted with the Alliance and who belongs to one (1) of the following medical groups which performs utilization management:

1. Children First Medical Group (CFMG) – Medi-Cal only
2. Community Health Center Network (CHCN) – D-SNP, Medi-Cal and Group Care

Our medical groups adhere to the same regulatory standards for UM as outlined above. With some exceptions, a provider serving an Alliance member as part of a medical group must verify authorization rules and obtain any required authorizations from the medical group. Providers can verify a member's group assignment by using one (1) of the Alliance's eligibility verification methods.

Behavioral Health Services are not delegated. The Alliance directly manages mental health services for Medi-Cal members with mild-moderate mental health conditions only. The Alliance directly manages all behavioral health services for Group Care members and DSNPD-SNP members.

For Medicare Advantage Dual Eligible Special Needs Plan (Alameda Alliance Wellness), utilization management will not be delegated. ~~initially.~~

DURABLE MEDICAL EQUIPMENT (DME)

The Alliance contracts with California Home Medical Equipment (CHME) for authorization management and servicing certain durable medical equipment (DME)

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services to all members.

CHME manages the following service categories:

- Breast pumps
- Continuous glucose monitoring (CGM) services for Group Care and Alliance Wellness only
- Blood pressure cuff services for Group Care only
- Diabetic Shoes
- Home respiratory equipment
- Hospital beds /decubitus care equipment
- Incontinence supplies
- Lymphedema products
- Medical supplies; wound care, ostomy, and urological supplies
- Nutritional supplements and feeding supplies
- Other home medical supply needs
- Wheelchairs, walkers, canes, and other ambulatory aids

PA requests for DME should be directed to CHME for processing. A complete list of service codes managed by CHME is available in the Alliance prior authorization gride under DME at **www.alamedaalliance.org**.

Please ensure that CHME has the following information to promptly review the request:

- Delivery address (equipment cannot be delivered to a PO Box)
- Diagnosis for equipment
- Member's height and weight
- Order/prescription from the prescribing provider
- Progress notes related to the equipment
- Settings for oxygen and PAP devices
- Test results such as oxygen saturation and/or arterial blood gas (ABGs)

For services excluded from CHME's service categories, the Alliance contracts with a select group of DME providers. Providers should submit a PA request directly to the Alliance UM Department or a member's assigned delegated group for these excluded services.

DIVISION OF UM RESPONSIBILITY WITH ALLIANCE MEDICAL GROUPS AND VENDORS

This grid is meant to direct providers to submit prior authorizations to the correct entity.

Delegated Medical Group	Line Of Business/ Plan	Phone Number	Website
Children First Medical Group (CFMG)	<u>Medi-Cal</u>	Phone Number: 1.510.428.3154 Fax: 1.510.450.5868	www.childrenfirstmedicalgroup.org
Community Health Center Network (CHCN)	<u>Medi-Cal and Group Care (D-SNP is not delegated)</u>	Phone Number: 1.510.297.0220 Fax: 1.510.297.0222	www.chcnetwork.org
California Home Medical Equipment (CHME)	<u>Medi-Cal, Group Care, and D-SNP</u>	Phone Number: 1.650.357.8550 Fax: 1.650.931.8928	www.chme.org To send orders by email: orders@chme.org

Provider-to-Provider Communication (HCS)

To ensure coordinated care when referring members for specialty services, the following communication and documentation guidelines must be followed.

PCPS

Provide the specialist with the following information:

- Condition/reason for referral
- Document the referral in the member's medical record
- Member name/Alliance member ID number
- Member's preferred language
- PCP's name
- Provide the member with the referral information
- Refer to network providers only – check the most recent online provider directory for a complete listing of current Alliance specialists
- Relevant clinical information

SPECIALISTS

Please complete the following:

- Document the referral information in the member's medical record
- Provide regular feedback to the PCP
- Verify the member's eligibility at the time of service
- Verify the referral from the member's PCP or obtain authorization from the Alliance for services requiring prior authorization

Transplant Services, including Major Organ Transplants (MOT) (HCS)

Effective Sunday, January 1, 2022, the Alliance covers the Major Organ Transplant (MOT) benefit for adult and pediatric transplant recipients and donors.

Medi-Cal [and D-SNP](#) members identified by Alliance providers as potential candidates for MOT/ Bone Marrow Transplants (BMT) procedures should be promptly referred to a Medi-Cal-approved Center of Excellence (COE) for transplant evaluation. [For D-SNP the organ transplant must be in a Medicare-approved facility.](#)

The Alliance will cover all medically necessary services for transplant recipients and both living donors and cadaver organs for the following major organs:

- Bone marrow
- Heart
- Heart-lung
- Kidney
- Liver
- Intestine
- Lung
- Kidney-pancreas
- [Pancreas](#)
- [Heart-lung](#)
- [Heart-kidney](#)
- [Liver-small bowel](#)
- [Liver-kidney](#)
- [Intestine-small bowel](#)

Medi-Cal [and D-SNP](#) members for whom a transplant procedure authorization is denied will continue to receive primary care and treatment services from the Alliance.

All beneficiaries previously disenrolled to fee-for-service (FFS) and who were approved for a transplant prior to Sunday, January 1, 2022, will remain in FFS Medi-Cal until they receive a transplant.

TRANSPLANT AUTHORIZATION PROCESS FOR PCP AND SPECIALISTS

The PCP or attending specialist must send an authorization request to the Alliance Utilization Management (UM) Department for a member seeking an evaluation as a potential candidate for a transplant.

The Alliance must directly refer adult beneficiaries or authorize referrals to a transplant program for an evaluation within **72 hours** of a beneficiary's PCP or specialist identifying the beneficiary as a potential candidate for transplant and receiving all the necessary information to make a referral or authorization.

The Alliance must refer pediatric beneficiaries to the County California Children's Services (CCS) program for CCS eligibility determination within **72 hours** of the beneficiary's PCP or specialist identifying the beneficiary as a potential candidate for transplant. The County CCS program will be responsible for referring the CCS-eligible beneficiary to the transplant Special Care Centers (SCC).

If the CCS program determines that the beneficiary is not eligible for the CCS program, but the transplant is medically necessary, the Alliance maintains complete responsibility for the medical care of that member.

TRANSPLANT CENTERS

If the transplant program confirms that the beneficiary is a suitable transplant candidate, the Alliance will be required to authorize the request for the transplant. The transplant program is responsible for placing beneficiaries on the National Waitlist maintained by the Organ Procurement and Transplantation Network (OPTN), administered by the Health Resources and Services Administration (HRSA), once it has determined that the beneficiary is a suitable transplant candidate.

COORDINATION OF CARE

The Alliance Health Care Services Department must ensure care management for all covered services and coordination of care for beneficiaries between all providers, organ donation entities, and transplant programs to ensure the transplant is completed as expeditiously as possible. The Alliance, Centers of Excellence (COE), or CCS will be responsible for providing care management and care coordination services to the transplant recipients as well as the living donors.

TRANSPLANT APPROVED

If the member is approved for transplant by CCS or the COE, then the member will not be disenrolled from the plan. The Alliance-contracted PCP and/or specialist will continue to be responsible for transferring the member's medical records directly to the COE or CCS as requested.

TRANSPLANT NOT APPROVED – ALL POTENTIAL DENIALS FOR TRANSPLANT SERVICES MUST BE SIGNED OFF/REVIEWED BY THE CHIEF MEDICAL OFFICER

If the member is not approved for the transplant, the Alliance will continue case management of the member in coordination with the PCP for ongoing care. The member's eligibility will continue with the Alliance until deemed otherwise.

Minor Consent Services (HCS)

Children ~~18 years of age~~ under age 12 or under may get certain confidential services without parental approval.

Minor consent services are services related to:

- Diagnosis and treatment of sexually transmitted diseases
- ~~Drug or alcohol use services*~~
- Family planning services
- Medical care after a sexual assault
- ~~Outpatient mental health care services*~~
- Pregnancy and pregnancy-related services

Children ages 12 years or older may access the following services without parental consent:

- ~~P~~regnancy and pregnancy-related services
- ~~F~~amily planning services
- ~~S~~exual assault services
- infectious, contagious, or communicable disease diagnosis and treatment
- ~~S~~exually transmitted disease prevention, diagnosis and treatment
- ~~D~~rug and alcohol use treatment/counseling (age 16 or older may consent to opioid disorder from a narcotic treatment program)
- ~~O~~utpatient mental health treatment and counseling
- ~~R~~esidential shelter services and other support services on a temporary or emergency basis
- intimate partner violence services

*Children must be **12 years of age** or older to receive drug and alcohol abuse services and outpatient mental health care services without parental approval.

Mental health providers must evaluate minors who are seeking mental health services without involving parents or guardians to ensure the minor is able to benefit from and ~~intellectually~~ intellectually engage in services. -A mental health provider who determines that they will provide mental health services to a minor without parental or guardian involvement must notify the Alliance by completing and submitting the Initial or Follow Up treatment plan and coordination of care form on the Alliance provider portal to notify the Alliance and ensure notifications related to the minor's mental health care are not sent to the minor's parents or guardians.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Providers can call the Alliance Member Services Department to find out how to coordinate minor consent services. Members can also receive minor consent services from a non-Alliance provider that accepts Medi-Cal. PCPs do not have to authorize these services.

Vision Care Services **(HCS)**

~~As of~~ **Starting January 1, 2026,** ~~the~~ Alliance contracts with Vision Service Plan (VSP) ~~MARCH Vision Care~~ to provide routine eye care services to Alliance Medi-Cal and Alliance Wellness members.

For Medi-Cal coverage includes and covers:

- Routine eye exam once every **24 months**
- Eyeglasses (frames and lens) once every **24 months**; contact lens when required for medical conditions such as aphakia, aniridia, and keratoconus

Prior authorization is not needed for appointments.

Medi-Cal Members may access VSP Services at:

Telephone number: **1.800.877.7195**

Medi-Cal Provider Directory: **www.vsp.com/medicaid**

For Alameda Alliance Wellness (D-SNP HMO), coverage includes one (1) pair of eyeglasses with standard frames (or one (1) set of contact lenses) after each cataract surgery that implants an intraocular lens as a Medicare-covered Medicare-covered benefit.

Alliance Wellness members also have supplemental benefit coverage that includes:

- One (1) routine eye exam every ~~12 months~~ year
- Allowance of up to \$150 for one pair of routine eyeglasses (frames) or contact lenses every two (2) years. Standard lenses (single vision, lined bifocals, or lined trifocals) are covered in full.

Alliance Wellness Members may access VSP services at:

Telephone number: **1.855.492.9028**

Alliance Wellness Provider Directory: **www.vsp.com/advantageonly**

- **Up to December 31, 2025,** \$150 every 24 months towards frames, contact lenses, and standard lenses covered in full (single vision, lined bifocals, lined trifocals)

For questions or to request a provider directory, please contact:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

~~VSP~~MARCH Vision Care

~~Toll-Free: 1.844.336.2724~~

To request online: ~~www.marchvisioncare.com~~

~~The MARCH Vision Care will continue to provide the above-listed Medi-Cal vision services to Medi-Cal members listed above.~~

For questions or to request a provider directory, please contact:

MARCH Vision Care

Toll-Free: 1.844.336.2724

To request online: www.marchvisioncare.com

~~provider will send a report to the patient's PCP after the visit which will include all diagnoses discovered during the vision exam. The vision provider will make a referral to the member's PCP whenever a medical problem is detected.~~

Group Care members have access to vision care services through their specific plans. Members should contact their vision plan for more information.²

Hospice Services (Medi-Cal) (HCS)

The Alliance will provide reimbursement for hospice care for members who are certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

A member who elects to receive hospice care must file an election statement with the hospice providing the care.

The election statement must include:

- Identification of the Hospice
- The member's or representative's acknowledgment that:
 - a. A member or representative may:
 - i. Execute a new election for any remaining entitled election period at any time after revocation
 - ii. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit
 - b. A member's voluntary election may be revoked or modified at any time
 - i. The member must file a signed statement with the hospice revoking the member's election for the remainder of the election period
- The effective date of the election

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- The signature of the member or representative
- They have a full understanding that the hospice care given as it relates to the member's terminal illness will be palliative rather than curative in nature

Hospice Services (D-SNP)

The Medicare hospice benefit provides comprehensive end-of-life care for beneficiaries with a terminal illness and a life expectancy of six months or less if the disease runs its normal course. It emphasizes palliative care, not curative treatment, and is covered under Original Medicare Part A, even for D-SNP enrollees.

Hospice services are carved out of the D-SNP benefit package and are provided and billed directly through Medicare by Medicare-certified hospice agencies, not the D-SNP plan.

The D-SNP plan will continue to cover and coordinate non hospice related care, Part D prescription drugs unrelated to the terminal condition, as well as Medi-Cal benefits such as LTSS.

Long-Term Care (LTC) (Medi-Cal Only) (HCS)

The Alliance is responsible for long-term care (LTC) services for Alliance Medi-Cal and D-SNP members. LTC may be provided in facilities, including Skilled Nursing facilities providing custodial care, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes, and Subacute Facilities.

If an Alliance member requires LTC placement, facilities need to request authorization prior to admission. If that is not possible due to an urgent need of an admission, the Alliance must be notified within 24 hours of admission. All out-of-network admissions also require a prior authorization (PA) request. To extend an authorization, a reauthorization should be submitted to the Alliance as early as 60 days, but no later than one (1) week prior to the expiration of the existing authorization for the member. For authorization turnaround timeframes, please see the following table.

Request Type	Turn Around Time
Urgent	72 hours
Routine	5 business days
Retrospective/Post Service	30 calendar days

The facility is responsible for notifying the Alliance of any change in the level of care within 24 hours of the change (such as being transferred to the hospital). The facility must request a new authorization any time the member's level of care changes. The facility must also notify the Alliance of any member admissions to the hospital (need for a bed hold), transfer to other levels of care, discharges, and expirations.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.



The facility is responsible for communicating any discharge plans or needs for members transitioning back into the community, prior to the discharge.

For more information, facilities may contact:

Alliance LTC Department
Phone Number: **1.510.747.4516**
Fax: **1.510.747.4191**
Email: **LTCHCS@alamedaalliance.org**

DOCUMENTATION

Providers must send the Alliance a complete history of the illness, including diagnostic tests, procedures, and treatments from all physicians involved in the member's care. Documentation must include a statement from the provider that verifies that the member will be an LTC resident, and all required documentation based on care level (i.e., Physicians order, HS 231, IPP, PASRR, MDS, etc.). To Access the Alliance Prior Authorization (PA) Request Form, please visit the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

LTC CLAIMS

Claims must be submitted utilizing the UB-04 claim form. Medi-Cal has issued the code sets to be used on the UB-04 claim form for each accommodation code and its related revenue and value codes. The only current acceptable accommodation codes that the Alliance accepts for billing are for NF-B & NF-A regular patient room & board (R&B), leave of absence days, and bed holds for custodial care.

For more information on accommodation codes, please visit **https://files.medi-cal.ca.gov/pubsdoco/hipaa/crosswalks/ltc_accommodation_code_to_revenue_code_value_code_and_value_code_amount_crosswalk.pdf**.

ADDITIONAL COSTS FOR LTC MEMBERS

Medi-Cal Share of Cost

Some Medi-Cal subscribers must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). A Medi-Cal subscriber's SOC is similar to a private insurance plan's out-of-pocket deductible. It is expected the provider will collect this SOC prior to billing the Alliance and show the collected amount in the Value Code section of the UB-04 claim form.

Community-Based Adult Services (CBAS) (HCS)

Community-Based Adult Services (CBAS) is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to Alliance members.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

The Alliance authorizes CBAS based on a referral from the member's PCP and an eligibility assessment completed by a CBAS provider.

CBAS MEDICAL NECESSITY CRITERIA

Except for those residing in an Intermediate Care Facility, Developmentally Disabled-Habilitative ICF/DD-H members must meet all of the following medical necessity criteria to qualify for CBAS:

- A high potential exists for the deterioration of the member's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS are not provided
- The member has one (1) or more chronic or post-acute medical, cognitive, or mental health condition(s) identified by the member's personal health care provider as requiring monitoring, treatment, or intervention, without which the member's condition(s) will likely deteriorate and require emergency department (ED) visits, hospitalizations, or other institutionalization
- The member has at least one (1) of the following:
 - a. Mild cognitive impairment
 - b. Organic, acquired, or traumatic brain injury
 - c. Chronic mental illness
- The member suffers from moderate to severe dementia
- The member has a developmental disability

- The member's condition(s) require all core CBAS performed on each day of attendance to be individualized and designed to maintain the ability of the member to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization
- Core services include:
 - a. Meal service/transportation
 - b. Personal care services/social services
 - c. Professional nursing services (which include observation, assessment, and monitoring of member's health status and medications; communication with member's health care providers regarding changes in health status; supervision of personal care services; and/or skilled nursing care and intervention)
 - d. Therapeutic activities
- The participant's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one (1) of the following:
 - a. The member has family or caregivers available, but those individuals require respite to continue providing sufficient and necessary care or supervision to the member
 - b. The member lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision
 - c. The member resides with one (1) or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the member

Community-Based Adult Services (CBAS) Emergency Remote Services (ERS) (HCS)

Community-Based Adult Services (CBAS) Emergency Remote Services (ERS) services ensure each member's needs continue to be met if the member is unable to return physically to a CBAS center for services. The goal is to support seniors and persons with disabilities (SPD) and their families and caregivers where and when services are needed. This expands access to home and community-based services to support individuals remaining in their homes and communities. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings in the community, the participant's home, or via telehealth to allow for immediate response during CBAS participant emergencies.

CBAS ERS is available only to CBAS participants.

A CBAS participant is defined as a member who:

- Is eligible for CBAS by the Alliance
- Has completed a person-centered care plan
- Has an approved authorization on file; and
- Signed a CBAS participation agreement at the CBAS Center

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There are two (2) unique circumstances that may result in the need for ERS services.

The provision of ERS supports and services is temporary and time-limited:

- **Short-term:** Members may receive ERS for an emergency occurrence for up to **three (3) consecutive months**. CBAS providers and MCPs must coordinate to ensure the duration of ERS is appropriate during the member's current authorized period and, as necessary, for reauthorization into a new period; or
- **Beyond three (3) consecutive months:** ERS for an emergency occurrence may not exceed **three (3) consecutive months**, either within or crossing over an authorized period, without assessment and review for the possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan
 - a. CBAS providers and MCPs must coordinate requests for authorization of ERS that exceed **three (3) consecutive months**

The two (2) types of circumstances for ERS are:

- Public emergencies, such as state or local disasters, regardless of whether formally declared
 - a. These may include but are not limited to earthquakes, floods, fires, power outages, and epidemic/infectious disease outbreaks such as COVID-19, tuberculosis, norovirus, etc.
- Personal emergencies, such as serious illness or injury, crises, or care transitions, as defined below
 - a. Specific personal emergencies may include:
 - i. Serious illness or injury - The illness or injury is preventing the member from receiving CBAS within the facility and providing medically necessary services and supports that are required to protect life, address or prevent significant illness or disability, and/or alleviate pain
 - ii. Crises – The member is experiencing, or threatened with, intense difficulty, trouble, or danger. Examples of personal crises include the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
 - iii. Care transitions – Transitions to or from care settings, such as returning to the home or another community setting from a nursing facility or hospital. ERS provided during care transitions should address service gaps and the member/caregiver needs and not duplicate responsibilities assigned to the intake or discharging entities

Members may choose to cease receipt of ERS at any time. The Alliance will cover ERS as part of the CBAS benefit when a member meets the criteria established as outlined above.

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SERVICES FOR MEMBERS WITH DEVELOPMENTAL DISABILITIES

Developmental Disability Referrals

The Alliance coordinates referrals to the Regional Center of the East Bay (Regional Center) for members with developmental disabilities.

Referral Guidelines

Providers or family members may refer directly to the Regional Center. The family must make the intake appointment with the Regional Center. Prior authorization is not required.

Providers must:

- Document the referral to the Regional Center in the member's medical record; and
- Provide necessary medical evaluations and obtain written consent prior to releasing any medical information directly to the Regional Center

For more information, please contact:

Regional Center of the East Bay
Creekside Plaza
500 Davis Street, Suite 100
San Leandro, CA 94577
Phone Number: **1.510.618.6100**
Fax: **1.510.678.4100**

Transgender Services (HCS)

The Alliance covers medically necessary care for transgender members, consistent with the state Medi-Cal benefit APL 20-018, [federal CMS benefits](#) and following the World Professional Association of Transgender Health (WPATH) Standard of Care for Gender Dysphoria. All services require prior authorization.

Examples of services may include:

- Gender confirmation surgery, including facial feminization surgery
- Hair removal services
- Hormone therapy for adults over 18 years of age
- Hormone therapy or pubertal suppression for children under 18 years of age
- Reconstructive surgery
- Voice/communication therapy services related to transgender care
- Voice feminization/modification surgery

State law defines “medically necessary” as follows:

- For Medi-Cal members **21 years of age** or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. (Welfare and Institutions Code section 14059.5.)
- For Medi-Cal members under **21 years of age**, a service is “medically necessary” or a “medical necessity” if the service corrects or ameliorates defects and physical and mental illnesses and conditions. (Title 42 USC 1396d(r)(5).)
- For Group Care members, “Medically necessary treatment of a mental health or substance use disorder” means a service or product addressing the specific ~~For D-SNP members, the Centers for Medicare & Medicaid Services (CMS) defines “medically necessary services as those that are; proper and needed for the diagnosis and treatment of your medical condition, provided for the diagnosis, direct care and treatment of your medical condition, and meet accepted standards of medical practice in the local area and are not mainly for the convenience of the member or the provider.~~
- -needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
 - i. In accordance with the generally accepted standards of mental health and substance use disorder care.
 - ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.
 - iii. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider (HSC 1374.72(a)(3)(A)).
 - For D-SNP members, the Centers for Medicare & Medicaid Services (CMS) defines “medically necessary services as those that are; proper and needed for the diagnosis and treatment of your medical condition, provided for the diagnosis, direct care and treatment of your medical condition, and meet accepted standards of medical practice in the local area and are not mainly for the convenience of the member or the provider.

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

1. Behavioral health services
2. Hormone therapy
3. Psychotherapy

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4. Surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender

Tertiary and Quaternary (TQ) Services (HCS)

The Alliance requires prior authorization for referrals and transitions to tertiary and quaternary (TQ) academic centers to ensure that members are accessing the right level of care at the right time for efficient and expedient access to services. All physician-based services (office visits and consultations) to a TQ center require prior authorization (initial and ongoing). To minimize the need for ongoing submission, please follow the Standing Referral process. The prior authorization process will make certain that a standardized process is utilized in reviewing the appropriateness of referrals and transitions to TQ centers. This will establish consistency of all reviews, both internally and externally (delegates, hospitals, clinics), resulting in highly specialized care prevention that will impact illness and restore health to the highest physical or psychological function. The Alliance makes utilization management decisions only on the appropriateness of care and the existence of coverage. The Alliance maintains a network of providers that is sufficient to provide adequate access to care.

TQ care referrals may be appropriate in the following situations:

- When a higher level of care in the form of a specialized diagnostic approach, treatment, and/or procedure is warranted.
- When a member is new to the Alliance (within the last **12 months**) and has been receiving acute care management from a TQ-level provider.
- When redirection may result in the delay of necessary medical treatment.
- Referrals to secondary sub-specialists when the member is being managed for a primary diagnosis to allow for multi-disciplinary collaboration for the member's overall plan of care.
- Services not available in the community or of limited availability.
- Ancillary requests (radiology, lab, etc.) may be considered to prevent potential delays in treatment decisions.

The information below should be included along with the PA request:

- Indicate the reason(s) why the member requires tertiary-level service
- Primary diagnosis driving TQ-level care
- Any information or records from community specialists
- Plan of care if applicable
- Anticipated length of treatment

All other services that currently require prior authorization will remain the same. For delegated members, the PA request will be submitted to the delegated medical group.

Second Opinions (HCS)

PCPs, specialists, and members (if the practitioner refuses) have the right to request a second opinion from a qualified health professional, at no cost to the member, from the Alliance regarding proposed medical or surgical treatments from an appropriately qualified participating health care professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition, or conditions associated with the request for a second opinion.

Second opinions from contracted providers do not require authorization and are arranged through the member's assigned PCP.

The Alliance provides a second opinion from a qualified health care professional in the network or arranges for the member to obtain one out of network, at no cost to the member.

A prior authorization from the Alliance is required to receive a second opinion from an out-of-network provider. The time frames for processing second opinions follow the standard authorization time frames.

The second opinion authorization or denial will be provided expeditiously appropriate to the member's condition, ~~not to exceed 72 hours~~ after the Alliance's receipt of the request.

Coordination of Care (HCS)

The Alliance provides comprehensive medical case management to all members. Comprehensive medical case management includes care coordination for medically necessary services provided to members within and outside of the Alliance's provider network based on the individual member's needs.

PRIMARY CARE PROVIDER (PCP) ROLE

Continuity and coordination of care are ensured through the PCP who is formally designated as having primary responsibility for coordinating the member's overall health care. The PCP has the responsibility and authority to direct and coordinate the member's services. For D-SNP the PCP is considered a member of the interdisciplinary care team (ICT).

These responsibilities include:

- Act as the primary case manager for all assigned members
- Assess the acute, chronic, and preventive needs of each member
- Employ disease management protocols to manage a member's chronic health conditions.
- For D-SNP (Alameda Alliance Wellness), the case manager will continue to serve as the lead case manager for the member, ensuring direct and frequent

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collaboration with the PCP

- For D-SNP (Alameda Alliance Wellness), the PCP or their representative is encouraged to participate in all ICT meetings to ensure members receive appropriate care and services to meet their needs

DELIVERY OF PRIMARY CARE

The establishment of an ongoing relationship between the member and their chosen PCP is crucial to the member achieving optimal health. Members are encouraged to make an appointment with their PCP immediately upon selection of their PCP. Primary care services will be available according to the health plan's established access and availability standards.

Coordination of Services (HCS)

The PCP has primary responsibility for evaluating the member's needs before recommending and arranging the services required by the member and facilitating communication and information exchange among the different providers/ practitioners treating the member.

Members are included in the planning and implementation of their care, with special emphasis on those members with mental health or substance use problems, co-existing conditions, and chronic illnesses, or those members at the end of life. Members who are unable to fully participate in their treatment decisions (i.e., minors, incapacitated adults) may be represented by parents, guardians, other family members, or conservators, as appropriate, and in accordance with the member's wishes.

The Alliance offers care coordination for the following services:

- Alcohol and substance use disorder treatment services
- Behavioral health care
- California Children's Services (CCS)
- Children with special health care needs
- Dental services
- Directly observed therapy (DOT) for the treatment of tuberculosis (TB)
- Early intervention service with the Early Start Program
- Emergency department (ED) follow-up
- Excluded services requiring member disenrollment
- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver program
- Local Education Agency services (LEA)
- Services for people with developmental disabilities (Regional Center)
- Services with out-of-network providers
- Waiver Program
- Women, Infants, and Children (WIC) Supplemental Nutrition Program

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES

PCPs are responsible for identifying members with active or potential substance use problems. Once members are identified, PCPs are responsible for providing services for the substance use problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical workup given the nature of the substance use problem. PCPs are also responsible, with the assistance of the Alliance, for referring members with substance use problems to an appropriate treatment practitioner or county department.

BEHAVIORAL HEALTH CARE

The Alliance collaborates with its behavioral health providers to identify opportunities to improve the coordination of behavioral health care with general medical care that may include but is not limited to collaboration between the organization and behavioral health providers. [Additionally, Mental Health providers are required to complete and submit Initial and follow-up treatment and coordination of care forms via the Alliance Provider Portal. -The Alliance sends these treatment summary to co-treating providers including the member's PCP to facilitate coordination of care between co-treating providers.](#)

Behavioral health care coordination is provided by the Alliance Behavioral Health Care Department. For more information, please visit the Alliance website at [**www.alamedaalliance.org**](http://www.alamedaalliance.org).

CALIFORNIA CHILDREN'S SERVICES

PCPs and specialists are responsible for the early identification of members who may have eligible CCS conditions. Medically necessary health care services will be administered throughout the referral process with the Alliance, regardless of whether the child is accepted into the CCS Program (e.g., Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for Medi-Cal members). The Alliance will consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The Alliance will assist with referrals/authorizations and care coordination to ensure that members receive the care appropriate for their medical, mental, or physical condition.

DENTAL SERVICES

[For Medi-Cal, dental services are not covered by Medi-Cal managed care. However, the Alliance will ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.](#)

[For Alameda Alliance Wellness, dental services are offered as a supplemental benefit. Please refer to the D-SNP Supplemental Benefits section for more information.](#)

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at [**www.alamedaalliance.org**](http://www.alamedaalliance.org).

DIRECT OBSERVED THERAPY (DOT) FOR TREATMENT OF TUBERCULOSIS (TB)

DOT is offered by the local health departments (LHDs) and is not covered by Medi-Cal managed care. PCPs will assess the risk of non-compliance with drug therapy for each member who requires placement on anti-tuberculosis therapy.

EARLY INTERVENTION SERVICE WITH THE EARLY START PROGRAM

PCPs are responsible for assessing children's developmental status during well-child exams or at other medical encounters as appropriate. Children from birth to 36 months identified at risk for or suspected of having a developmental disability or delay must be referred to the Regional Center of the East Bay (RCEB) for evaluation for the Early Start Program. The Alliance will collaborate with RCEB or the local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start Program.

EXCLUDED SERVICES REQUIRING MEMBER DISENROLLMENT

For services related to incarceration, the Alliance will initiate the disenrollment process.

HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS) WAIVER PROGRAM

Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered by Medi-Cal or D-SNP managed care. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer Medi-Cal and D-SNP managed care members to an HIV/AIDS waiver program if they meet the criteria.

LOCAL EDUCATION AGENCY SERVICES (LEA)

Services provided by Local Education Agencies (LEA) as called for in the LEA's Individual Education Plan (IEP) are not covered benefits under Medi-Cal managed care. In compliance with the Children and Youth Behavioral Health Initiative (CYBHI), the Alliance ~~will cover~~ behavioral health services provided by school-based providers who are approved to provide mental health services under the CYBHI program.- On an as-needed basis, the Alliance will work with the PCP to coordinate care for a member to ensure the provision of all medically necessary covered diagnostic, preventive, and treatment services identified in the Individual Education Program (IEP) developed by the LEA, with the PCP's participation. The Alliance is working in collaboration with LEAs to expand behavioral health care services in and near schools.

SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (REGIONAL CENTER)

Contracted PCPs and specialists (practitioners) are responsible for the identification and referral of members with developmental disabilities/ behavioral health disorders outside their scope of practice. The Alliance implements and maintains systems to identify members with developmental disabilities who may meet requirements for Regional Center Services.

SERVICES WITH OUT-OF-NETWORK PROVIDERS

The Alliance identifies members who may need or who are receiving services from out-of-network (non-contracted) providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management.

WAIVER PROGRAM

Members who may qualify for one (1) of the Waiver Programs will be identified by their PCP, with Alliance UM Department support, based on their diagnosis and need for a specific level of care. Authorization of services should be medically necessary and recommended by the PCP or the specialty care provider (SCP). Members have a right to request any covered services, whether or not the service has been recommended by the PCP/SCP. Members who may qualify for one of the Waiver Programs can be identified by their PCP, the Alliance Case Management Department, or Alliance Utilization Management Department based on the member's diagnosis and need for a specific level of care. Authorization of services should be medically necessary and recommended by the PCP or specialty care provider (SCP). Members have a right to request any covered services, whether or not the service has been recommended by the PCP/SCP. The authorization for services must be approved through a utilization management system (either the health plan or the delegated medical group/IPA) based on medical necessity.

WOMEN, INFANTS, AND CHILDREN (WIC) SUPPLEMENTAL NUTRITION PROGRAM

The Alliance PCP, obstetrical (OB), and pediatric practitioners will inform members of the availability of Women, Infants, and Children (WIC) services and make appropriate referrals to the local WIC program for their assigned members who are potentially eligible for WIC services. [Eligibility is based on income. Members that have active Medi-Cal eligibility may qualify for WIC.](#)

[Alliance providers may refer pregnant women to WIC by having them call toll-free at 1.800.852.5770 or by visiting \[myfamily.wic.ca.gov\]\(http://myfamily.wic.ca.gov\).](#)

Coordination of Care – California Children’s Services (CCS) (HCS)

PCPs and specialists are responsible for:

- Early identification and referral of children with potentially eligible conditions to California Children’s Services (CCS)
- Notifying the Alliance Utilization Management (UM) Department of members referred to CCS
- Administering medically necessary health care throughout the referral process, with the Alliance, regardless of whether or not the child is accepted into CCS
 - a. For example, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for Medi-Cal members

CCS is responsible for:

- Treatment for CCS-eligible conditions
- Reimbursement of CCS-paneled providers and CCS-approved hospitals
- Covering EPSDT services related to the CCS condition for Medi-Cal members

Section 7: Behavioral Health Services

Medi-Cal Mental Health Services (Behavioral Health)

Medi-Cal members can access mental health care in two (2) ways:

- Through Alameda County Behavioral Health (ACBH) for severe conditions or
- Through the Alliance for mild-to-moderate conditions

Medi-Cal members with severe mental health needs receive what are called "specialty mental health services" (SMSHS). On the other hand, the Alliance offers "non-specialty mental health services" (NSMH) to Medi-Cal members with mild to moderate mental health needs.

Medi-Cal members are screened using a Department of Health Care Services (DHCS) tool to determine which system of care they will receive services. To access the tool, please visit <https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx>.

The screening is completed by Alameda County Behavioral Health (ACBH) ACCESS or the Alliance. Providers are not required to complete the screening.

If a member who is currently in mental health treatment requires a higher level of care beyond outpatient visits, providers should complete the DHCS required transition of care form, at <https://www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf>. This form can be forwarded directly to ACBH ACCESS.

Medi-Cal: Specialty Mental Health Services (SMHS) (Behavioral Health)

Medi-Cal members are eligible to receive specialty mental health services (SMHS) from the Alameda County Behavioral Health (ACBH). SMHS services focus on treating severe conditions that require treatment beyond outpatient visits.

Providers may also contact ACCESS for urgent conditions to receive a triaged consultation. For crisis resources available in Alameda County please visit <https://www.crisissupport.org/get-help-now/alameda-county-crisis-referrals/>.

These referrals can be made 24 hours a day, 7 days a week, by calling the ACCESS helpline for Medi-Cal members:—

Phone Number: **1.510.346.1000**
Toll-Free: **1.800.491.9099**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

If a member's mental disorder is outside the scope of the provider's practice, or requires a higher level of care beyond outpatient visits, the provider may also refer the Medi-Cal member to specialty mental health care by calling ACCESS and completing the Department of Mental Health Services (DHCS) required transition of care form which can be accessed [here, at https://www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf](https://www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf).

ACBH ACCESS serves all ages. Medi-Cal members seeking mental health services for themselves or their minor children may directly access specialty mental health care by calling ACCESS. The county will provide consultations by phone to Alliance PCPs. Consultations are available Monday – Friday, 8 am – 5 pm, through the ACCESS helpline.

Medi-Cal: Non-Specialty Mental Health Services (NSMHS) (Behavioral Health)

Alliance Medi-Cal members are eligible for NSMHS with Alliance Network Providers in the following situations:

- The members screens as mild to moderate based on the DHCS mental health screening tool (score less than 6) or
- The member is receiving SMHS, but the outpatient services are not available within SMHS

The Alliance covers the following medically necessary non-specialty mental health services:–

- Dyadic therapy
- Family therapy
- Group therapy
- Individual therapy
- Psychiatric consultation and medical management
- Neuropsychological and Psychological testing
- Transcranial Magnetic Stimulation
- [Esketamine/Spravato](#)

Prior Authorization for NSMHS – Alliance Provider Network

No prior authorization is required for an initial mental health evaluation and ongoing outpatient visits with contracted mental health providers.

Prior authorization is required for the following outpatient services:

- Psychological/neuropsychological testing
- Transcranial magnetic stimulation (TMS)
- Outpatient electroconvulsive therapy (ECT)
- Ketamine/Spravato drug treatment

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

All prior authorization requests may be submitted with supporting clinical documentation demonstrating medical necessity.—

Intensive outpatient, partial hospitalization and inpatient care is not a covered benefit under the NSMH benefit through the Alliance. However, comparable services are available to members via the SMHS offered by ACBH.

If a member's mental disorder is outside the scope of the provider's practice, or requires a higher level of care beyond outpatient visits, the provider may also refer the Medi-Cal member to specialty mental health care by calling ACCESS and completing the Department of Mental Health Services (DHCS) required transition of care form which can be accessed [here](https://www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf); <https://www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf>.

Group Care Members: Mental Health And Substance Use Disorders (Behavioral Health)

For Group Care members, the Alliance offers a non-exhaustive list of behavioral health care services that evaluate and treat mental health and substance use disorders regardless of severity.

—Prior authorization is not required for routine outpatient behavioral health care services with contracted Alliance providers. Members can self-refer to most services.

Prior authorization is required for medically necessary higher levels of care beyond outpatient services such as intensive outpatient programs (IOP), residential treatment and inpatient psychiatric treatment. In addition, the following outpatient services require prior authorization:—

- Psychological/neuropsychological testing
- Transcranial magnetic stimulation (TMS)
- ~~Outpatient~~ Electroconvulsive therapy (ECT)
- [Esketamine](#)/Spravato drug treatment

All prior authorization requests must be submitted with supporting clinical documentation demonstrating medical necessity.—

DSNPD-SNP Members: Mental Health (Behavioral Health)

For DSNPD-SNP members, the Alliance covers the following medically necessary services:

- Crisis Services
- Mental health evaluation and treatment, including individual, couples, group, and family psychotherapy
- Outpatient services that include lab work, drugs, and supplies—*
- Outpatient services to monitor drug therapy.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Psychiatric consultation
- Psychological and neuropsychological testing to evaluate a mental health condition^{*,}
- Transcranial Magnetic Stimulation (TMS)^{*,}
- Spravato/Esketamine^{*}
- Electroconvulsive Therapy^{*}
- Intensive Outpatient Programs for mental health and substance use^{*}
- Partial Hospitalization Programs for mental health and substance use^{*}
- Residential Mental Health Services^{*}
- Inpatient psychiatric care^{*,}

^{*}Services require prior authorization.

No prior authorization is required for outpatient **most** visits with contracted mental health providers.

Substance Use Treatment Services **(Behavioral Health)**

For Medi-Cal members, all substance use treatment is managed by Alameda County Behavioral Health Plan (ACCESS):

-Phone Number: **1.510.346.1000**

Toll-Free: **1.800.491.9099**

ACBH ACCESS.

SUBSTANCE USE TREATMENT SERVICES

Medi-Cal Members

Alameda County Behavioral Health Plan (ACCESS) Helpline

Phone Number: **1.510.346.1000**

Toll-Free: **1.800.491.9099**

Alliance Group Care Members

Alliance Member Services Department

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

For Group Care members, the Alliance covers a non-exhaustive list of medically necessary substance use treatments.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

For ~~Group Care~~ members in need of substance use disorder treatment, prior authorization is required for the following substance use services:

- ~~Psychological/neuropsychological testing~~
- ~~Transcranial magnetic stimulation (TMS)~~
- ~~Outpatient electroconvulsive therapy (ECT)~~
- ~~Spravato drug treatment~~
- ~~Residential~~
- ~~Intensive Outpatient Program~~

~~Partial Hospitalization Program~~ These include but are not limited to:

- Crisis Services
- Outpatient substance use recovery services
- Outpatient services that include lab work, drugs, and supplies—*
- Outpatient services to monitor drug therapy
- Psychiatric consultation
- Medication Assisted Treatment (MAT)
- Intensive Outpatient Programs for substance use*
- Partial Hospitalization Programs for substance use*
- Residential*
- Inpatient and outpatient detox services*

**These services are available to members. It is the responsibility of the treatment provider to seek authorization.*

For DSNPD-SNP Members, the Alliance covers the following substance use treatments:

- Crisis Services
- Outpatient substance use recovery services
- Outpatient services that include lab work, drugs, and supplies—*
- Outpatient services to monitor drug therapy
- Psychiatric consultation
- Medication Assisted Treatment (MAT)
- Intensive Outpatient Programs for substance use*
- Partial Hospitalization Programs for substance use*
- Inpatient and outpatient detox services*

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

**These services are available to members. It is the responsibility of the treatment provider to seek authorization.*

Alameda County Behavioral Health provides coverage for residential substance use treatment.- The Alliance does not cover residential substance use treatment for **DSNPD-SNP**. Members may receive these services through Alameda County Behavioral Health by contacting ACCESS 1.800.491.0900.

Behavioral Health Evaluation and Treatment for Autism for Members Under Age 21 years (Behavioral Health)

PCP REFERRAL REQUIREMENTS FOR APPLIED BEHAVIORAL ANALYSIS (ABA) OR COMPREHENSIVE DIAGNOSTIC EVALUATION (CDE)

Members who may need an autism evaluation can be referred by completing the Alliance Behavioral Health (BH) Care – Autism Evaluation, BHT/ABA Referral Form. To access the form, please visit www.alamedaalliance.org/providers/provider-forms.

Below are sample scenarios to determine the next steps for referrals.

SCENARIO #1	SCENARIO #2	SCENARIO #3
a. You or a member's family suspects the member has autism. b. The member has never had a psychological assessment to rule out autism, there are behavioral health concerns, and you are unsure of what type of BHT member may need (ABA or other types of BHT).	a. You determine that other behavioral health or mental health services may be medically necessary (you are not recommending ABA either due to lack of supporting documentation or ABA is not clinically indicated).	a. You have conducted your own assessment/screening, are familiar with ABA treatment, and deem that the member can benefit from ABA treatment. b. A licensed psychologist has diagnosed the member with autism or another diagnosis, and you deem that a referral for ABA treatment is medically necessary.
↓	↓	↓
Refer for Diagnostic Evaluation A diagnostic evaluation for autism is administered by a licensed psychologist. This assessment is conducted to rule out	Next Steps: Referral for Mental Health Mental health services include all evidence-based services for the treatment of mental and/or substance use disorders that may	Next Steps: Referral for ABA ABA treatment is a specific type of behavioral health treatment that addresses socially significant behaviors (e.g., maladaptive behaviors, social interactions,

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

SCENARIO #1	SCENARIO #2	SCENARIO #3
autism (evaluation of child/adolescent with indications from screening of possible autism but no formal diagnosis has been given). It will either yield a diagnosis of autism or not and will provide recommendations as needed. Please complete the Behavioral Health (BH) Care – Autism Evaluation, BHD/ABA Referral Form, and check the box for Diagnostic Evaluation/ Psychological Assessment to rule out autism.	include depression, post-traumatic stress, anxiety disorders, phobias, ADHD, mood disorders, attachment disorders, and more. Treatments may include individual and group counseling, medication, and other supportive services. Please complete and submit the Behavioral Health (BH) Care Referral Request Form.	communication, and self-help skills) through the application of behavioral strategies. ABA was first implemented with individuals with autism and intellectual disability; therefore, empirical research has mostly been concentrated on efficacy with these populations. Please complete the Behavioral Health (BH) Care – Autism Evaluation, BHD/ABA Referral Form, and check the box for Applied Behavioral Analysis (ABA) Treatment and complete Section 4: Evaluation/ Referral Information within the form. If the PCP has information regarding the member or family's availability for services (times of day and days of the week), please include it in Section 5: Additional Information.

AUTHORIZATION REQUIREMENTS FOR ABA

Members must have a recommendation for ABA treatment from a licensed physician or licensed psychologist. Medi-Cal members must also meet the criteria outlined in the California Department of Health Care Services (DHCS) All Plan Letter 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21.

The Alliance Behavioral Health team will help link members to ABA providers for the initial assessment. Members can also seek out preferred in-network providers once they obtain a referral from a licensed physician/licensed psychologist. ABA providers can also submit a prior authorization (PA) request for the initial ABA assessment/Functional Behavioral Assessment (FBA) if they have the member's referral/recommendation from a licensed physician/licensed psychologist.

The initial assessments/FBA [and subsequent treatment reports](#) with all treatment plan elements and requests for authorization must be [completed on the Alliance treatment plan web form and](#) submitted through our Provider Portal. For more information, please refer to the most current Applied Behavior Analysis (ABA) Treatment Plan (TP) Report Guidelines for Providers. These can be found on the provider portal, or in the provider section of The Alliance's website.

RE-AUTHORIZATION REQUIREMENTS FOR ABA

All PA requests and treatment plans for the continuation of ABA treatment must be [completed using the Alliance treatment plan web form and](#) submitted through our Provider Portal. [Treatment plans are reviewed by the Alliance behavioral health team and may be sent to the member's PCP or Pediatrician to facilitate coordination of c](#)

The treatment plans must contain all of the following elements as required by DHCS:

- Description of patient information, the reason for referral, brief background information (e.g., demographics, living situation, or home/school/ work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services
- Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors
- Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation
- Include outcome measurement assessment criteria that will be used to measure the achievement of behavior objectives

The member's current level of need (baseline, expected behaviors the guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria (the objective goal), date of introduction, estimated date of mastery, specify a plan for generalization and report goal as met, not met, or modified (include explanation)

- Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member

- Clearly identify the service type, number of hours of direct service(s), observation and direction, guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services
- Include care coordination that involves the guardian, school, state disability programs, and other programs and institutions, as applicable
- Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision
 - a. However, the Alliance must not reduce the number of medically necessary BHT hours that a member is determined to need by the hours the member spends at school or participating in other activities.
- Deliver BHT services in a home or community-based setting, including clinics BHT intervention services provided in schools, in the home, or in other community settings, must be clinically indicated, medically necessary, and delivered in the most appropriate setting for the direct benefit of the member
 - a. BHT service hours delivered across settings, including during school, must be proportionate to the member's medical need for BHT services in each setting
- Include an exit plan/criteria
 - a. However, only a determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services

To avoid a lapse in treatment and backdating of authorizations, please submit the updated treatment plan/progress report two (2) weeks before the current ABA treatment authorization ends.

PLEASE NOTE: ABA treatment requires prior authorization before services are rendered. Providers must have an approved authorization for the dates of service as indicated in the PA request.

ABA PROCEDURE CODE AND UNITS

For each procedure code, please enter the total number of units for the authorization period (e.g., 6 months). The number of units must be in whole numbers.

To convert the total number of treatment hours for the 6 months to units, please use the following formula:

Total number (#) of hours for 6 months x 4 units = Total # of units (for the authorization period)

Example: If requesting 100 total hours of H2019, it would be submitted as:

$$100 \times 4 = 400 \text{ units.}$$

To convert the number of hours per week to the total number of units for the 6-month authorization period, please use the following formula:

Number of hours per week $\times$ 26 (weeks) $\times$ 4 (units) = Total # of units (for the authorization period)

Example: If requesting 10 hours per week of H2109, it would be submitted as:

$$10 \times 26 \times 4 = 1,040 \text{ units}$$

PROCEDURE CODES AND DESCRIPTIONS FOR ABA TREATMENT

H0031 – Behavior identification assessment. This will be utilized for the initial assessment/FBA and treatment plan development.

H0032 – Observational behavioral follow-up assessment. This will be included in the initial ABA services authorization letter and will be utilized for the progress report and re-assessment.

H2012 – Adaptive behavior treatment with protocol modification. This will be utilized for program supervision (direct and indirect).

Examples of direct and indirect supervision activities:

Direct Supervision	Indirect Supervision
Directly observe treatment implementation to determine if any changes are needed. Sometimes treatment plans need to be modified more frequently.	Analyze and summarize direct observation data to evaluate the member's progress toward goals. Typically done weekly (depending on member's needs/response to treatment).
Provide direction/guidance to staff and/or caregivers in the implementation of the treatment plan (with the member present). Typically done during treatment sessions.	Engage in care coordination with other service providers.
Observe and monitor treatment reliability to ensure implementation of treatment plan/protocols by behavior interventionist (BI)/staff. This will be important if there are staff changes or revisions to a member's treatment plan.	• Develop treatment plans and data collection systems. • Develop transition/discharge plans. • Make adjustments/revise treatment plans and protocols.

H2019 – Adaptive behavior treatment with one (1) patient. This is utilized for direct/1:1 ABA services provided to the member (member must be present).

H2014 – Adaptive behavior treatment social skills group with multiple patients. This is utilized for social skills groups with members and other peers. Typically, there are four (4) children/clients/members to one (1) adult/provider in the group setting.

S5111 – Family adaptive behavior treatment guidance. This is utilized for parent/caregiver training targeting parent/caregiver goals.

Section 8: D-SNP Supplemental Benefits

Supplemental Benefits Overview (Medicare Ops)

DENTAL SERVICES PROVIDED THROUGH LIBERTY DENTAL

The Alliance contracts with Liberty Dental Plan for authorization management and a dental network that is available to members who enroll in the Alliance Wellness Plan.

Liberty Dental Plan

Toll-free: 1.888.704.9838/03.6999

P.O. Box 26110

Santa Ana, CA 92799

To find a dental provider: <https://www.libertydentalplan.com/Find-a-Dentist/Find-a-Dentist.aspx>.

FLEX CARD PROVIDED THROUGH NATIONS

The Alliance contracts with Nations to provide a flex cards with \$50 per year that is available to members who enroll in the Alliance Wellness Plan that and can be used for to buy a variety of eligible OTC products, such as cough and cold medicine, vitamins, pain relievers, bandages, and other eligible products. <details need to be filled in>.

Alliance Wellness Members may contact Nations at toll-free at telephone number 1.877.408.7542.

HEARING AID (SUPPLEMENTAL SERVICES) PROVIDED THROUGH NATIONS

The Alliance contracts with Nations to provide additional supplemental hearing aid services that is available to members who enroll in the Alliance Wellness Plan and can be used for prescription hearing aids.

- Member contacts Nations to schedule a hearing exam.
- Member visits provider for hearing exam at no charge.
- If the member is a candidate for hearing aids, they can order hearing aids utilizing their benefit allowance.
- The provider programs and fits the member with their hearing aids.
- The member receives a 60-day evaluation period, 3 follow-up visits, and a 3-year comprehensive warranty to ensure quality of care and total satisfaction

Alliance Wellness Members may contact Nations at toll-free telephone number at 1.877.408.7542.

~~Section 8:~~Section 9: Claims

Claims Overview (Claims)

Effective January 1, 2026, Medicare Advantage (MA) Health Maintenance Organization (HMO) Dual Special Needs Plan (D-SNP) (Alameda Alliance Wellness) will be implemented.

CLAIM REQUIREMENTS

The Alliance has established requirements for filing a claim for payment consideration. These requirements include that the claim is valid and complete, furnished within a prescribed time, and delivered to the correct business address. Failure to comply with these requirements may jeopardize the claim for reimbursement.

To be accepted as a valid claim, the submission must meet the following criteria:

- Must be submitted on a standard current version of a CMS 1500, CMS-1450 (UB04), or the ANSI X12-837-5010 (current version electronic format).
- Must contain appropriate information in all required fields.
- Must be a claim for an Alameda Alliance Wellness (D-SNP) member eligible at the time of service. (Always verify eligibility; for more information, please refer to “How to verify eligibility” in Section 3: Eligibility and PCP Choice).
- Must be an original bill.
- Must contain correct national standard coding, including but not limited to CPT, HCPCS, NDC (as published by the Food and Drug Administration (FDA), Revenue, and ICD-10 codes).
- Must not be altered by handwritten additions to procedure codes and/or charges.
- Must be signed by the rendering provider, if submitted as a paper claim.
- Must be printed with dark ink that is heavy enough to be electronically imaged, if submitted as a paper claim.
- Must be received within **180 days** from the service date for contracted providers unless otherwise indicated in your agreement and **365 days** for non-participating (non-contracted) providers.
- Must submit attachments on an 8 ½ x 11-inch sheet of paper and be legible.

Submitting a Claim (Claims)

HEALTH INSURANCE CLAIM FORM (CMS 1500) – PROFESSIONAL CLAIMS

The Centers for Medicaid and Medicare Services (CMS) form 1500 or the electronic equivalent 837p must be used to bill the Alliance for medical services. This form is used by physicians and allied health professionals to submit claims for medical services.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

HEALTH INSURANCE CLAIM FORM (CMS 1450) – FACILITY CLAIMS

A CMS 1450 (UB-04) or the electronic equivalent 837i is the only acceptable claim form type for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by the Alliance. In addition, a CMS 1450/837i is required when billing for nursing home services, swing bed services with revenue and occurrence codes, inpatient hospice services, Ambulatory Surgery Centers (ASC), and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

PAPER CLAIMS SUBMISSION

Paper claims for Alliance members should be submitted for payment as follows:

Claim Type	Responsible Entity
Professional Medical Service Claims	<u>Medi-Cal and Group Care Members:</u> If the member/patient is assigned to an Alliance PCP: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460 If the member/patient is assigned to a CHCN PCP: Community Health Center Network 101 Callan Ave., 3rd Floor San Leandro, CA 94577 If the member/patient is assigned to a CFMG PCP: Children's First Medical Group PO Box 99680 Emeryville, CA 94662-9680 <u>For Alameda Alliance Wellness (D-SNP) Members effective January 1, 2026:</u> <u>If the member/patient is assigned to an Alliance, CHCN, or CFMG PCP:</u> <u>Alameda Alliance for Health</u> <u>PO Box 2460</u> <u>Alameda, CA 94501-0460</u>
Institutional (Hospital, SNF, Long-Term-Care, etc.) Services Claims	Hospital/facility claims for all Alliance members: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Claim Type	Responsible Entity
Behavioral Health Claims (Includes mental health and applied behavioral analysis)	For Medi-Cal members and if the services are moderate-to-severe, such as specialty mental health ~~and~~ severe mental illness <u>and all substance use treatment</u>: ACCESS, Alameda County Behavioral Health Care Services Toll-Free: 1.800.491.9099 For Medi-Cal members, and if the services are mild-to-moderate: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460 For Group Care members: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460 For ~~(D-SNP)~~ <u>(Alameda Alliance Wellness members(D-SNP))</u> ~~e~~Effective January 1, 2026: <u>Alameda Alliance for Health</u> <u>PO Box 2460</u> <u>Alameda, CA 94501-0460</u>
Vision Claims	Medi-Cal members: <u>uUp to December 31, 2025:</u> MARCH Vision Care Attn: Claims Department 6701 Center Drive West, Suite 790 Los Angeles, CA 90045 www.marchvisioncare.com For Medi-Cal and (D-SNP) <u>(Alameda Alliance Wellness (D-SNP))</u> and Medi-Cal members: ~~E~~ effective January 1, 2026: <u>Attn: Claims Department</u> <u>Vision Service Plan</u> <u>Attn: Claims Department</u> <u>P.O. Box 997100</u> <u>Sacramento, CA 95899-7100</u>
Dental Claims	Medi-Cal members: Medi-Cal Dental California Medi-Cal Dental Program PO Box 15609

Questions? Call the Alliance Provider Services Department, Monday – Friday,
7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Claim Type	Responsible Entity
	Sacramento, CA 95852-0609 ~~(D-SNP)~~ (Alameda Alliance Wellness (D-SNP members)) <u>eEffective January 1, 2026:</u> <u>Dental Services—</u> <u>Attn: Claims</u> <u>LIBERTY Dental Plan</u> <u>Attn: Claims</u> <u>P.O. BOX 15149</u> <u>Tampa, FL 33684-5149</u>

ELECTRONIC CLAIMS SUBMISSION

The Alliance offers providers the speed, convenience, and lower administrative costs of electronic claims filing, also known as Electronic Data Interchange (EDI). Providers interested in submitting claims electronically should call the Alliance Provider Services Department at **1.510.747.4510**.

Claims that require attachments may not be sent electronically. They must be submitted using the appropriate paper claim forms with the attachments.

TIME FRAME FOR CLAIMS SUBMISSION

All claims must be submitted on time for consideration of payment. Claims submitted after the appropriate filing deadline will be denied unless documentation substantiating the delay in billing is provided. Claims submitted prior to the actual date of service (or date of delivery for supplies and DME) will also be denied.

Timely filing rules are as follows:

- When the Alliance is the primary payer on the claim:
- Participating (contracted) providers must submit claims post-service within the timely filing time frame identified in your agreement with the Alliance
- Post-service is defined as after the date of service for professional or outpatient institutional providers, or after the date of discharge for inpatient institutional providers
- Unless otherwise indicated in your agreement, contracted providers must submit claims within **180 calendar days** post-service
- Non-participating (non-contracted) providers must submit claims within **365 calendar days** post-service
- When the Alliance is not the primary payer under Coordination of Benefits (COB):
- Providers must submit a claim to the Alliance within **180 days** from the date of

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

payment or date of denial notice from the primary payer

- Effective January 1, 2026, claims for ~~Dual-Eligible Special Needs Plans (D-SNP)~~, Alameda Alliance Wellness (D-SNP) members ~~claims~~ will be automatically processed under the ~~both the D-SNP and Medi-Cal lines~~ of business. Providers do not need to submit a separate claim for the Medi-Cal line of business.

- For Medi-Cal only members: Providers must also submit a copy of the Remittance Advice (RA)/ Explanation of Benefits (EOB) from the primary payer which indicates the date of resolution by the primary payer, whether paid, contested, or denied
- When an Alliance member does not present accurate insurance information, and another payer or the member is billed for the service:
- ~~The provider must submit a claim to the Alliance within 60 days of receiving the correct insurance information from the member or incorrect payer~~
- The provider must also submit proof that the member or another payer has been billed
- Claims or any portion thereof previously denied by the Alliance as an incomplete claim due to missing or invalid information:
- For Medi-Cal and Group Care members: A corrected claim must be submitted for reconsideration of payment within **180 days** from the date of the original denial by the Alliance. A corrected claim may be mistaken as a duplicate claim submission unless it is clearly identified as such
- Effective January 1, 2026, fFor Alameda Alliance Wellness (D-SNP) membersDual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness: A corrected claim must be submitted for reconsideration of payment within **365 days** from the date of the original denial by the Alliance for Contracted and Non-Contracted Providers. A corrected claim may be mistaken as a duplicate claim submission unless it is clearly identified as such
- Effective January 1, 2026, fFor Alameda Alliance Wellness (D-SNP) membersDual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness: For certain claim related issues, Non-Contracted Providers will be sent a formal request for additional information needed to complete a claim. This request will be issued within 60 days of receiving the claim. -Not all denials result in this request for additional information.

CLAIMS STATUS AND INQUIRY

Claim status can be verified for providers using our Online Provider Portal. Contact the Alliance Provider Services Department at **1.510.747.4510** for information regarding the use and how to obtain a Provider Portal account if you do not already have one.

Providers should call the Alliance Provider Services Department at **1.510.747.4510** for more complex claim status questions or submission requirements. Alliance Provider Services Representatives can assist with the resolution of complex claims issues and arrange for the adjustment of claims, if necessary.

PROOF OF TIMELY FILING

If a claim has been denied for timely filing, the following are acceptable forms of documentation for payment reconsideration:

- Certified mail receipt proving claims were received by the Alliance.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Copy of the Remittance Advice (RA) or **Explanation of Benefits (EOB)** from the primary payer indicating the date of resolution (payment, date of contest, denial, or notice) if the claim was denied for untimely **filing**. ~~EOB~~.
- Copy of the Alliance Electronic Data Interchange (EDI) Preprocessing Acceptance or Error Report for claims originally submitted electronically.
- Copy of the Alliance RA indicating the date and reason for the original denial for **unclean claim denials**.

~~RA/EOB FROM THE PRIMARY CARRIER~~

~~COPY OF ENROLLMENT CARD PRESENTED AT TIME OF SERVICE~~

MISDIRECTED CLAIMS

For Medi-Cal and Group Care members: When a claim is incorrectly sent to the Alliance that should have been sent to one (1) of its delegated partners (e.g., CHCN, CFMG, etc.), the Alliance will forward the claim to the appropriate delegated partner within **10 working days** of receipt of the claim.

The provider will also receive a notice of denial with instructions to bill the delegated partner.

Claims Receipt and Determinations **(Claims)**

ACKNOWLEDGEMENT OF CLAIM RECEIPT

The Alliance will acknowledge the receipt of an electronic claim within **2 working days** from receipt of the claim or within **15 working days** of receipt of the claim if it was submitted on paper.

CLEAN CLAIM

A clean claim is defined as a claim that, when it is originally submitted, contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability and make timely payment.

CLEAN CLAIM PROCESSING TIME

- ~~The Alliance will adhere to the following claims processing guidelines **until: Up to December 31, 2025**.~~
- 90% of clean claims within **30 calendar days** from receipt
- 95% of clean claims within **45 working days** from receipt
- 99% of clean claims within **90 calendar days** from receipt

The Alliance will adhere to the following claims processing guidelines **as of: Effective January 1, 2026**.

- 10095% of clean claims within 30 calendar days from receipt

INTEREST ON CLAIMS

For claims processed and paid through Up to Wednesday, December 31, 2025: The Alliance will calculate and automatically pay interest, in accordance with Assembly Bill (AB) 1455 requirements, to all providers of service who have not been reimbursed for payment, within **45 working days** after the receipt of a clean claim.

Effective Thursday, January 1, 2026: For Medi-Cal and Group Care members, ~~t~~The Alliance will calculate and automatically pay interest, in accordance with Assembly Bill (AB) 32751455 requirements, to all providers of service who have not been reimbursed for payment, within 30 calendar days after the receipt of a clean claim.

Effective Thursday, January 1, 2026: For ~~Contracted Providers submitting claims for Alameda Alliance Wellness (D-SNP) members, Dual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness: For Contracted Providers,~~ the Alliance will calculate and automatically pay interest in accordance with the terms outlined in the Provider contract.

Effective Thursday, January 1, 2026: For ~~Non-Contracted Providers submitting claims for Alameda Alliance Wellness (D-SNP) members, Dual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness Non-Contracted Providers:~~ Clean claims will incur interest if paid greater than 30 calendar days from the claim received date or the date the requested additional information is received

BILLING MEMBERS

Providers are prohibited from billing Alliance members for covered services. Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California, it is illegal to bill a member who is enrolled in a state program for which services were provided. Alliance members are never responsible for paying participating providers any amount for covered medical services, other than approved co-insurance, deductibles, or co-payment amounts as a part of the member's benefit package. d

Providers may not seek reimbursement from the member for a balance due. Providers may not bill Alliance members for covered services, open bills, or balances in any circumstance, including when the Alliance has denied payment. In some cases, providers may bill members for co-payments, non-benefits, and non-covered services.

Effective Thursday, January 1, 2026: For ~~Alameda Alliance Wellness (D-SNP) members, Dual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness:~~ In Network Providers may not seek reimbursement from the member for a balance due. Providers may not bill Alliance members for covered services, open bills, or balances in any circumstance, including when the Alliance has denied payment. In some cases, providers may bill members for co-payments, non-benefits, and non-covered services.

Effective Thursday, January 1, 2026: For ~~Alameda Alliance Wellness (D-SNP) members, Dual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness:~~ Out of Network Providers cannot bill members for the remaining balance after the plan has paid their portion of the claim, except in specific cases like non-covered services.

OVERPAYMENTS AND RECOUPMENTS

Overpayments can happen for many reasons, including, but not limited to:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Alliance claim processing error
- Another party paid for covered services (i.e., coordination of benefits)
- Duplicate payment made by the Alliance when covered services are payable, in part or full, to another provider
- Retroactive change to eligibility

For Medi-Cal and Group Care members: A written overpayment request will be sent to the provider within **365 days** of the date the original claim was paid. The provider must either dispute or refund the requested monies within **30 working days** from receipt of the notification of overpayment. If the provider does not dispute or refund the requested monies within **30 working days**, the Alliance may offset the requested amount against future claim payments, as documented in the contractual agreement or when a non-contracted provider has agreed in writing.

Effective Thursday, January 1, 2026: For Alameda Alliance Wellness (D-SNP) members, aDual-Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness: A written overpayment request will be sent to the provider within 365 days of the date the original claim was paid. The provider must either dispute or refund the requested monies within 30 working days from receipt of the notification of overpayment. If the provider does not dispute or refund the requested monies within 30 working days, the Alliance may offset the requested amount against future claim payments, as documented in the contractual agreement or when a non-contracted provider has agreed in writing.

COORDINATION OF BENEFITS (COB)

For Medi-Cal members, the Order of Benefit Determination Rule is used to determine the order of payment responsibility when an Alliance member is covered by more than one (1) health plan or insurer. The Alliance is always the payer of last resort for Medi-Cal members and all other coverage is primary. State and federal laws require providers to bill other health insurers prior to billing the Alliance.

Effective Thursday, January 1, 2026: For Alameda Alliance Wellness (D-SNP) members, Dual-Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness: the Order of Benefit Determination Rule is used to determine the order of payment responsibility when an Alliance member is covered by more than one health plan or insurer.

For D-SNP members who also have a Commercial (COMM) plan, the order of payment is as follows:

- COMM Plan – Primary payer
- D-SNP Plan – Secondary payer
- Medi-Cal – Payer of last resort, covering any remaining eligible balance

COORDINATING BENEFITS

For Medi-Cal members: All claims must be submitted to the Alliance within **180 days** from the date of payment on the primary payer's RA/EOB. A copy of the RA/EOB must accompany the claim. If the primary payer denies services asking for additional information, the information must be submitted to the primary payer and the claim finalized prior to submitting the claim to the Alliance. Since a copy of the primary payer's RA/EOB must be submitted along with the claim, these claims must be submitted on paper. Claims submitted electronically where the member has other coverage will be denied with instructions to resubmit as a paper claim with the RA/EOB attached.

When the Alliance is the primary payer, providers are reimbursed at their full contracted reimbursement rate or based on Medi-Cal rates for non-participating (non-contracted) providers.

When the Alliance is the secondary payer under COB rules, the Alliance will generally pay the lesser of the following amounts for covered services:

- The actual charge made by the provider less the amount paid by the other coverage up to the patient responsibility portion (co-insurance, deductible, or co-pay amounts).
- Up to the amount the Alliance would have paid if the individual did not have other coverage.

If the primary insurance payment exceeds the fully allowed contracted rate, neither the Alliance nor its member is financially responsible for any additional amount.

THIRD-PARTY LIABILITY

Providers may often learn of a possible Third-Party Liability (TPL) case before the Alliance. Therefore, providers must assist with recovery by promptly notifying the Alliance when a TPL case is discovered.

Notification and TPL information may be either mailed or faxed to:

[Attn: Claims Department](#)
Alameda Alliance for Health
[Claims Department](#)
PO Box 2460
Alameda, CA 94502-0460
Fax: **1.877.747.4506**

Providers must promptly notify the Alliance Claims Department of a TPL case when:

- The patient has filed or intends to file a claim or lawsuit against a third party for injuries
- A third party that caused or allegedly caused the patient's injury has insurance that will cover the expenses

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Below are some situations where a possible TPL case may exist:

- Member involved in an auto accident
- Member injured on premises owned by another (e.g., slip-and-fall)
- Member injured on the job (worker's compensation)
- Member injured by another's negligence

TPL SUBMISSION REQUIREMENTS

When a TPL case is identified, the provider's staff should obtain the following information from the member and forward it with the TPL Notification Form to the Alliance:

- Patient name, social security number, address, and telephone
- Date of injury
- Attorney's name, address, and telephone number (if any)
- Third party's insurance carrier or attorney's name, address, and telephone number (if known)

Service Specific Information (Claims)

AMBULANCE, EMERGENCY, URGENTLY NEEDED, AND POST-STABILIZATION CARE SERVICES

The Alliance is responsible for ambulance, emergency, urgent, and post-stabilization care services, whether services are obtained in or out of network.

During Business Hours: A contracted or non-contracted hospital can call the Alliance Authorization Unit when the hospital determines that a member is stable for transfer or to obtain authorization for post-stabilization care. The hospital only needs to make one (1) call to the Alliance to request prior authorization for post-stabilization care. If the Alliance does not respond to the request within one-half hour (30 minutes), the post-stabilization care shall be deemed as approved. The Alliance Authorization Unit coordinator will confirm the member's eligibility and forward the information to an Alliance Utilization Management (UM) nurse. The Alliance UM nurse will perform a telephonic review of the member's current medical conditions and coordinate any necessary post-stabilization care.

To contact the Alliance Authorization Unit, please call:

Alliance Authorization Unit
Phone Number: **1.510.747.4540**
Toll-Free: **1.855.891.9161**

After Business Hours, Weekends, and Holidays: Contracted and non-contracted hospitals can call the Alliance On-Call nurse when the hospital determines that a member is stable for transfer or to obtain authorization for post-stabilization care. The hospital only needs to make one (1) call to the Alliance to request prior authorization for post-stabilization care. If the Alliance does not respond to the request within one-half hour (30 minutes), the post-stabilization care shall be deemed as approved. The first day of post-stabilization will be authorized if the member is eligible with the Alliance on the date of service. The Alliance will follow up with the hospital on the next business day with the authorization number.

To contact the Alliance On-Call Nurse, please call:

Alliance On-Call Nurse
Phone Number: **1.510.326.5271**

To provide medically necessary post-stabilization care services within 30 minutes of the request, the services are deemed authorized. This requirement applies to requests submitted directly to the Alliance and/or its delegates.

The Alliance will make a prompt determination and reasonable payment to, or on behalf of, the member for the service(s) when the financial responsibility is that of the Alliance.

FAMILY PLANNING SERVICES AND SENSITIVE SERVICES (MEDI-CAL AND GROUP CARE ONLY)

Sensitive services are those services designated by the state Medi-Cal program as available to members without a referral or authorization to protect patient confidentiality and promote timely access. Sensitive services include family planning, screening and treatment for sexually transmitted diseases, HIV testing, and abortions. All Alliance Medi-Cal members may go outside of their medical group's network for sensitive services, which does not include prenatal care. Authorization is not required for prenatal care, but members must stay within their medical groups.

Family planning and sensitive services may be billed fee-for-service. All PCPs or OB-GYNs rendering family planning and sensitive services must be documented on the claim form. For Medi-Cal members, family planning and sensitive services may be obtained in or out of network without any prior authorization requirements. For Group Care members, family planning and sensitive services obtained in network do not require prior authorization, but services obtained out of network will require prior authorization.

STERILIZATION SERVICES (MEDI-CAL AND GROUP CARE ONLY)~~(MEDI-CAL ONLY)~~

Written informed consent must be obtained from all members seeking sterilization services. This applies to tubal sterilization, vasectomy, and hysterectomy. For Medi-Cal members only, regulations require that a copy of the signed PM-330 consent form be submitted to payers before payment can be released. Consequently, the Alliance will not reimburse professional or facility fees associated with tubal sterilizations, vasectomies, or hysterectomies, unless an appropriately completed PM-330 consent form is submitted by the primary surgeon.

HIV TESTING AND COUNSELING (MEDI-CAL AND GROUP CARE ONLY)

PCPs rendering HIV counseling and testing to assigned members may bill fee-for-service for those procedures.

Providers, other than the assigned PCP, who render HIV counseling and testing services, may bill the Alliance fee-for-service (FFS).

MINOR CONSENT SERVICES (MEDI-CAL AND GROUP CARE ONLY)~~(MEDI-CAL ONLY)~~

Minor Consent Services, described below, may be billed fee-for-service when rendered by a PCP to their assigned Medi-Cal members. Minor Consent Services include:

- Abortions
- Confirmation or rule out pregnancy
- Family planning
- HIV testing
- Sexual assault
- Sexually transmitted diseases

VACCINES (MEDI-CAL AND GROUP CARE ONLY)

Administration of routine pediatric immunizations is ~~a~~ paid on a fee-for-service basis~~FFS~~ to the PCP. The appropriate administration codes must be submitted on the CMS 1500 form or the electronic equivalent 837p.

For Medi-Cal members, PCPs have access to free vaccines through the Vaccines for Children (VFC) Program. To enroll, call the VFC Program directly. Community and county clinics should call **1.510.267.3230**. Private providers should call **1.510.704.3750**. Vaccines not covered by the VFC Program should be billed directly to the Alliance for reimbursement. If a claim is received and the provider is registered with VFC, the claim will be denied.

LABORATORY: CLINICAL, CYTOPATHOLOGY, AND PATHOLOGY

Quest Diagnostics is the Alliance's contracted partner for most outpatient clinical laboratory services. Apart from emergency, urgent, PCP-covered labs, sensitive services, or labs specifically identified as reimbursed fee-for-service, laboratory services are carved out to the Alliance's capitated laboratory provider, Quest Diagnostics. Pathology services, identified as CPT-4 procedure code range 88300- 88399, are payable by the Alliance only when performed in conjunction with emergency or urgent care services, or surgical services performed in an inpatient hospital, outpatient hospital, or freestanding surgical facility setting.

Members who are assigned to Alameda Health System (AHS) are capitated for lab services and will receive laboratory services through one (1) of the following AHS clinics:

AHS Clinic	Phone Number	Address
Eastmont Wellness	1.510.567.5700	6955 Foothill Blvd. Oakland, CA 94605
Hayward Wellness	1.510.266.1700	664 Southland Mall Dr. Hayward, CA 94545
Highland Wellness	1.510.437.5039	1411 East 31st St. Oakland, CA 94602
Newark Wellness	1.510.505.1600	6066 Civic Terrace Ave. Newark, CA 94560

The Alliance also contracts with Foundation Laboratory.

They provide on-site lab services to members who are seen by these Oakland providers:

Clinic	Phone Number	Address
MacArthur Gastroenterology	1.510.562.7467	10520 MacArthur Blvd. Oakland, CA 94605
Roots Community Health Center – Main Clinic	1.510.777.1177	9925 International Blvd. Oakland, CA 94603
Roots Community Health Center – Headquarters Clinic	1.510.533.1248	7272 MacArthur Blvd. Oakland, CA 94605

OFFICE-BASED INJECTABLES

Except for injectables administered in an inpatient setting, claims for injectables administered in the office must be billed with the appropriate HCPCS code and include the corresponding National Drug Code (NDC) for each drug. Claims that do not include NDCs, invalid NDCs, or NDCs that do not correspond to the procedure code billed will be denied.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Code Sets (Claims)

BILLING CODES

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete or invalid codes will result in a potential denial of the claim and a subsequent delay in payment.

All providers need to bill with approved Medicare code for D-SNP members or Medi-Cal codes for Medi-Cal and Group Care members. Using non-approved Medicare or Medi-Cal codes will result in a denial of services.

For Medi-Cal and Group Care claims, if you use unlisted or miscellaneous approved Medi-Cal CPT-4 or HCPCS codes, notes and/or a description of services rendered must accompany the claim. The use of unlisted or miscellaneous codes will delay claims payment and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

Providers will also improve the efficiency of their reimbursement through proper coding and reporting of a member's diagnosis. We require the use and reporting on a claim of valid ICD-10 diagnosis codes, to the appropriate specificity, for all claims. This means that ICD-10 codes must be carried out to the fifth, sixth, or seventh digit when indicated by the coding requirements in the ICD-10 manual. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

Effective January 1, 2026: For Alameda Alliance Wellness (D-SNP) members, Dual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness: It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete or invalid codes will result in a potential denial of the claim and a subsequent delay in payment.

All providers need to bill with approved Medicare codes. Using non-approved Medicare codes will result in a denial of services.

If you use unlisted or miscellaneous approved Medicare CPT-4 or HCPCS codes, notes and/or a description of services rendered must accompany the claim. The use of unlisted or miscellaneous codes should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

Providers will also improve the efficiency of their reimbursement through proper coding and reporting of a member's diagnosis. We require the use and reporting on a claim of valid ICD-10 diagnosis codes, to the appropriate specificity, for all claims. This means that ICD-10 codes must be carried out to the fifth, sixth, or seventh digit when indicated by the coding requirements in the ICD-10 manual. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

CODE AUDITING AND EDITING

The Alliance utilizes code-auditing software for automated claims coding verification, and to ensure that the Alliance is processing claims in compliance with general industry, [Medicare](#), and Medi-Cal standards.

The code-auditing software takes into consideration the conventions set forth in the health care insurance industry, such as regulatory state and federal standards, the National Correct Coding Initiative (NCCI), [Medicare guidelines](#), and Medi-Cal guidelines.

Using a comprehensive set of rules, the code auditing software:

- Accurately applies coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology, and anesthesiology, as outlined by the American Medical Association's (AMA) CPT-4 manual
- Evaluates the CPT-4 and HCPCS codes submitted by detecting, correcting, and documenting coding inaccuracies, including, but not limited to, unbundling, up-coding, fragmentation, duplicate coding, invalid codes or modifiers, and mutually exclusive procedures
- Incorporates historical claims auditing functionality that links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service
- The Alliance reviews providers' claim billing patterns and requests medical records for review when needed. Providers are responsible for submitting the requested medical records to the Alliance
- Failure to comply with the request may lead to corrective action plans or a possible hold on payments

Effective January 1, 2026, the above process also applies to for Alameda Alliance Wellness (D-SNP) claimsDual-Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness in accordance with the National Correct Coding Initiative (NCCI), and Medicare guidelines

Electronic Visit Verification (EVV) ~~(Claims)~~ (MEDI-CAL ONLY)

Effective Sunday, January 1, 2023, the Electronic Visit Verification (EVV) requirements established by the California Department of Health Care Services (DHCS) required providers who offer Personal Care Services (PCS) and Home Health Care Services (HHCS) in a member's home to capture and transmit six (6) mandatory data components to DHCS' vendor, Sandata. Sandata ~~will~~ supply the visit verifications required by DHCS to process claims for services. Claims for unverified visits that have not been logged through Sandata may be subject to claim denials.

Below are the six (6) mandatory data components:

- The type of service performed
- The individual receiving the service
- The date of service
- The location of the service
- The individual providing the service
- The time the service begins and ends

Provider types who are required to comply with EVV requirements are:

- Day habilitation program providers
- Home health providers
- Personal care and homemaker providers
- Respite providers

Registration link and/or training resources:

- Registration: www.dhcs.ca.gov/provgovpart/Documents/CalEVV-Provider-Self-Registration-QRG.pdf
- Training: <https://sandata.zendesk.com/hc/en-us/articles/8614759432211--CalEVV-New-Provider-Self-Registration-and-Onboarding-Video>
- Provider/Claim Types: www.dhcs.ca.gov/provgovpart/Documents/EVV-Provider-Types-and-Codes-November.pdf

~~Section 9:~~ Section 10: **Provider Dispute Resolutions (PDR) (Claims)**

For Medi-Cal and Group Care Members: -The Alliance offers a fair, fast, and cost-effective dispute resolution mechanism to process and resolve provider disputes. A PDR request may be submitted in writing using the PDR Request Form. Dispute requests must be submitted within **365 calendar days** of the Alliance's most recent action on the disputed claim.

A contracted or non-contracted provider dispute is a provider's written notice challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted, or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim or appeal of medical necessity/utilization management decision.

Corrected claims are not accepted through the PDR process. For more information on how to submit a corrected claim, please refer to "Submitting a Claim" in Section 8: Claims.

Note: The Provider Dispute Resolution (PDR) process should not be used to request retroactive authorization. - Instead, retrospective authorization requests, —even if a claim denial is already on file, —must be submitted to the Alliance Utilization Management (UM) Department for medical necessity review. These requests must be submitted within 90 calendar days from the date of service.

Alliance Utilization Management (UM) Department

Phone Number: **1.510.747.4540**

To submit a request via E-Fax line: **1.855.891.7174**

www.alamedaalliance.org/providers/authorizations

Each contracted provider dispute must contain, at a minimum, the following information:

- Provider name
- Provider NPI/TIN
- Member name and identification number
- Provider identification number
- Provider contact information
- Claim number
- Supporting documentation
- Reason for the dispute, including a clear explanation of the issue and the provider's position thereon

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim – A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
- If a dispute is about a claim – Must have a processed (paid or denied) claim
- If the dispute involves a member or group of members – Must include the individual claims numbers, name(s) and identification number(s) of the member(s), and a clear explanation of the disputed item, including the date of service and the provider's position thereon

Providers can access the Provider Dispute Resolution (PDR) Form on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

Provider disputes can be submitted by mail or through the Alliance Provider Portal:

Mail:

Attn: Provider Dispute Resolution (PDR) Unit

Alameda Alliance for Health

~~Attn: Provider Dispute Resolution (PDR) Unit~~

PO Box 2460

Alameda, CA 94501-0460

Provider Portal:

To submit the form through the Alliance Provider Portal:

- Visit the Alliance website at **www.alamedaalliance.org**.
- Click on the 'Provider Portal' link in the upper right-hand corner and log in.
- Select 'Claims Submission Form.'

Provider disputes that do not include all required information may be returned to the submitter for completion. An amended dispute which includes the missing information may be submitted within **30 working days** of your receipt of a returned provider dispute.

PDRs submitted by mail will be acknowledged within **15 working days** of the receipt date and PDRs submitted electronically (through the Alliance Provider Portal) will be acknowledged within **two (2) working days**; either submission type will be resolved within **45 working days** of the receipt date of the dispute.

A determination from the Alliance is the final decision and will not be reconsidered if resubmitted.

Effective January 1, 2026: For Alameda Alliance Wellness (D-SNP) claimsDual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness:

For Contracted Providers, the Alliance offers a fair, fast, and cost-effective dispute resolution mechanism to process and resolve provider disputes. A dispute request may be submitted in writing using the provider dispute Request Form. Dispute requests must be submitted within **120 calendar days** of the Alliance's most recent action on the disputed claim. Contracted Providers do not have appeal rights.

Non-contracted providers: ~~May~~ **only** dispute a claim payment when reimbursement is less than what the provider would have expected under eOriginal Medicare-to-the PDR department.

Providers can access the Provider Dispute Resolution (PDR) Form on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

Provider disputes can be submitted by mail or through the Alliance Provider Portal:

Mail:

Attn: [Provider Dispute Resolution \(PDR\) Unit](#)
Alameda Alliance for Health
~~Attn: [Provider Dispute Resolution \(PDR\) Unit](#)~~
PO Box 2460
Alameda, CA 94501-0460

Provider Portal:

To submit the form through the Alliance Provider Portal:

- Visit the Alliance website at **www.alamedaalliance.org**.
- Click on the 'Provider Portal' link in the upper right-hand corner and log in.
- Select 'Claims Submission Form.'

Non-contracted providers may submit an appeal for claim denials along with a Waiver of Liability (WOL) statement to the Alliance's Grievance and Appeals Department. Please refer to Section XX, Grievance and Appeals, for information on submitting an appeal. Appeals requests must be submitted within **120 calendar days** of the Alliance's most recent action on the claim.

Alameda Alliance Wellness Customer Services (~~D-SNP~~)
~~We are open~~Monday – Sunday (seven (7) days a week), 8 am — 8 pm
Phone Number: **1.510.747.4508**
Toll-Free: **1.888.88A.DSNP (1.888.882.3767)**

If you cannot hear or speak well (~~CRS/TTY~~): ~~711~~use TTY or call **1.800.735.2929**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Corrected claims are not accepted through the PDR process. For more information on how to submit a corrected claim, please refer to “Submitting a Claim” in Section 98: Claims.

Please Note: The Provider Dispute Resolution (PDR) process should not be used to request retroactive authorization. Instead, retrospective authorization requests, —even if a claim denial is already on file, —must be submitted to the Alliance Utilization Management (UM) Department for medical necessity review. These requests must be submitted within 90 calendar days from the date of service.

Alliance Utilization Management (UM) Department

Phone Number: 1.510.747.4540

To submit a request via E-Fax line: 1.855.891.7174

www.alamedaalliance.org/providers/authorizations.

Each provider dispute must contain, at a minimum, the following information:

- Provider name
- Provider NPI/TIN
- Member name and identification number
- Provider identification number
- Provider contact information
- Claim number
- Supporting documentation
- Reason for the dispute, including a clear explanation of the issue and the provider's position thereon
- If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim – A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
- If a dispute is about a claim – Must have a processed finalized (paid or denied) claim
- If the dispute involves a member or group of members – Must include the individual claims numbers, name(s) and identification number(s) of the member(s), and a clear explanation of the disputed item, including the date of service and the provider's position thereon

Providers can access the Provider Dispute Resolution (PDR) Form on the Alliance website at www.alamedaalliance.org/providers/provider-forms.

Provider disputes can be submitted by mail or through the Alliance Provider Portal:

Mail:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at 1.510.747.4510. Visit us online at www.alamedaalliance.org.

Attn: Provider Dispute Resolution (PDR) Unit
Alameda Alliance for Health
~~Attn: Provider Dispute Resolution (PDR) Unit~~
PO Box 2460
Alameda, CA 94501-0460

Provider Portal:

To submit the form through the Alliance Provider Portal:

- Visit the Alliance website at **www.alamedaalliance.org**.
- Click on the 'Provider Portal' link in the upper right-hand corner and log in.
- Select 'Claims Submission Form.'

The Alliance Dispute team will make attempts to work with the Contracted Provider for disputes that do not include all required information to make a final determination.- If the information is not received by the 60th calendar day, the case will be closed.

Contracted Provider Submissions shall be resolved within 60 calendar days of the receipt date of the dispute. Non-Contracted Provider Submissions shall be resolved within 30 calendar days of the receipt date of the dispute.

If an investigation shows that a claim was originally denied or paid incorrectly due to **the AllianceAAH's** error, any interest and penalty due for late payment will be included in the claim payment. Payment will be made within **five (5)** working days from the issuance of **the AllianceAAH's** determination

A determination from the Alliance is the final decision and will not be reconsidered if resubmitted.

For further instructions on how to submit a PDR request, please call:

Alliance Provider Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4510**.

~~Section 10:~~ Section 11: Telehealth (PS) (MEDI-CAL Medi-Cal and Group Care ONLY Only)

This section details telehealth requirements for providers who may provide services via audio or visual telehealth modality as required by state and federal regulations.

Telehealth Requirements for Medi-Cal and Group Care

VIDEO AND AUDIO REQUIREMENTS (PS)

Effective Monday, January 1, 2024, all providers conducting telehealth via audio-only synchronous interactions must also offer those same services via video synchronous interactions.

Providers furnishing services through video or audio-only synchronous interaction must also do one (1) of the following:

- Offer those same services via in-person, face-to-face contact
- Arrange for a referral to and facilitation of in-person care that does not require a member to independently contact a different provider to arrange for that care
- Document member consent prior to the initial delivery of covered services via telehealth
- Inform the member that telehealth is voluntary, and consent for telehealth may be withdrawn at any time without affecting their ability to access Medi-Cal-covered services in the future
- Inform the member about the availability of non-medical transportation (NMT) to in-person visits
 - Please direct Alliance members to call the Alliance Transportation Services toll-free at **1.866.791.4158**
- Inform the member of the potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable

MODEL LANGUAGE FOR TELEHEALTH PATIENT CONSENT (PS)

The California Department of Health Care Services (DHCS) has created a document with model language that providers may use as part of their Telehealth Policy Implementation Patient Consent. To view or download the document, please visit the DHCS website at www.dhcs.ca.gov/provgovpart/Documents/Patient-Consent-Model-Written-Verbal-Language.pdf. Providers are not required to use the DHCS language but may be used as a resource.

Please Note: Providers must also document when a member consents to receive covered services via telehealth before the initial delivery of the services. Member consent can be obtained verbally or in writing and then documented by the provider.

REQUIREMENTS TO PROVIDE TELEHEALTH SERVICES (PS)

Telehealth modality may only be provided and reimbursed if all the following criteria are satisfied:

- The treating provider at the distant site believes the covered services being provided are clinically appropriate to be delivered via telehealth based on evidence-based medicine and/or best clinical judgment
 - The member has provided verbal or written consent
 - The medical record documentation substantiates that the covered services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service
- Providers are not required to:
- Document a barrier to an in-person visit for covered services provided via telehealth (WIC section 14132.72(d)); or
 - Document the cost-effectiveness of telehealth reimbursement for covered services provided via a telehealth modality
- The covered services provided via telehealth meet all state and federal laws regarding confidentiality of health care information and a member's right to their medical information

REIMBURSABLE TELEHEALTH SERVICES (PS)

Certain types of covered services cannot be appropriately delivered via telehealth. These include covered services that would otherwise require the in-person presence of the member for any reason, such as those that are performed in an operating room or while the member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

The provider must assess the appropriateness of the telehealth modality to the member's level of acuity at the time of the service. The provider is not required to be present with the member at the originating site unless determined medically necessary by the provider at the distant site.

All providers, with the exception of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs), are allowed to be reimbursed for consultations provided via a telehealth modality. These electronic consultations (e-consults) are permissible using the appropriate CPT-4 code, modifier(s), and medical record documentation defined in the Medi-Cal Provider Manual.

Members cannot initiate e-consults as they are interprofessional interactions, and therefore only permissible between providers. Providers, including FQHCs, RHCs, and THPs are permitted to be reimbursed for brief virtual communications that consist of a brief communication with a member who is not physically present (face-to-face) at the fee-for-service (FFS) rate.

The virtual communications reimbursement for FQHCs, RHCs, and THPs was discontinued with the end of the COVID-19 Public Health Emergency on Thursday, May 11, 2023.

TELEHEALTH BILLING - PLACE OF SERVICE CODES AND MODIFIERS (PS)

Telehealth visits may ONLY use CPT codes for an office visit with the appropriate place of service and/or modifier option, regardless of the modality. Providers will continue to be reimbursed at the contracted rate for office visits for these services and are responsible for determining the appropriate place of service code and modifier option to use based on the visit and guidance by DHCS.

Place of Service Code	Modifier Options	Modifier Description
02 – Telehealth Provided Other than in Patient's Home.	95	For services or benefits provided via synchronous, interactive audio and visual telecommunications systems . Synchronous means a real-time interaction between a patient and a health care provider located at a distant site.
Or	GQ	For services or benefits provided via asynchronous store and forward telecommunications systems . Asynchronous store and forward means the transmission of a patient's medical information from an originating site to the health care provider at a distant site.
10 – Telehealth Provided in Patient's Home.	93	For services or benefits provided via synchronous telephone or other real-time interactive audio-only telecommunications systems . Synchronous means a real-time interaction between a patient and a health care provider located at a distant site.

TELEHEALTH RESOURCES (PS)

- DHCS website www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
- DHCS Telehealth Resource Page for Providers
www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx
- California Code, Business and Professions Code - BPC § 2290.5
- Senate Bill 184

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Telehealth Requirements for Alameda Alliance Wellness (D-SNP)

Effective January 1, 2026 For Dual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness will become effective January 1, 2026.

CMS guidance for telehealth is valid

Through September 30, 2025, you can get telehealth services at any location in the U.S., including your home.

CMS guidance for telehealth Starting October 1, 2025, you must be in an office or medical facility located in a rural area (in the U.S.) for most telehealth services.

If you aren't in a rural health care setting, you can still get certain Medicare telehealth services on or after October 1, including:

- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis
- Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit

Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder (including a substance use disorder) in your home.

~~Section 11:~~ **Section 12: Service and Referrals for Adults – Adult Clinical Preventive Services (HCS)**

This section details the services for adults receiving benefits as required by state and federal regulations. The Alliance requires PCPs to follow uniform guidelines for adult periodic health examinations in accordance with the US Preventive Services Task Force’s “A” and “B” recommendations in the *Guide to Clinical Preventive Services*.

The preventive guidelines can be found [on the U.S. Preventive Services Taskforce website at **www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations**](http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations). PCPs are required to provide preventive health services to their assigned members.

In addition, all Alliance members over the **age of 21** are required to receive an Initial Health Appointment (IHA) from their PCP, including a complete physical examination, ~~and history, and risk assessment.~~ (see www.alamedaalliance.org/providers/initial-health-assessment). ~~At that time, they should also complete a Staying Healthy Assessment (SHA).~~

For assistance ~~in obtaining a copy of the guide~~, providers may contact the Alliance Provider Services Department at **1.510.747.4510**.

OB/GYN Services

Alliance members have open access to services provided by in-network OB/GYNs and qualified family practice physicians. Gynecological services provided to a member in the provider’s office do not require prior authorization or a referral from their PCP.

Cancer Screening

All generally medically accepted cancer screening tests are covered by the Alliance.

Screening and diagnosis of breast cancer is a covered benefit. Mammograms do not require prior authorization. Treatment for breast cancer includes prosthetic devices or reconstructive surgery for a patient incident to mastectomy.

Documentation

Documentation of all clinical preventive service encounters must be included in the member’s medical record. The medical record will be reviewed for completeness during site reviews conducted by the Alliance.

Providers should report all adult preventive health encounters, whether capitated or fee-for-service, to the Alliance using the CMS 1500.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

For more information on adult preventive health services, providers can visit www.ahrq.gov/prevention/guidelines/index.html.

Immunizations (Rx)

Vaccinations provided to Alliance members over **age 18** do not require prior authorization. Providers may bill the Alliance for administering the vaccine and submitting a CMS 1500 claim form.

Alliance Wellness (DSNPD-SNP)

Vaccines for DSNP members may be covered under Part B (medical) or Part D (pharmacy) benefit. –Part D covers vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) at no cost to the member. –Vaccines administered in office will require the member to pay and submit a reimbursement request to Alliance. ACIP recommended Part D vaccines obtained at a network pharmacy have no cost share to the member. For specific vaccines covered under Part D refer to the Alliance DSNPD-SNP formulary at www.alamedaalliance.org/alliancewellness. <available at insert website>.

Family Planning Services (HCS)

Medi-Cal members are entitled to timely, convenient, and confidential access to the full range of family planning services. In accordance with federal regulations, Medi-Cal members are allowed freedom of choice in selecting a family planning provider. Therefore, Medi-Cal members may receive such services from a PCP, non-PCP, or an out-of-plan provider, without prior authorization. Members enrolled in other Alliance product lines may see Alliance-contracted providers for family planning services.

SCOPE OF SERVICES

The following family planning services (Medi-Cal members only) are covered for both in-network and out-of-plan providers:

- Abortions
- Diagnosis and treatment of STDs if medically indicated
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider, if provided in an ambulatory setting
- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Laboratory tests if medically indicated as part of the decision-making process for the choice of contraceptive methods
- Limited history and physical examination
- Pregnancy testing and counseling
- Provision of contraceptive pills/devices/supplies

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Screening, testing, and counseling of members at risk for HIV; referral for treatment
- Tubal ligation
- Vasectomies

TYPES OF PROVIDERS WHO MAY RENDER FAMILY PLANNING SERVICES

The following types of contracted providers may provide family planning services, as listed previously, within their scope of practice, to Alliance members:

- Assigned PCPs
- Family and general practitioners
- Pediatricians
- County and community clinics
- Obstetricians/Gynecologists and Certified Nurse Midwives
- Family planning clinics
- STD clinics

Nurse practitioners and physician assistants may provide family planning services through a contracted physician.

REFERRALS

If the member's family planning needs exceed the provider's scope of practice, the member should be referred to an appropriate family planning provider. This referral does not require prior authorization and can be made to a provider within or outside the Alliance provider network (Medi-Cal only).

Providers should assist members in identifying family planning providers. Refer to the Provider Directory or encourage the member to call the Alliance Member Services Department at **1.510.747.4567**. The Alliance Member Services Department can provide referrals for family planning services.

INFORMED CONSENT

Providers must obtain signed informed consent for any invasive procedure done during a family planning visit, such as the insertion of a Norplant or an intrauterine device (IUD) and for sterilization. Although signed consent is not required for all family planning methods, providers must document that members have been informed of the full range of contraceptive choices.

OUT-OF-PLAN FAMILY PLANNING SERVICES FOR MEDI-CAL

Covered Out-of-Plan

Medi-Cal members may access family planning services out-of-network but are encouraged to choose a plan provider in order to promote continuity of care. Out-of-network family planning providers must be qualified to provide family planning services based on their licensed scope of practice. Medi-Cal members seeking care from an out-of-network provider should be advised that services are limited to those listed under Scope of Services in this section.

Excluded Out-Of-Plan

Out-of-plan providers will not be reimbursed for the following family planning services:

- Hysterectomy
- Reversal of voluntary sterilization
- Routine infertility studies or procedures
- Transportation, parking, and childcare

Confidential Human Immunodeficiency Virus (HIV) Testing (HCS)

The Alliance's policy is to ensure members receive information regarding access to confidential HIV counseling and testing. Alliance Medi-Cal members have the right to confidential HIV counseling and testing within and outside of the Alliance's provider network. Members enrolled in other Alliance product lines may see any Alliance-contracted provider for HIV services.

IDENTIFICATION

The following procedures should be followed for the identification of patients who may need confidential HIV counseling and testing:

- All hemophiliacs
- Any other STD (i.e., syphilis, gonorrhea, human papillomavirus, chlamydia, pelvic inflammatory disease)
- Behavior/history Indications
- Behavior resulting in other blood-to-blood contact, sadomasochism (S&M), tattooing, piercing, etc.
- Cervical cancer
- Child of an HIV-infected woman
- Hepatitis B or C
- Herpes zoster outbreak in a person under 50 years old
- Inquire about illicit drug use to identify members who may need HIV counseling and testing
- Medical indications
- Men who have had sex with men
- Perform a thorough history and physical exam, including taking a sexual history
- Persistent, recurrent, or refractory vaginal candidiasis
- Persons who have had anal intercourse
- Received blood/blood transfusion before 1985 or in a country where blood was not tested for HIV
- Received drugs for sex
- Received money for sex
- Refer members for HIV counseling and testing under the following conditions:
 - Sex with a prostitute/sex partner

- Tuberculosis, active disease in a U.S. native, and TB patients unresponsive to treatment
- Unexplained, persistent weight loss, diarrhea, or fever
- Use of intravenous drugs or other substances

All pregnant women should be offered and encouraged to have HIV counseling and testing whether or not they seem to be at risk for HIV infection, in accordance with California law.

For a complete list of test sites, please call the County Office of Acquired Immune Deficiency Syndrome (AIDS) at **1.510.873.6500**.

REFERRAL

Providers may refer a patient requesting confidential HIV testing to a confidential test site, family planning, or a sexually transmitted disease provider within the Alliance provider network for all product lines. Referrals to in-plan sites are encouraged; however, Medi-Cal members do have the option of seeking HIV testing through non-contracted providers.

Providers should advise any member who chooses to go to an out-of-plan confidential test site to sign a release of information form to allow their name to be submitted on the claim. If the claim is submitted without a name to determine eligibility for services, the Alliance will not reimburse the provider.

ALLIANCE-CONTRACTED HIV TEST SITES

The following test sites are within the Alliance's network:

Test Site	Phone Number	Address
Alameda County Medical Center - Highland Hospital	1.510.437.4800	1411 E. 31st St. Oakland, CA 94602
Asian Health Services	1.510.986.6800	818 Webster St. Oakland, CA 94607
Axis Community Health Center	1.925.462.1755	5925 W. Las Positas Blvd. #100 Pleasanton, CA 94566
Berkeley Public Health Clinic	1.510.981.5350	830 University Ave. Berkeley, CA 94710
East Oakland Health Center	1.510.430.9401	7450 International Blvd. Oakland, CA 94621
Eastmont Wellness Center	1.510.577.5668	6955 Foothill Blvd. Oakland, CA 94605
La Clínica de la Raza - Clínica Alta Vista	1.510.535.4000	3451 E. 12th St. Oakland, CA 94601

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Test Site	Phone Number	Address
Native American Health Center	1.510.535.4460	3124 International Blvd. Oakland, CA 94601
Planned Parenthood, Hayward	1.510.733.1819	1866 B St. Hayward, CA 94541
San Antonio Health Center	1.510.238.5400	1030 International Blvd. Oakland, CA 94606
Bay Area Community Health	1.510.770.8133	39500 Liberty St. Fremont, CA 94538
West Oakland Health Center	1.510.835.9610	700 Adeline St. Oakland, CA 94607

Please remember to report all AIDS cases to the County Communicable Disease Division at **1.510.267.3240**.

Abortion Services (HCS)

The following guidelines apply to Alliance abortion services:

- In-network and out of network abortion services are available to all members without a referral or prior authorization
- ~~Alliance Medi-Cal members have the right to abortion services within and outside of the Alliance provider network without a referral or prior authorization~~
- The Alliance will not reimburse for abortions provided by out-of-plan providers for Group Care members without prior authorization
- Every effort shall be made to assist members seeking abortion services
 - This includes providing timely and appropriate counseling, education, information, and referral
- Providers shall assist members in identifying abortion service providers
 - Providers should refer to the Provider Directory or encourage the member to call the Alliance Member Services Department at **1.510.747.4567**

Sterilization Services (HCS)

Written informed consent must be obtained from all members seeking sterilization procedures in accordance with state law. This applies to all members regardless of the product line in which they are enrolled and includes services for tubal ligations, sterilization, vasectomies, and hysterectomies.

A copy of the signed sterilization consent form must be maintained in the member's medical records. For Medi-Cal members, a copy of the consent must also be submitted to the Alliance in order to be reimbursed (see below). Consent submission to the Alliance only applies to Medi-Cal members. Providers do not need to submit a copy of the consent to the Alliance for members in other product lines.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Prior authorization is not required for tubal ligations or vasectomies. Prior authorization is required for hysterectomies.

REQUIREMENTS REGARDING CONSENT

The legal requirements listed below apply to the provision of sterilization services. Sterilization is covered only if all applicable requirements are met at the time the procedure is performed. If the member obtains retroactive coverage, previously provided sterilization services for tubal ligations and vasectomies are not covered unless all applicable requirements and California State Law, including the timely signing of an approved sterilization consent form, have been met.

MEDI-CAL MANAGED CARE REQUIREMENTS

Alliance members enrolled in Medi-Cal Managed Care must meet the requirements of the law specific to Medi-Cal-funded members. This means that a member cannot waive the **30-day** waiting period between the date of written consent and the actual performance of the procedure unless an emergency is documented in accordance with Title 22 CCR 51305.1.

When submitting claims for Medi-Cal members, a copy of an appropriately completed PM-330 must be submitted with a claim for vasectomies and tubal ligations. Failure to submit the PM-330 will result in the denial of payment to all providers involved in the delivery of the service until a properly completed PM-330 is submitted. If the PM-330 has not been properly completed in accordance with Medi-Cal guidelines, payment may be denied.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (Behavioral Health)

Providers must provide alcohol and drug screening, assessment, brief interventions and referral to treatment (SABIRT) to members **11 years of age** and older, including pregnant women. Unhealthy alcohol and drug use screening must be conducted using validated screening tools. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use, alcohol use disorder (AUD), or substance use disorder (SUD) is present. Assessment can be done without first using screening tools.

Brief misuse counseling should be offered for unhealthy alcohol use. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered for patients with probable AUD or SUD.

Brief interventions must include the following:

- Discussing negative consequences and the overall severity of the problem
- Supporting the patient in making behavioral changes
- Discussing and agreeing on plans for follow-up with the patient, including referral

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

to other treatment if indicated

Member medical records must include the following:

- The service provided
- The name of the screening instrument and score
- The name of the assessment instrument and score
- If and where a referral to an AUD or SUD program was made

VALIDATED SCREENING AND ASSESSMENT TOOLS

Below are resources for validated screening and assessment tools.

Screening tools:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID): **www.pedagogyeducation.com/Main-Campus/Resource-Library/Correctional-Nursing/CAGE-AID-Substance-Abuse-Screening-Tool.aspx**
- Tobacco Alcohol, Prescription medication and other Substances (TAPS): **www.drugabuse.gov/taps**
- National Institute on Drug Abuse (NIDA) Quick Screen for adults – The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening: **archives.drugabuse.gov/nmassist**
- Drug Abuse Screening Test (DAST-10) (fee required): To use this tool, please email Dr. Harvey Skinner at **hskinner@yorku.ca**
- Alcohol Use Disorders Identification Test (AUDIT-C): **www.hepatitis.va.gov/alcohol/treatment/audit-c.asp**
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents: **www.ntiupstream.com/4psabout**
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFT) for non-pregnant adolescents: **www.crafft.org**
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population: **hign.org/sites/default/files/2020-06/Try_This_General_Assessment_17.pdf**

Assessment tools:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST): **<https://archives.drugabuse.gov/nmassist/>**
- Drug Abuse Screening Test (DAST-20) (fee required): To use this tool, please contact Dr. Harvey Skinner at **hskinner@yorku.ca**
- Alcohol Use Disorders Identification Test (AUDIT): **auditscreen.org**

BILLING FOR SERVICES

SABIRT Billing Codes and Frequency Limits Table

Billing Code	Description	When To Use	Frequency Limit
G0442	Annual alcohol misuse screening, 15 minutes	Alcohol use screening	One (1) per year, per provider
H0049	Alcohol and/or drug screening	Drug use screening	One (1) per year, per provider
H0050+	Alcohol and/or drug services, brief intervention, per 15 minutes	Alcohol misuse counseling or counseling regarding the need for further evaluation/treatment	One (1) per year, per provider

REFERRALS FOR TREATMENT

For Alliance Medi-Cal members:

Alameda County Behavioral Health Substance Use Treatment and Referral Helpline
Toll-Free: **1.844.682.7215**
www.acbhcs.org/substance-use-treatment

For Alliance Group Care: ~~and members:~~

Alameda Alliance Member Services
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**

For Alliance ~~DSNPD-SNP~~ members:

Alameda Alliance Wellness Member Services
Phone Number Toll-Free: **1.888.882.3767**

Tobacco Cessation (Health Ed)

Alliance providers are responsible for tobacco use tracking, counseling, and referrals. Providers should ask all patients about tobacco use at every visit and have a tobacco user identification system to track use.

Below are various ways to track:

- Record in your electronic health record (EHR)
- Use ICD-9 codes for pregnancy-related tobacco use
- Use ICD-10 codes for nicotine dependence
- Use CPT codes for tobacco cessation counseling

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

TOBACCO CESSATION COUNSELING

The Alliance covers the following types of tobacco cessation counseling and referrals:

- **Individual Counseling:** Providers can bill for tobacco cessation counseling.
- **Group Counseling:** Refer patients to Alliance Health Programs at **1.510.747.4577** for group classes
- **Telephone Counseling:** Refer patients to Kick It California. Patients can call toll-free at **1.800.300.8086** or visit **kickitca.org**. Kick It can help people quit smoking, vaping, and smokeless tobacco

For additional training and resources on tobacco cessation counseling, please visit **www.alamedaalliance.org/providers/provider-resources/tobacco-provider-guide**.

~~Section 12:~~ **Section 13: Services and Referrals for Newborns, Children, and Adolescents** **(QI)**

This section describes the health care services that children in the Alliance are entitled to receive. Like adults, children are entitled to some services outside of the scope of a provider's practice. In such cases, providers should make assessments and, as appropriate, referrals for the conditions covered in this section.

Newborn Services **(QI)**

ELIGIBILITY

Babies born to mothers who are Alliance members are covered by the Alliance during the "newborn period."

The newborn period is not the same for all lines of business, and is calculated as follows:

- Medi-Cal Newborns – Covered for the calendar month of birth and the month after
- If the mother does not apply for the baby to receive their own insurance benefits, the baby will not be eligible for services, including Alliance services, after the newborn period
 - When this occurs, providers will not receive reimbursement or capitation for the baby from the Alliance
- The Alliance sends reminders regarding newborn eligibility to the mother and can assist by providing enrollment information
 - However, providers are encouraged to also remind the parent/guardian to obtain separate benefits for the newborn and to choose a health plan and a PCP for continuity of care
- Group Care Newborns – Covered from the date of birth through the first **30 days** of life only
- Dependents are not eligible to enroll in the Alliance Group Care Program

BILLING

Pediatric care will be paid on a fee-for-service basis for attending the delivery, routine newborn care, and sick newborn care during the newborn period. It is important to verify the mother's eligibility before providing service to the newborn.

PHENYLKETONURIA (PKU) TESTING & TREATMENT

Testing and treatment of phenylketonuria (PKU), including formulas and special food products, are a covered benefit based upon the following guidelines:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Alliance; and
- Provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU

Clinical Preventive Services for Children – Periodic Health Assessments (QH)

This section outlines the PCP's responsibilities for preventive care services for children.

Periodic health assessments must be provided by PCPs for all members under **21 years of age**, according to the periodicity schedule and content of the most current Bright Futures/American Academy of Pediatrics (AAP) recommendations for preventive pediatric health care.

If the provider sees a child for urgent care and that child is not yet assigned to a PCP, the provider will be reimbursed at the base Medi-Cal fee-for-service rate for care, including preventive care provided at that visit.

BLOOD LEAD SCREENING

The PCP must provide oral or written anticipatory guidance to a parent or guardian of the child that, at minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from **six (6) months** until **72 months** of age. This guidance must be performed at each periodic health assessment, starting at **six (6) months** of age and continuing until **72 months** of age.

Blood lead screening is required for all children at **12 months** and **24 months** of age. If the provider performs a periodic health assessment and becomes aware that a child between **12 months** and **72 months** has no documented blood lead testing at either the **12-month** or **24-month** interval, the provider performs blood lead testing, or blood lead testing is completed anytime it is requested by the parent or guardian. The blood lead level test is not required if the parent or guardian refuses to consent or the PCP determines it poses a risk to the child's health that is greater than the risk of lead poisoning. Any reason for not screening must be documented in the child's medical record. In cases where consent has been withheld, the medical record must include a signed statement of voluntary refusal or documentation of the reason for not obtaining one. Blood lead screening encounters should be identified using the appropriate CPT codes.

PCPs must follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidance when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up. CLPPB guidelines can be found at www.cdph.ca.gov/Programs/ccdphp/deodc/clppb/pages/prov.aspx.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

WRITTEN RESULTS

For Medi-Cal members, PCPs must provide written results to the member (or the member's parent or guardian, as appropriate) of the initial or periodic health assessments.

FOLLOW-UP ON MISSED OR CANCELED APPOINTMENTS

PCPs/Providers must follow up on missed or canceled appointments for preventive care. At least three (3) attempts to contact the member should be made and documented in the medical record.

DOCUMENTATION OF PREVENTIVE SERVICES

The DHCS Facility Site Review (FSR) requirements include outreach from the provider when members have missed appointments.

The process established on-site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult Initial Health Appointments (IHA), specialty care and appointments, and follow-up of missed or canceled appointments. Systems, practices, and procedures used for making services readily available to patients will vary from site to site.

Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record.

For all Alliance members, preventive services including visits and immunizations must be billed to the Alliance, using the CMS 1500 billing form.

Cognitive Health Assessments (QH)

Cognitive health assessments are covered directly by the Alliance for members who are **65 years of age** and older and who do not have Medicare coverage. Providers must obtain Dementia Care Aware training approved by the Department of Health Care Services (DHCS) on conducting the assessment before administering and billing for the assessment. Cognitive health assessment training is available at www.dementiacareaware.org.

BILLING

To appropriately bill and receive reimbursement for conducting an annual cognitive health assessment, providers must do all of the following:

- Complete the DHCS Dementia Care Aware cognitive health assessment training.
- Be a contracted and credentialed provider with the Alliance.
- Bill in accordance with Medi-Cal billing requirements Current Procedural

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Terminology (CPT) code 1494F and quantity limits.

- Administer the annual cognitive health assessment as a component of an E&M visit including, but not limited to an office visit, consultation, or preventive medicine service.
- Document all the following in the member's medical records and have such records available upon request:
- The screening tool or tools that were used (at least one (1) cognitive assessment tool listed below is required)
- Verification that screening results were reviewed by the provider
- The results of the screening
- The interpretation of results; and
- Details discussed with the member and/or authorized representative and any appropriate actions taken regarding screening results

At least one (1) cognitive assessment tool listed below is required. Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

- Cognitive Assessment Tools or patient assessment tools
- General Practitioner assessment of Cognition (GPCOG)
- Mini-Cog
- Informant tools (family members and close friends)
- Eight-item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly

Immunizations (QI)

STANDARDS

The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC) and other medical associations, regardless of member's age, sex, or medical condition, including pregnancy. Immunization information is available from the CDC at www.cdc.gov/vaccines. ACIP-recommended immunizations are viewed as preventive services, these services are not subject to Prior Authorization.

PROMOTION

Pediatric immunizations must comply with the most recent standards of the Pediatric Immunization Practices (U.S. Public Health Service and AAP) and the Recommended Childhood Immunization Schedule (ACIP and AAP). These schedules are accessible via the Alliance website at www.alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines. Additional information is available on the CDC website at www.cdc.gov/vaccines/index.html.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

Adult vaccines recommended by the U.S. Food and Drug Administration (FDA) and ACIP are covered by the Alliance, without cost sharing.

Additional information is available on the CDC website at www.cdc.gov/vaccines/?CDC_Aref_Val=https://www.cdc.gov/vaccines/schedule.

To increase immunization rates, all PCPs are encouraged to:

- Use the California Immunization Registry (CAIR), ideally with a bi-directional interface between CAIR and the practice's electronic health record (EHR) Resources for practices can be found at <http://cairweb.org/how-cair-helps-your-practice>
- Establish or update electronic medical record (EMR)/EHR templates to accurately reflect coding for visit reason and diagnosis
- Utilize “flag” alerts in the EMR/EHR system for staff to identify and communicate with members/parents/guardians that immunization is due at every member encounter
- Appoint a vaccine coordinator
- Use huddle time to brief/communicate member/patient needed service(s)
- Use all visits, as appropriate, to provide immunizations
- Create immunization-only services or walk-in immunization clinics
- Communicate with families when vaccinations are due (reminders) or late (recall) via portals, texts, and/or calls
- Train staff on immunization schedule and how to address vaccine hesitancy

VACCINES FOR CHILDREN (VFC) PROGRAM (MEDI-CAL ONLY)

PCPs have access to free vaccines for Medi-Cal members **0-18 years of age** through the Vaccines for Children (VFC) Program. The administration fee for routine pediatric immunizations is paid on a fee-for-service basis for Alliance directly contracted providers. When the VFC Program does not provide the vaccine for the Medi-Cal program or other Alliance product lines, the PCP may bill the Alliance without prior authorization for the vaccine by submitting an invoice with the CMS 1500 claim form. Providers who would like to inquire about how to bill the Alliance directly should contact Alliance Provider Services at **1.510.747.4510** for more information.

To contact the VFC Program:

- Community and county clinics can call **1.510.267.3230**
- Private providers can visit the California Vaccine Programs – California Vaccines for Children (VFC) 155 website at eziz.org for more information

IMMUNIZATION EDUCATION

Federal law requires that Vaccine Information Sheets be handed out (before each dose) whenever certain vaccinations are given. These sheets are produced by the CDC,

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which explains to vaccine recipients, their parents, or their legal representatives both the benefits and the risks of a vaccine.

All handouts can be downloaded from the Immunization Action Coalition website at www.immunize.org.

VACCINE STORAGE

Providers are required to have a freezer and a refrigerator for vaccine storage.

DOCUMENTATION

Medical record documentation of member immunization status is required. Immunization status and immunizations given should also be documented. Documentation of each member's need for ACIP recommended immunizations is required as part of all regular health visits, including but not limited to illness, care management, or follow-up appointments, initial health appointment (IHAs), pharmacy services, prenatal and postpartum care, pre-travel visits, sports, school, or work physicals, visits to a local health department, and well patient check ups

REPORTING

All health care providers who administer vaccines must submit patient vaccination records to local health departments, Division of Communicable Diseases Control and Prevention, using the Confidential Morbidity Report Card and appropriate immunization registries within the specified timelines in accordance with Health and Safety Code (H&S) 120440 and 16 CCR 174.4 (e) as applicable. All immunization records must be reported within 14 calendar days, in accordance with state and federal law.

Medi-Cal for Kids & Teens (Early Periodic Screening Diagnosis and Treatment (EPSDT) (Medi-Cal Only) (QI)

Medi-Cal for Kids and Teens (also known as EPSDT) services are a benefit for Medi-Cal members under **21 years of age** to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early, such as a defect, physical or mental illness, or other conditions. EPSDT services must be identified and referred in a timely manner.

METHODS OF SCREENING

- Well-child visits.
- Regular check-ups to look for any problems with the member's medical, dental, vision, hearing, mental health, and any substance use disorders. The Alliance covers screening services any time there is a need for them, even if it is not during a regular check-up.
- Preventive care can be shots. The PCP must make sure that all enrolled children

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get the needed shots at the time of any health care visit.

When a physical or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem.

These services covered by the Alliance include:

- Behavioral health treatment for autism spectrum disorders and other developmental disabilities
- Case management, targeted case management, and health education
- Doctor, nurse practitioner, and hospital care
- Home health services, which could be medical equipment, supplies, and appliances
- Physical, speech/language, and occupational therapies
- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance
- Shots
- Treatment for vision and hearing, which could be eyeglasses and hearing aids

OTHER EPSDT SERVICES

If the care is medically necessary and the Alliance is not responsible for paying for the care, then the PCP should refer the member to California Children's Services (CCS) to get the care they need.

These services include:

- Private duty nursing services
- Treatment and rehabilitative services for mental health and substance use disorders
- Treatment for dental issues, which could be orthodontics

REFERRALS FOR EPSDT SERVICES

PCPs have a responsibility for identifying the need for EPSDT services through routine primary care of Alliance members under **21 years of age**. Appropriate diagnostic and treatment services must be initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

Members/families must request EPSDT services through their PCP. An Alliance Prior Authorization (PA) Request Form must be submitted for EPSDT services. The Alliance will not pay for EPSDT services that have not received prior authorization. If EPSDT services are rendered under emergency conditions, standard procedures for emergency care must be followed.

If an out-of-plan provider (such as a mental health specialist, school nurse, or family planning provider) who is providing services to an Alliance member determines that EPSDT services are needed, that provider must contact the Alliance Health Care Services Division. The Alliance Health Care Services Division will notify and consult with the member's PCP.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

PROVIDER TRAINING REQUIREMENTS FOR EPSDT SERVICES

Alliance contracted pediatric and family medicine providers must complete the new Medi-Cal for Kids & Teens Provider Training developed by the California Department of Healthcare Services (DHCS). The self-paced training outlines the requirements for the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit for Medi-Cal members under age 21.

Starting Monday, January 1, 2024, providers must complete the training no less than once every two (2) years. This also includes any contracted primary care providers (PCPs) such as medical doctors (MD), Doctor of Osteopathic Medicine (DO), physician assistants (PA), and nurse practitioners (NP) levels that see members under the age of 21 years of age.

Alliance contracted providers can access the training by visiting the Alliance website at www.alamedaalliance.org/providers/provider-resources/training-and-technical-assistance-opportunities.

CASE MANAGEMENT & COORDINATION OF CARE

The PCP must maintain ongoing communication with the EPSDT services provider in order to ensure coordination of care. This communication shall be documented in the medical record. The PCP is still responsible for providing primary care services, diagnostic and treatment services, and appropriate referrals for specialty care.

Women, Infants & Children (WIC) (CMDM)

The WIC Program provides supplemental food vouchers and nutritional counseling to pregnant and postpartum breastfeeding women, and infants, and children **five (5) years of age**. Eligibility is based on income. Members that who have an active Medi-Cal eligibility may qualify for WIC.

Alliance providers of pediatric care should ensure the appropriate and timely referral of infants and children to the WIC Program. Alliance prenatal providers may refer pregnant women to WIC by having them call toll-free at **1.800.852.5770** or by visiting myfamily.wic.ca.gov.

Early Intervention Services (HCS)

The Early Start Program is designed to provide comprehensive, coordinated, and family-focused early intervention services to children from **birth to age three (3)**, who have, or are at risk for, developmental disabilities. Providers are responsible for the appropriate and timely referral of children from **birth to age three (3)** to the Early Start Program, and for participating in the coordination of care provided to children enrolled in the program.

IDENTIFICATION

PCPs are responsible, through the assessment and examination process, for identifying Alliance members with the Early Start Program's eligible conditions. Identification of the following conditions in a child **0-36 months** of age requires a referral within **two (2) working days** to the program.

DEVELOPMENTAL DELAYS

A developmental delay may exist where there is a significant difference between the infant or toddler's current level of functioning and the expected level of development for his or her chronological age in one (1) or more of the following developmental areas:

- Adaptive
- Communication
- Physical and motor including vision, hearing, and health status
- Social or emotional

REFERRALS

Providers should refer directly to the appropriate agency for the Early Start Program as outlined below. Attempts should be made to obtain consent from the parents prior to making the referral. Providers must also release any requested information directly to the referral agency. Members may also self-refer to the Early Start Program.

For developmental delays or disabilities or high-risk infants, providers should refer to:

- Regional Center of the East Bay at **1.510.618.6100**
- Family Resource Network at **1.510.547.7322**
- Help Me Grow toll-free at **1.888.510.1211**

CASE MANAGEMENT AND ONGOING CARE

PCPs maintain responsibility for basic case management of a child enrolled in the Early Start Program and for referrals for specialty care as indicated. PCPs should participate, as appropriate, in the development and monitoring of the Individual Family Service Plan managed by the referral agency. PCPs must also make medical reports available, as requested, to the early intervention team in order to support their completion of the Individual Family Service Plan within the mandated **45-day** time limit after the referral is made.

~~Section 13:~~ Section 14: **Perinatal Services (HCS)**

The Alliance defines perinatal services as care delivered to a pregnant woman to diagnose and manage the pregnancy and related conditions, the delivery, and the postpartum follow-up. The standards for the treatment of pregnant women in this section will help providers meet the goals we all share – healthy mothers and children. All providers who offer obstetrical (OB) services to members are required to follow the most current editions of the Standards for Obstetric Services, ~~and~~ guidelines from the American College of Obstetricians and Gynecologists (ACOG), and other regulatory requirements or guidelines.

The Alliance recognizes that the Medi-Cal enrollment process may present a challenge to providers in the provision of quality prenatal care. Many women enter the plan well into their pregnancies. Regardless of when a pregnant woman enters the Seet plan, it is imperative that providers see pregnant women as soon as possible.

PRENATAL PROVIDER ROLE

Prenatal providers should follow the same authorization protocols as PCPs.

The prenatal provider, during the course of the member's pregnancy, is considered the gatekeeper or manager of the member's care. As such, prenatal providers may refer members to specialty services, all such referrals and authorizations must be given prior to the provision of care. Retrospective authorization of services is not permitted.

Perinatal Services (HCS)

PREGNANCY TESTING

Pregnancy testing is available to members through their PCP or from any obstetrician/gynecologist (OB/GYN), or family planning provider. No prior authorization is needed. A Medi-Cal member may receive a pregnancy test within or outside of the Alliance network. Alliance members enrolled in Alliance programs other than Medi-Cal must receive pregnancy test services in-network.

PRENATAL CARE APPOINTMENTS

Entry into prenatal care does not require a referral or prior authorization. Prenatal appointments should be scheduled within **two (2) weeks** of the member's request.

Members may go to any OB provider in the Alliance network unless they are assigned to CHCN. CHCN members must receive OB care from a CHCN provider, or a provider contracted with CHCN.

HIGH-RISK PRENATAL CARE

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

If a member's medical history or current condition indicates she may have a high-risk pregnancy, the member may be referred to the following types of Alliance practitioners:

- A Sweet Success affiliate for pregnancy and diabetes
- Genetic counselors
- Pediatricians and neonatologists for intensive newborn care and follow-up
- Perinatologists and obstetricians certified for high-risk care
- Tertiary ultrasonographers

To find the above providers, please refer to the Alliance Provider Directory.

MATERNAL MENTAL HEALTH

The Alliance requires providers to follow the American College of Obstetrics and Gynecology (ACOG), Bright Futures/American Academy of Pediatrics (AAP) guidelines for perinatal mental health screening, and other regulatory requirements.

Providers are encouraged to use an evidence-based screening tool to screen for depression. Screenings are required at least once during each pregnancy, at least once during the first six (6) weeks of the postpartum period, and when determined to be medically necessary and clinically appropriate.

The program guidelines below aim to support members at risk for perinatal depression during pregnancy and in the first year after birth. They include quality measures to encourage screening, diagnosis, treatment, and referral.

Maternal Depression Screening Guidelines can be found at [alamedaalliance.org](https://www.alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/) or on the Alliance website at <https://www.alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/>.

DELIVERY

Members must deliver at an in-network hospital with which their prenatal provider is affiliated.

NOTIFICATION OF ADMISSION

The hospital is responsible for contacting the Alliance Health Care Services Department when the member is admitted for delivery within **one (1) working day** of admission.

POSTPARTUM CARE

The routine postpartum visit should generally be provided **21-56 days** after delivery, although this interval may be modified if warranted by the needs of the patient. The postpartum review should include interval history and physical examination, laboratory data as indicated, family planning counseling, nutritional health education, and psychosocial reassessments.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

The Alliance reimburses fee-for-service (FFS) for the postpartum visit using CPT code 59430, as long as the date of service is on or between **21-56 days** from the date of birth.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notice During Prenatal Care

During the course of prenatal care, prenatal providers must give Alliance members written notice of their benefits coverage under the Newborns' and Mothers' Health Protection Act of 1997 (NMHPA). NMHPA may not restrict benefits for a hospital stay in connection with childbirth to less than **48 hours** following a vaginal delivery or 96 hours following a delivery by cesarean section beginning at the time of the hospital admission.

If the attending provider, in consultation with the mother, determines that either the mother or the newborn child can be discharged before the **48-hour** (or **96-hour**) period, the Alliance does not have to continue covering the stay for the one ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to the mother or the newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. A health plan, hospital, insurance company, or HMO would not be an attending provider.

Maternity Lengths of Stay

A health plan cannot require discharge from a maternity stay sooner than **48 hours** (vaginal delivery) or **96 hours** (cesarean section) unless certain criteria are met. The Alliance does not limit maternity lengths of stay. A decision to discharge must be made by the treating physician in consultation with the mother. The prenatal provider must then advise the mother that she may receive a post-discharge follow-up visit within **48 hours** of discharge.

PERINATAL ASSESSMENT

Many providers may be affiliated with the Comprehensive Perinatal Services Program (CPSP). The forms and protocols connected with this program satisfy Medi-Cal Managed Care requirements for perinatal assessment and intervention.

If a provider is not affiliated with CPSP, it is necessary to do comparable perinatal assessments. This assessment should be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified should be followed up on by appropriate interventions, which must be documented in the medical record. The assessment must also be kept in the medical record. The Alliance provides prenatal assessment forms in the Alliance threshold languages. The Alliance recommends all providers use the Alameda CPSP postpartum assessment.

Please see the referenced sections of this manual for details on how to refer to these programs or services:

1. Dental Services
2. Family Planning
3. Genetic Screening and Counseling
4. Perinatal Health Education Classes and Handouts
- STD Screening and Treatment
- 5.
- 5-6. [Women, Infants & Children \(WIC\)](#)

PRENATAL CARE AND CONSULTATIONS BY PERINATOLOGISTS

Perinatologists may provide three (3) types of services to Alliance members:

1. Consultations
2. Perinatology OB care
3. Routine OB care

The authorization and claims process that perinatology practices must follow for each of these types of services is detailed below. Payment will be denied for any service that requires but has not received prior authorization from either the prenatal provider or the Alliance Health Care Services Department.

ROUTINE OB CARE (NOT PERINATOLOGY)

Routine OB care provided to Alliance members by a Perinatology practice, which is not Perinatology care, must be billed according to the standard OB billing procedures.

Routine OB care does not require an authorization number and will be paid at the applicable global rate.

ONGOING PERINATOLOGY CARE

If an Alliance member's total OB care must be managed by the perinatologist because of a high-risk medical condition, the following procedures apply:

1. The perinatologist must submit an Alliance Prior Authorization (PA) Request Form to the Alliance in order to obtain authorization for that pregnancy to be billed fee-for-service (FFS) by the perinatology practice. The medical condition necessitating perinatology management must be documented
2. The Alliance Health Care Services Division will issue an authorization number for all services related to that high-risk pregnancy
3. The CMS 1500 is submitted for all services rendered and payment is made on an FFS basis. Each CMS 1500 must have the original authorization number issued for that pregnancy documented in Box #23

4. The perinatologist is responsible for the administration of the required perinatal assessments. Forms for this assessment have been developed and translated by the Alliance. Per the Medi-Cal Managed Care direction, this assessment should be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified should be followed up on by appropriate interventions, which must be documented in the medical record. The assessment must also be kept in the medical record

Reimbursement and Documentation of OB Services (Claims) (MEDI-CAL Medi-Cal and Group Care ONLY)

Use an HCFA 1500 (CMS 1500) form to bill for all prenatal, delivery, and postpartum services.

Submit claims within the following time frame:

- Initial prenatal visit - within **90 days** of the first prenatal visit.
- The balance of the prenatal care and the delivery – within **90 days** of the delivery postpartum office visit (must be provided between **21-56 days** after the delivery date) – within **90 days** of the date of service.

When submitting a claim for the initial prenatal visit:

- Use the appropriate ICD-10 codes to document a high-risk pregnancy. The diagnosis code submitted on the initial prenatal visit claim will determine whether that visit is paid at the normal or at-risk rate.

When submitting a final claim for antepartum and/or delivery care, services will be paid according to the following:

- Global payment when antepartum care and delivery services are provided.
- FFS when antepartum care only is provided; determined by the total number of visits.
- If only two (2) or three (3) antepartum visits are provided, bill individually for each of these visits. If a total of four (4)-six (6), or seven (7) or more visits are provided, bill the appropriate code for that number of visits (in addition to the initial visit).
- FFS when delivery only.

Postpartum office visits will only be reimbursed when the postpartum visit is between

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21-56 days after delivery.

SERVICES INCLUDED IN GLOBAL PAYMENTS FOR OB CARE

The following services are included in the risk-adjusted global OB payments:

- Prenatal visits
- Prenatal laboratory tests sent to Quest
- Hospital visits for delivery stays less than **72 hours**
- Health education, nutrition, and psychosocial counseling provided by office staff, unless authorized by Alliance
- Hospital visits, except antepartum greater than **72 hours**
- Delivery

SERVICES NOT INCLUDED IN GLOBAL PAYMENTS FOR OB CARE

The following services are not included in the global OB payments and may be billed fee-for-service:

1. Abortions
2. Amniocentesis
3. Chorionic villus sample
4. Family planning visit
5. Immunizations
6. Lab tests included in the PCP capitation scope of service
7. Non-stress tests
8. Postpartum care (only when provided **21-56 days** from delivery)
9. Pregnancy test
10. Prenatal genetic testing
11. Sonograms
12. Treatment of a sexually transmitted disease
13. Tubal ligations

~~Section 14:~~Section 15: Community Supports (CS) (HCS)

Community Supports (CS) services may be available for all Alliance members that qualify. CS are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for members to receive. These services are short-term services that may help members live more independently, but do not replace benefits they already get under Medi-Cal or other entities. Community Supports follows all Utilization Management regulations.

For authorization turnaround timeframes, please see the table below.

Request Type	Turnaround Time
Urgent	72 hours
Routine	5 business days
Retrospective/Post Service	30 calendar days

CS SERVICES OFFERED BY THE ALLIANCE

The Alliance is currently offering the following CS services:

- Asthma Remediation
- Caregiver Respite Services
- Community or Home Transition Services/~~Nursing Facility Transition to Home~~
- Environmental Accessibility Adaptations (Home Modifications)
- Homeless-related CS (includes Housing Transition Navigation, Housing Deposits, and Housing Tenancy & Sustaining Services)
- Medically Tailored Meals/Medically Supportive MealsFood
- ~~Nursing Facility Transition/Diversion to Assisted Living Facilities~~Assisted Living Facility (ALF) Transitions
- Personal Care and Homemaker Services
- Recuperative Care (Medical Respite)
- Transitional Rent (coming 01/01/2026)

There is no cost to the member for CS services.

Members can be referred to ~~Community Supports~~CS by their provider ~~or by calling:~~

Alliance ~~Case Management~~ Community SupportsCS Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.451245**
Email: **CSDept@alamedaalliance.org**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

~~Section 15:~~ Section 16: **Out-of-Plan Services (PS)**

Alliance Medi-Cal members are entitled to many services that are not provided through the Alliance. Providers must ensure that members have access to these out-of-plan services and may also be referred to as carved-out services or other Medi-Cal programs and services. The Alliance requires providers to assess each member for the various types of services included in this section and refer members appropriately.

California Children Services (CCS) (HCS)

California Children Services (CCS) Alliance Medi-Cal members **0-21 years of age** can receive care through CCS for specific eligible conditions as outlined in this section. CCS financial eligibility is automatic with Medi-Cal coverage. Providers treating a member with a CCS-eligible condition and/or an open CCS case should obtain authorization for services for that condition directly from CCS. The Alliance will also work directly with CCS to coordinate the payment of care; this involves referring eligible cases, obtaining authorization from CCS, and forwarding claims for payment if there is an open authorization. If the condition is not CCS-eligible or if CCS eligibility is uncertain, providers should follow the authorization procedures for the Medi-Cal Program members.

Please Note: The provider must be an authorized (also known as paneled) CCS provider to provide care and receive compensation for the treatment of a CCS patient for the eligible condition.

To obtain more information about the paneling process and to apply, please visit <https://cmsprovider.cahwnet.gov/PANEL/index.jsp>.

CONDITIONS ELIGIBLE FOR CCS

Please refer to the DHCS website for conditions eligible for CCS listing at www.dhcs.ca.gov/services/ccs/Pages/default.aspx.

ESTABLISHING A CCS CASE

Any provider, parent, social worker, or teacher may contact CCS to establish a case. Contacting CCS is not an authorization of service but does establish the earliest date for which eligibility may apply and begins the process of opening the case. A CCS referral, an Alliance authorization, or a PCP referral must be in place for any services to be covered.

The Alliance will pay for all medically necessary services during the interim referral

period and if CCS denies the case. PCPs who identify a condition that may require CCS services should complete and submit an Alliance Prior Authorization (PA) Request Form for other services, such as DME or inpatient and outpatient services. Submission of the form ensures that providers will be paid by the Alliance for medically necessary services, if CCS determines the condition is not medically eligible for CCS.

Indicate on the Alliance PA Request Form that a referral to CCS is requested. The Alliance will refer any case to CCS whose diagnosis might meet CCS eligibility criteria. Members can begin care with the specialist immediately.

Providers do not have to wait for CCS to determine eligibility because the services have been authorized by the Alliance or the PCP and will be paid by the Alliance in the interim period.

DIRECT REFERRAL TO CCS

If providers wish to contact CCS directly, the following information is required:

- Patient name
- Date of birth
- Medi-Cal member identification number
- Name, address, and telephone number of the parent/legal guardian
- Address and telephone number of the child, if different
- Medical condition
- Referring provider's name and phone number
- Medical notes, which must include a plan of treatment

The information may be faxed or mailed to CCS. Identify the specialist for referral if one has been selected. CCS will honor the request if the physician is CCS-paneled. Referrals should be made to specialists in the Alliance network who are also CCS paneled.

California Children Services (CCS)
1000 Broadway, Suite 5000
Oakland, CA 94607
Phone Number: 1.510.208.5970
Fax: 1.510.267.3254

California Children Services (CCS)

1000 Broadway, Suite 5000
Oakland, CA 94607
Phone Number: 1.510.208.5970
Fax: 1.510.267.3254

Providers should also forward copies of medical reports that support the CCS-eligible condition or suspected condition. In addition to a history and physical, these might include laboratory test results, diagnostic imaging reports, and operative reports or

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pathology findings.

COORDINATION OF CARE

PCPs are required to coordinate services with CCS specialty providers. If the member is eligible for CCS services, CCS will provide medical case management for the specific CCS condition. In all cases, PCPs must continue to provide primary case management to the member. Children with CCS-eligible conditions should still see their PCP for routine care, urgent care of non-eligible conditions, and for preventive care, including immunizations.

CLAIMS

If the specialist has received CCS authorization for services, the specialty provider should submit claims for payment directly to the county CCS program. If CCS eligibility is pending or denied, specialty providers can send claims for care authorized by the Alliance or referred by an Alliance provider to the Alliance Claims Department. Upon CCS authorization, the Alliance will forward the claim to CCS.

Dental Screening – Medi-Cal (HCS)

Dental screening is a component of a comprehensive health assessment for all members. PCPs should refer Medi-Cal members **0-20 years** of age to fee-for-service (FFS) Medi-Cal Dental Program providers. Members may also self-refer to dental services.

IDENTIFICATION, DOCUMENTATION, AND REFERRAL FOR CHILDREN

Dental screening for children is a required component of an oral exam. Mouth and teeth should be assessed, and referrals made as follows:

1. For children younger than **three (3) years old**, make a dental referral if any problems are suspected.
2. For children **3-20 years old**, ask the family/guardian if the child has seen a dentist in the past **12 months**. A referral should be made if the child has not seen a dentist or a problem is identified.

IDENTIFICATION, DOCUMENTATION, AND REFERRAL FOR ADULTS

Medi-Cal does not pay for dental care for adults **21 years of age** and older. PCPs should still assess whether adult patients have seen a dentist in the past **12 months**. If not, adult patients should be encouraged to find a dentist who provides low-cost dental care. For more information, please call the Medi-Cal Dental Program toll-free at **1.800.322.6384**.

TOPICAL FLUORIDE VARNISH

Topical fluoride varnish is a benefit for Medi-Cal children younger than **six (6) years of age**, up to three (3) times in a **12-month** period. [From 6 years to 21 years at least 2 applications each year](#). In addition to dentists, physicians, nurses, and medical personnel are permitted to apply fluoride varnish when the attending physician delegates the procedures and establishes protocol.

CARVE-OUT DRUGS COVERED BY FEE-FOR-SERVICE MEDI-CAL

The California Department of Health Care Services (DHCS) covers certain drug classifications and are considered non-capitated to the Medi-Cal managed care (the Alliance) plan, in other words they are carved out of the Plans (the Alliance) responsibility.

For Medi-Cal members, the Alliance is not responsible to cover drugs under the below listed drug classifications in a professional, outpatient, or inpatient setting, and would need to be billed to Fee-For-Service (FFS) Medi-Cal.

- Antivirals (HIV/AIDS/Hepatitis B) Drugs
- Alcohol and Heroin Detoxification and Dependency Treatment Drugs
- Blood Factor: Clotting Factor Disorder Treatment Drugs
- Cell and Gene Therapies for Sickle Cell Disease: Casgevy, Lyfgenia
- Psychiatric/Antipsychotic Drugs

These drugs should be billed to Fee-For-Service (FFS) Medi-Cal.

The Alliance routinely reviews the above listed drug classifications to make changes to our claim and authorization system and processes to ensure we are in alignment with the DHCS requirements.

We encourage providers to review drugs in this classification provided to Alliance Medi-Cal members to ensure they are submitted directly to FFS Medi-Cal. May result in delays or denial of non-payment from the Alliance. For more information, please refer to the additional resources below.

Medi-Cal billing manual, MCP:

- Single Plan publication: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/11F02F0E-1773-4278-90B3-B934358F0D45/mcpsingle.pdf?access_token=6UyVkRRfByXTZEWlh8j8QaYyIPyP5ULO
- DHCS All Plan Letter 16-004, Medi-Cal Managed Care Health Plans Carved-Out Drugs:
<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-004.pdf>

Tuberculosis (TB) Control Services (HCS)

CLINICAL GUIDELINES

Providers should follow the guidelines of the American Thoracic Society in the provision of TB services. The Mantoux tuberculin test is the only screening test to be used.

Alliance providers must identify, refer, and coordinate services with the Alameda County Health Care Services Agency, Division of Communicable Disease Control and Prevention, or Directly Observed Therapy (DOT) or Directly Observed Preventive Therapy (DOPT) for tuberculosis. All suspected or confirmed TB cases should be reported to the TB Controller.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

REPORTING

Per Title 17 of the California Code of Regulations, providers must promptly report all suspected or confirmed TB cases to the TB Controller within **one (1) day** of identification.

A completed Confidential Tuberculosis Report must be faxed to:

Tuberculosis Controller
Division of Communicable Disease Control and Prevention
Phone Number: **1.510.577.7000**
Fax: **1.510.577.7024**

REFERRAL CRITERIA

Some TB patients may require more medical management than typically provided by a PCP.

Patients meeting any of the following criteria require a referral DOT or DOPT when there is suspected or diagnosed TB:

- Adverse reaction to TB medications
- Any patient the physician or nurse case manager deems at risk for noncompliance
- Children and adolescents
- Demonstrated drug resistance to either Isoniazid or Rifampin
- History of drug or alcohol abuse
- History of previous TB treatment
- Homeless or shelter residents
- Immunocompromised, or at risk of being immunocompromised
- Individuals demonstrating non-compliance
- Living in a home with another case of DOT
- Major psychiatric, memory, or cognitive disorder
- Patients on intermittent therapy
- Patients whose treatment has failed, who have relapsed after completing a prior regimen, or who demonstrate slow sputum conversion or clinical improvement
- Poor or non-acceptance of TB diagnosis
- Smear and culture positive **three (3) months** into therapy
- Too ill for self-management

Document the referral to DOT/DOPT in the member's medical record.

HOSPITAL DISCHARGE

Providers must notify the TB Control Unit at **1.510.208.5940** at least **24 hours** prior to the anticipated hospital discharge of a member who is a TB suspect/case. Fax a completed TB Discharge Treatment Plan to **1.510.628.7898**.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Medi-Cal Rx – Outpatient Pharmacy Benefit (Medi-Cal Only) (Rx)

Effective Saturday, January 1, 2022, the Medi-Cal pharmacy benefit is covered by the Department of Health Care Services (DHCS). The Alliance will no longer cover outpatient pharmacy. All providers will be required to use the Medi-Cal Rx Portal to submit authorizations for medications that require authorization and receive payment for these claims. The new program will be called “Medi-Cal Rx.”

Individual prescribers will each need to register to the Medi-Cal Rx portal to be a user by:

1. Visiting **www.medi-calrx.dhcs.ca.gov**
2. Clicking on “Provider Portal”
3. Then click on “Register”

Once registered, providers will receive a PIN in the mail to the address used when they signed up through the Medi-Cal Rx portal. It could take up to **three (3) months** to receive a PIN in the mail. Once received, the rest of the Medi-Cal Rx registration process may be completed online using the assigned PIN.

MEDI-CAL RX APPEALS

Providers will be able to submit appeals for prior authorization denials, delays, and modifications through the Medi-Cal RX portal once they have registered or by mail to:

Medi-Cal CSC, Provider Claims Appeals Unit
PO Box 610
Rancho Cordova, CA, 95741-0610

Member appeals will be handled through a State Fair Hearing by the California Department of Social Services. This process is different from the appeal process you may have used with the Alliance. In a State Hearing, a judge reviews the request and makes a decision.

The State Hearing Request Form is available at **www.dhcs.ca.gov/services/medi-cal/pages/medi-calfairhearing.aspx**. Instructions and additional options can be found on the DHCS website.

~~Section 16:~~ Section 17: **Health Education** ~~(Health Ed)~~

Health education services are important benefits that the Alliance offers to providers and members. This section outlines some of the available services.

Health Education Services ~~(Health Ed)~~

@The Alliance offers health education services to Alliance members at no cost. Alliance-sponsored classes, materials, [medical ID bracelets](#), and self-management programs help members achieve healthy lifestyles, prevent illness and injury, and manage health conditions. The Alliance partners with many local organization and providers to offer health education services. Programs and handouts are designed to meet the cultural, linguistic, and health literacy needs of our members. Providers can find a listing of health education offerings and community referrals in our Provider Health Education Resource Directory on the Alliance website at www.alamedaalliance.org/providers/patient-health-wellness-education.

Alliance Health Programs currently offers the following:

- Enrollment for eligible members into a CDC-approved Diabetes Prevention Program (DPP) [or Medicare Diabetes Prevention Program \(MDPP\)](#).
- Interpreter services and transportation for members who attend health education classes sponsored by the Alliance.
- Patient handouts on many health topics in English, Spanish, Chinese, Vietnamese, and Tagalog.
- Referrals to classes or groups on diabetes, hypertension, CPR/first aid, weight management, pregnancy/breastfeeding/childbirth, and parenting.
- Referrals for one-on-one support with diabetes, asthma (adults and children), hypertension and breastfeeding.

There are many ways to request health education services:

- Call Alliance Health Programs at **1.510.747.4577**
- Download materials and forms at www.alamedaalliance.org/live-healthy
- Members can mail the Member Wellness Programs and Materials Request Form
- Providers can fax the Provider Wellness Programs and Materials Request Form

Our programs often change to ensure we meet the needs of our members and providers. Please contact us to receive the most current information:

Alliance Health Programs
Phone number: **1.510.747.4577**
Email: livehealthy@alamedaalliance.org
www.alamedaalliance.org/providers/patient-health-wellness-education

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

~~Section 17:~~ **Section 18: Serving Our Diverse Population (C&L, Health Equity)**

Alameda County is culturally diverse, and residents speak a wide variety of languages. This section will help you provide Alliance members with culturally and linguistically appropriate services.

In accordance with the US Code of Federal Regulations, Title 42, CFR Section 440.262, we ask that all Alliance providers promote access and delivery of service in a culturally sensitive **and culturally responsive** manner to all patients, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. These methods must ensure that patients have access to covered services that are delivered in a manner that meets their unique needs.

The Alliance is committed to providing language assistance in the member's preferred language, including American Sign Language (ASL), and effective communication for individuals with disabilities. This section outlines how language preferences are identified and the requirements for providers with respect to language access and documentation.

TITLE VI COMPLIANCE

Alliance providers must comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d and 45 C.F.R. Part 80). Title VI prohibits recipients of federal funds, such as Medicare/Medi-Cal providers, from discriminating against persons based on race, color, or national origin.

In accordance with Title VI, all Alliance providers (PCPs, ancillary, specialty, and inpatient providers) must provide access to services in the member's language at all points of contact. At no time should a provider rely on translation or interpretation services from a member's family members or friends, unless the member insists, and the use of a non-qualified interpreter is documented.

When a member selects a provider who does not speak the member's language, the provider is still obligated to meet the member's language needs in compliance with Title VI by utilizing in-house bilingual and/or bi-cultural staff, using over-the-phone or video interpreter services, or scheduling in-person services for American Sign Language (ASL), complex, or highly sensitive appointments. These services are provided at no cost to the member.

Documenting Staff Language Proficiency (C&L, Health Equity)

All Alliance providers must keep documentation of the language proficiency for all their clinical and non-clinical employees who are bilingual and communicate with a patient in a language other than English. Documentation should include demonstration of proficiency in both English and the other language(s) being assessed and fundamental knowledge of health care terminology and concepts relevant to health care delivery systems in English and other language(s) being assessed.

Signage for Interpreter Services (C&L, Health Equity)

Providers should have multilingual signage available for non-English-speaking patients. This will help providers and office staff identify which languages Alliance members speak. The Alliance can provide providers with a sign for use in their office that states: “Point to your language! We will get you an interpreter” in multiple languages. For a laminated copy, please call the Alliance Provider Services Department at **1.510.747.4510**.

If a provider is unable to offer language access for the member through their office’s own resources, the Alliance will assist with interpreter services at no cost to the provider or member. Please refer to “Requesting Interpreter Services” in this section.

QUALIFIED MEDICAL INTERPRETER SERVICES

The Alliance provides interpreter services that include telephonic, video, or in-person interpretation when a provider cannot meet the language needs of an Alliance member. These interpreter services are used during discussions of medical and non-medical information.

Hospitals are required to provide interpreter services to patients in accordance with state and federal law.

~~At the time of~~When scheduling a the medical appointment, please ask the patient member (or the parent/guardian of a minor patient’s parents) what about their preferred spoken and written language is for speaking and reading. When an Alliance member’s language needs cannot be met by the provider, please offer to coordinate interpreter services. Please document the members’ preferred language and any refusal of qualified interpreter services in the medical chart.

When members call our Member Services Department, the Alliance ensures that they are connected to a qualified interpreter within 8 minutes.

Requesting Interpreter Services (C&L, Health Equity)

The Alliance provides no-cost interpreter services including ASL for all Alliance-covered services, 24 hours a day, 7 days a week. Interpreter services include access to TTY and

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.



on-demand interpreter services in over 100 languages, including, but not limited to: Arabic, Armenian, French, German, Greek, Gujarati, Haitian Creole, Hindi, Italian, Japanese, Korean, Polish, Portuguese, Russian, Ukrainian, and Urdu.

Please confirm your patient's eligibility before requesting for interpreter services.

TELEPHONIC INTERPRETER SERVICES

Common uses for telephonic interpreter services:

- Administrative communications with patients
- Allied health services such as physical, occupational, or respiratory therapy
- Freestanding radiology, mammography, and lab services
- Routine and follow-up clinic visits

To access telephonic interpreters, please follow the steps below:

1. Please call **1.510.809.3986**, available 24 hours a day and 7 days a week.
2. Enter your PIN:
 - a. Other Alliance providers – press **1004**
 - b. Alameda Health Systems – **1005**
 - c. Behavioral health care – press **1003**
 - d. Children First Medical Group (CFMG) – press **1002**
 - e. Community Health Center Network (CHCN) – press **1001**
3. Say or enter the language you need:
 - a. Spanish – press **1**
 - b. Cantonese – press **2**
 - c. Mandarin – press **3**
 - d. Vietnamese – press **4**
 - e. For all other languages – press **0**
4. Provide the nine (9)-digit Alliance member ID number.

For communication with a patient who is deaf, hearing, or speech impaired, please call the California Relay Service (CRS) at **711**.

TELEHEALTH AND VIDEO INTERPRETER SERVICES

When you are ready to connect with a telephonic interpreter during a telehealth visit, please follow steps 1-4 above. Provide the telehealth phone number and login information to the interpreter. The interpreter will then call in to join your telehealth visit. For more information about video interpreters and telehealth visits using online platforms, please email interpreters@alamedaalliance.org.

IN-PERSON INTERPRETER SERVICES

Members can receive in-person interpreter services for the following:

- Sign language for the deaf and hard of hearing.
- Complex courses of therapy or procedures, including life-threatening diagnoses (e.g., cancer, pre-surgery instructions, and evaluation or reevaluation for physical or occupational therapy, chemotherapy, transplants, etc.).
- Highly sensitive issues (e.g., sexual assault/abuse, end-of-life, and initial evaluation for behavioral health, etc.).
- Other conditions by exception. Please include your reason in the request.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

If the appointment requires an in-person interpreter, please follow these steps to request:

1. You must request in-person interpreter services at least **five (5) business days** in advance. For ASL, **five (5) days** is recommended, but not required.
2. You can complete the online Interpreter Services Request Form on the Alliance Provider Portal or download the fillable form on the Alliance Website:
 - Online form:
 - Visit the Alliance website at www.alamedaalliance.org.
 - Click on the 'Provider Portal' link in the upper right-hand corner, then log in.
 - Look up your patient's eligibility, then click on the link at the top of the eligibility page to access the online form.
 - Fillable form:
 - Visit the Alliance website at www.alamedaalliance.org/language-access.
 - Download the Interpreter Services Request Form.
 - Complete and fax the form to 1.855.891.9167.

If you need to revise a request, please cancel the original request and submit a new one. The Alliance will notify providers by fax or phone if for any reason we cannot schedule interpreter services.

If needed, please cancel interpreter services at least **48 hours** prior to the appointment by calling the Alliance Provider Services Department at **1.510.747.4510**.

TRANSLATION OR ALTERNATIVE~~EE~~ FORMAT OF ALLIANCE DOCUMENTS

Members can also request written member materials in a language or alternative format ~~they need~~. All vital ~~Medi-Cal and Group Care~~ Alliance member materials are offered in our threshold languages: English, Spanish, Chinese, Vietnamese, and ~~Tagalog~~ Farsi. ~~Vital Group Care materials are offered in English, Spanish, and Chinese.~~ Members can call the Alliance Member Services Department to request materials in their preferred language, or materials in audio, Braille, large print, or other alternative formats.

Professional medical interpreter services, written translation, and alternate formats of plan member literature are available to Alliance members at no cost. Auxiliary aids are also available to Alliance members' authorized representatives, or someone involved in the member's healthcare.

Members may request language assistance, translations, alternative~~ee~~ formats, and auxiliary aids by calling:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

If you cannot hear or speak well ~~People with hearing and speaking impairments~~
(CRS/TTY): 711/1.800.735.2929

MATCHING MEMBER AND PRIMARY CARE PROVIDER LANGUAGE

Members may select their PCP by language using the Provider Directory. The Provider Directory identifies the language capabilities available ~~in the~~ for each provider office. Alliance members are encouraged to choose their own PCP. However, if a member does not choose a PCP within 30 days of becoming an Alliance member, one will be chosen for the member through auto-assignment. If auto-assignment is necessary, the Alliance makes every effort possible to match the member's preferred language with the provider office's language capabilities.

Cultural and Linguistic Provider Training and Development ~~(C&L, Health Equity)~~

CULTURAL SENSITIVITY DIVERSITY, EQUITY, AND INCLUSION (DEI) TRAINING PROGRAM

~~All~~ Alliance providers and clinic staff are required to complete sensitivity DEI training as a part of the new provider orientation ~~and within 90 days of hire and during recredentialing and contract renewals annually and regularly thereafter to keep remain~~ staff updated on best practices and changing member demographics and needs.

The training includes:

- Diversity, Equity, Inclusion, and Belonging
- Cultural Competency and / Ssensitivity.
- Health Equity Fundamentals
- Diversity among the Alliance's member population.
- Provider and member resources to include language assistance services and translated materials.
- Best practices for providing health care services to members with limited English proficiency, diverse cultural and ethnic backgrounds, seniors and persons with disabilities (SPDs), and diverse gender, sexual orientation, or gender identities.
- How structural and institutional racism and health inequities impact members, staff and network providers.

The Alliance's Cultural Sensitivity DEI Training is updated annually and available online at **www.alamedaalliance.org/providers/provider-resources/training-and-technical-assistance-opportunities**. Providers can also request a copy by calling the Alliance Provider Services Department at **1.510.747.4510**.

Providers and office staff who need help locating culturally and linguistically appropriate health education materials and programs can call Alliance Health Programs at

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Monitoring Alliance Cultural and Linguistic Services Access and Quality of Program Care (C&L, Health Equity)

Alameda Alliance for Health is committed to ensuring that all members receive culturally cultural and linguistically linguistic services (CLAS) that aligns align with state and federal regulations, including National CLAS Standards. To learn more about the National CLAS Standards, visit <https://thinkculturalhealth.hhs.gov/clas>.

The Alliance's Cultural and Linguistic Services (CLS) Program monitors language access and culturally and linguistically care through the following activities:

- Tracking utilization of interpreter services
- Surveying member satisfaction on access and quality of interpreter services
- Document translation and readability review to ensure that member materials are available in Alliance threshold languages and are written at a 6th-grade reading level and follow plain language best practices
- Ensuring the Alliance provider network has the capacity to meet members' cultural and linguistic needs.
- County level data review to inform of language trends and needs.
- Quality monitoring and grievance data review to identify trends and address language access concerns through provider education.
- Facility site review of provision and documentation of language services
- DEI and cultural sensitivity training participation

These monitoring activities support the CLS Program's goal to ensure that all members receive equitable access to high quality health care services that are culturally and linguistically appropriate.

Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training (Health Equity)

The Alliance has implemented an evidence-based cultural competency training for the purpose of providing informed trans-inclusive health care in accordance with the Department of Healthcare Services (DHCS) All Plan Letter (APL) 24-017, Department of Managed Health Care (DMHC) 24-018 and SB 923.

The Alliance requires all of its staff, Subcontractors, and Downstream Subcontractors who are in direct contact with enrollees in the delivery of care or enrollee services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI). The evidence-based cultural competency training includes:

- Information about the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of TGI communities.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Information about—communicating more effectively across gender identities, including TGI-inclusive terminology, using people’s correct names and pronouns, even when they are not reflected in records or legal documents; avoiding language, whether verbal or nonverbal, that demeans, ridicules, or condemns TGI individuals; and avoiding making assumptions about gender identity by using gender-neutral language and avoiding language that presumes all individuals are heterosexual, cisgender or gender conforming, or non-intersex.
- Discussion on health inequities within the TGI community, including family and community acceptance.
- Perspectives of diverse, local constituency groups and TGI-serving organizations, including, but not limited to, the California Transgender Advisory Council.
- Recognition of the difference between personal values and professional responsibilities with regard to serving TGI people.
- Facilitation by TGI-serving organizations that meets the criteria of §150900(f)(2).

TGI Provider Directory Updates:

The Alliance’s provider directory will include information identifying which of the plan’s in-network (contracted and credentialed) providers have voluntarily affirmed they offer gender-affirming services and agree to identify them as such in our provider directory by making a survey available to providers.

Gender affirming services include but not limited to, the services listed in Section 1367.28: Gender-affirming services, including, but not limited to, feminizing mastectomy, male chest reconstruction, mastectomy, gender-confirming facial surgery, hysterectomy, oophorectomy, penectomy, orchiectomy, feminizing genitaloplasty, metoidioplasty, phalloplasty, scrotoplasty, voice masculinization or feminization, hormone therapy related to gender dysphoria or intersex conditions, gender-affirming gynecological care, or voice therapy related to gender dysphoria or intersex conditions.

Click this link [to access and complete the TGI survey, please visit https://aahportal-forms.alamedaalliance.org/tgisurvey](https://aahportal-forms.alamedaalliance.org/tgisurvey)

~~ONE OF THE ALLIANCE’S GOALS IS TO EVALUATE, IMPLEMENT, AND INTEGRATE CULTURAL AND LINGUISTIC COMPETENCY ACROSS PLAN OPERATIONS IN ORDER TO TO CREATE A CULTURALLY COMPETENT ORGANIZATION, INCREASE ACCESS TO CARE, ENHANCE THE QUALITY OF CARE AND HEALTH OUTCOMES, MAXIMIZE PATIENT SATISFACTION AND RETENTION, AND REDUCE HEALTH DISPARITIES. MEASURING AND IMPROVING CULTURAL COMPETENCY IS A KEY FACTOR IN REDUCING SOCIOCULTURAL BARRIERS TO HEALTH CARE. THE ULTIMATE GOAL IS TO~~

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

~~INCREASE THE QUALITY OF CARE FOR ALL ALLIANCE MEMBERS, WITH AN EMPHASIS ON REDUCING HEALTH DISPARITIES FOR OUR LARGEST ETHNIC AND LANGUAGE GROUPS.~~

~~THE ALLIANCE MONITORS CULTURAL AND LINGUISTIC ACCESS AND QUALITY OF CARE THROUGH MEMBER SURVEYS, MEMBERSHIP DATA, CLAIMS DATA, UTILIZATION DATA, COUNTY LEVEL DATA SPECIAL STUDIES, FACILITY SITE REVIEWS, COMPLAINT POTENTIAL QUALITY ISSUES (PQIS) AND GRIEVANCE DATA, AND QUALITY INDICATORS.~~

FACILITY SITE REVIEWS (FSR)

During PCP facility site reviews (FSR), Alliance staff will evaluate:

- Whether providers are recording the member's preferred language in medical records or on a computerized system.
- The procedures followed when serving a member whose preferred language is not English.
- Whether persons providing language interpreter services, including American Sign Language, are trained in medical interpretation.
- Whether site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities, and whether a written policy is in place.
- The provider's system for scheduling members who require interpretation services.
- The availability of patient literature and sign~~ages~~ in languages other than English.

REVIEW OF QUALITY INDICATORS

The Alliance examines culture and language as elements in its quality studies. These studies allow the Alliance to identify patterns of use that may indicate unmet cultural and linguistic needs.

Results are used to help the Alliance and its providers develop services that meet members' cultural and linguistic needs.

~~Section 18:~~ Section 19: **Transportation Services**

This section contains information on the transportation benefits covered by the Alliance.

Transportation Benefits (CMDM)

The Alliance provides the following transportation benefits to Medi-Cal members for all medically necessary services covered by the Alliance:

- Emergency medical transportation (EMT)
- Non-emergency medical transportation (NEMT)
- Non-medical transportation (NMT)

The Alliance provides the lowest-cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation vendor.

The following guidelines will be used when reviewing requests for transportation services:

- **Emergency medical transportation (EMT)** is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization.

The following guidelines apply to EMT:

- Emergency medical transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.
- Ground emergency medical transportation is covered when ordinary public or private medical transportation is medically contraindicated, and transportation is needed to obtain care.
- Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.
- Medical transportation, which represents a continuation of an original emergency transportation event does not require prior authorization.
- **Non-emergency medical transportation (NEMT)** is covered for all medically necessary Medi-Cal services covered by the Alliance. Members may schedule a ride for services by calling 1.866.791.4158 at least three (3) business days (Monday - Friday) before your appointment. –Providers may schedule a ride on behalf of a member by calling 1.866.529.2128 at least three (3) business days (Monday - Friday) before your appointment. –For urgent appointments, call as soon as possible. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services.

The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with the Department of Health Care Services (DHCS).

Requests for NEMT transportation services must meet the following requirements:

- To determine the appropriate level of service, the treating physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender (PA or NP) must complete and sign the Alliance Physician Certification Statement (PCS) Form approved by the Department of Health Care Services (DHCS).
 - The PCS Form collects data regarding the member's functional limitations, prescribed dates of service, and prescribed mode of transportation. The provider must also attest that medical necessity was used to determine the type of requested transportation. The provider must document the member's functional limitations justification on the PCS Form to provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicle.
 - The PCS form must be completed **before** NEMT services can be provided to the member. The PCS form includes the certification statement (prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested). The signed PCS form with the required fields will be considered completed.
 - Based on medical necessity, a provider may prescribe NEMT for up to **12 months** for members.

The completed PCS Form must be submitted to:

Alliance Case and Disease Management Department

Phone: **1.510.747.4512**

Email: **deptcmdm@alamedaalliance.org**

Fax: **1.510.747.4130**

- Once the completed PCS Form is received by the Alliance, it may not be modified. The Alliance and its transportation vendor coordinate with the prescribing provider to ensure the PCS Form submitted captures the lowest-cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

- The Alliance captures data from the PCS Form for reporting and submitting the data to the DHCS.

NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with the written consent of a parent or guardian or when applicable state or federal law does not require parental consent for the minor's service.

NEMT is provided in the following modalities and situations:

- NEMT ambulance services are provided for:
 - Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
 - Transfers from an acute care facility to another acute care facility. Members transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate licensed care facility. These NEMT services do not require the PCS form.
 - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
 - Transport for members with chronic conditions who require oxygen when monitoring is required.
 - Advanced Life Support services are provided when the member requires a paramedic during transport.
 - Critical Care Transportation/Specialty Care Transportation services are provided when the member's condition requires cardiac monitoring.
 - Life Support (LS) services are provided when the member's condition requires oxygen that is not self-administered or regulated.
- Litter / Gurney van services are provided when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets both of the following:
 - Requires that the member be transported in a prone or supine position because the member is incapable of sitting for the period of time needed to transport.
 - Requires specialized safety equipment over and above that is normally available in passenger cars, taxicabs, or other forms of public conveyance.
- Wheelchair van services are provided when the member's medical and physical condition does not meet the need for litter van services but meets any of the following:
 - Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.

- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
- Requires specialized safety equipment over and above that is normally available in passenger cars, taxicabs, or other forms of public conveyance.
- NEMT by air is provided only when transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician or mid-level provider.

For Medi-Cal services not covered by the Alliance, including specialty mental health substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance will make its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

- **Non-medical transportation (NMT)** is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation vendor.
Members may schedule a ride for services by calling 1.866.791.4158 at least three (3) business days (Monday-Friday) before your appointment.- Providers may schedule a ride on behalf of a member by calling 1.866.529.2128 at least three (3) business days (Monday-Friday) before your appointment.- For urgent appointments, call as soon as possible.- The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

The Alliance does not require prior authorization for NMT services, unless over **50 miles** in one (1) direction.

NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with the written consent of a parent or guardian or when applicable state or federal law does not require parental consent for the minor's service.

NMT coverage includes transportation costs for the member and one (1) attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation. This must be requested at the time of the initial NMT request.

NMT is provided using the lowest-cost modality appropriate for the member's condition.

NMT modalities include the following:

- Public transportation/mass transit
- Paratransit
- Taxicab/curb-to-curb passenger vehicle
- Door-to-door passenger vehicle
- Any other form of private conveyance (private vehicle), including mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged.

Members seeking NMT must attest to the Alliance's transportation vendor in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member does not have a valid driver's license, no working vehicle available in the household, is unable to travel or wait for medical or dental services alone, or has a physical, cognitive, mental, or developmental limitation.

In order to receive gas mileage reimbursement for the use of a private vehicle (driven by someone other than member), members must first inform transportation vendor of intent to use private vehicle for upcoming NMT.

-After the NMT occurs, the following documentation must be submitted to the Alliance's transportation vendor in compliance with all California driving requirements, including:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance

NMT services for Medi-Cal carved-out services will be provided upon the member or provider's request to the Alliance. NMT can continue to be provided through Medi-Cal FFS agencies, such as CCS if requested directly to the agency.

Transportation Liaison (CMDM)

The Alliance Transportation liaison is available to members and providers to ensure eligible transportation requests are scheduled.

You can reach the transportation liaison at **1.510.373.5654**.

~~Section 19:~~Section 20: **Formulary and Pharmacy Services ~~(Group Care Only)~~ (Rx)**

This section covers how to obtain pharmacy services for Group Care and Alameda Alliance Wellness members ~~only~~. Please refer to section 152: Out-of-Plan Services for information on the pharmacy benefit for Medi-Cal members.

The Alliance subcontracts with a Pharmacy Benefit Manager (PBM) for select pharmacy services through PerformRX LLC (PerformRX).

The role of PerformRX ~~in the Alliance Group Care network~~ includes:

- Conducting online Drug Utilization Evaluation-Review (DURE) programs at the point of sale
- Developing and leading the drug class reviews in the Pharmacy & Therapeutics (P&T) committee meetings
- Managing the pharmacy network
- Monitoring and reporting drug utilization patterns
- Processing initial prior authorization and exception requests
- Processing pharmacy claims

Providers and pharmacies are encouraged to contact PerformRX for questions related to pharmacy prior authorizations and claim transactions. The most current contact information, operating hours, and operating manual related to PerformRX are located online at **www.alamedaalliance.org**.

Formulary (Rx)

The Alliance maintains a formulary (Preferred Drug List) for Group Care members for the outpatient prescription benefit (also known as a retail pharmacy benefit). The formulary lists drugs available to ~~Alliance Group Care~~ members without the need for a prior authorization (PA) request.

The Alameda Alliance Wellness Drug List covers brand name, generic, and biologic products (which may include biosimilars.) Alliance offers a one-tier formulary for its **DSNPD-SNP** members. Providers can refer to the **DSNPD-SNP** Drug List for further explanation and a list of specific drugs and UM requirements The Drug List is updated each month and the most current version is posted <Insert Website>.

Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Alliance **DSNPD-SNP** Drug List. For information on how to submit a coverage determination (prior authorization or formulary exception request), please refer to the section below called “Pharmacy Prior Authorizations and Exceptions.”

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

The Alliance P&T Committee is responsible for the development of the formulary using sound clinical evidence. Therapeutic classes in the formulary are reviewed at least annually by the P&T Committee. The P&T Committee consists of the Alliance Chief Medical Officer (CMO) or designee, Alliance Director of Pharmacy, licensed practicing pharmacists, and licensed practicing physicians from the community with expertise in elderly and disabled care. The group meets at least quarterly.

Updates to the formulary are communicated online to both members and providers. Providers may request changes to the formulary. Requests for changes are reviewed during the P&T meeting in the following quarter.

The Alliance P&T Committee uses the following criteria in the evaluation of drug selection for its formulary:

- Comparable cost and outcomes of the total cost of drug and medical care
- Comparison of relevant drug benefits to current formulary drugs of similar use, with a goal of minimizing duplication
- Drug effectiveness
- Drug efficacy
- Drug safety profile

The Alliance provides coverage for at least one medication approved by the FDA in each of the following categories without prior authorization, step therapy, or utilization review:

- Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.
- Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.
- A long-acting buprenorphine product.
- A long-acting injectable naltrexone product.

FORMULARY CATEGORIES

There are five (5) drug dispensing categories on the Alliance formulary, including restrictions and preferences:

1. Formulary Drugs

Drugs on the formulary are preferred and may or may not require prior authorization for claim adjudication.

When covered, the drugs may also have one (1) or more of the following restrictions:

- Generic Substitution – The generic equivalent has to be dispensed when

available.

- Biosimilar substitution required for bioidentical biosimilars
- Quantity Limits – A limit on the quantity and/or duration of therapy.
- Step Therapy – Requires one (1) or more of a prerequisite first step drug to be tried before progressing to a second step drug.
- Age Restriction – Restriction to a specific age when medically appropriate for the drug.

Providers can refer to the comprehensive formulary for further explanation and a list of specific drugs that are subject to generic substitution and step therapy or have quantity limits or age/gender restrictions.

2. Therapeutic Interchange

Therapeutic interchanges promote rational pharmaceutical therapy when evidence suggests that clinical outcomes are comparable when substituting a drug that is therapeutically equivalent but chemically different from the prescribed drug. The substituted drug may be of a different drug class but has comparable effectiveness.

Therapeutic interchange protocols are never automatic and require authorization from the prescribing provider

3. Drugs Requiring Prior Authorization

Non-formulary drugs subject to prior authorization require approval from the Alliance or the PerformRX Authorization Department for the Group Care line of business. The prior authorization review process serves as a quality measure to ensure the drug is safe and cost-effective. To review requests for the outpatient pharmacy benefit, the Alliance and PerformRX uses drug treatment guidelines (criteria), reviewed and approved by the P&T Committee.

If a drug is not listed as covered on the comprehensive formulary, it can be assumed that it requires prior authorization or exception.

4. Drugs Requiring Exception

Non-formulary drugs can also be requested and processed as an exception. An exception is similar to a prior authorization except the Alliance does not have drug review guidelines (criteria) to guide the clinical reviewer, or the requested drug exceeds the scope of coverage (see Non-Formulary Drugs below). Rather, approval will be based on evidence of medical necessity on a case-by-case basis.

The exception review process serves as a quality measure to ensure the drug is safe, cost-effective, and medically necessary. The PerformRX Prior Authorization Department for the Group Care line of business will forward all exception requests to the Alliance to be reviewed by a licensed pharmacist or physician. Providers can

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

request an exception authorization by submitting a Prescription Drug Prior Authorization (PA) Request Form to PerformRX per the exception protocols.

Please contact PerformRX for inquiries on any of the above formulary categories or to submit a verbal or written prior authorization or exception request. The most current contact information is located online at www.alamedaalliance.org.

5. Emergency Supply

In compliance with state rules, the Alliance will cover a **three (3)-day** supply of medication for Alliance members in emergency situations. This policy applies to medication that normally would require a Prescription Drug PA Request or exception request.

Emergency situations include:

- A recent discharge from an emergency room (ER)
- A recent discharge from the hospital
- Any event that involves an imminent and serious threat, including (but not limited to) severe pain, potential loss of life, limb, or major bodily function

Contracted Alliance pharmacies can help Alliance members obtain an emergency supply. Alliance members can find a list of pharmacies that work with us in the Alliance Provider Directory or online Pharmacy Search.

After the **three (3)-day** supply is over, providers will need to submit a Prescription Drug PA Request Form. The Alliance will review the request and will inform the doctor of the decision within **one (1) business day**.

HOW TO ACCESS THE FORMULARY

Providers can access the Alliance formularies online at www.alamedaalliance.org.

Pharmacy Prior Authorizations and Exceptions (Rx)

In some instances, a provider may want to prescribe a drug for a member that is not listed on the formulary or does not meet a step therapy restriction, quantity limit, or duration of therapy limits (as listed on the formulary). Providers can submit a prior authorization or exception request to obtain coverage for these drugs.

HOW TO REQUEST A PRIOR AUTHORIZATION OR EXCEPTION

If a drug is not listed as covered on the comprehensive formulary, it can be assumed that it requires prior authorization or exception.

Prescribers can be proactive with obtaining prior authorization or exception approvals to ensure continuity of care. Prescribers do not have to wait until the claim is rejected at the pharmacy to initiate a request. Once the request is received and approved, an

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

authorization will be entered into the pharmacy claims system. The patient can fill the prescription at any network pharmacy without further involvement by the provider or the pharmacist.

Providers should submit a prior authorization or exception request using the Prescription Drug PA Request Form. It is important to document the appropriate clinical information that supports the medical necessity of the requested drug, quantity, refill frequency, and/or duration of therapy. A determination decision will be made within regulatory time frames per the member's line of business. The Prescription Drug PA Request Form can be found on the Alliance website at **www.alamedaalliance.org**.

Prior authorization requests for Group Care can be submitted by fax to PerformRX at **1.855.811.9329** (24 hours a day, 7 days a week) or by calling toll-free at **1.855.508.1713** (Monday – Friday, 8:30 am – 5:30 pm PT).

Prior authorization requests for [DSNPD-SNP/Alameda Wellness] can be submitted by fax (24 hours a day, 7 days a week) to PerformRX at **1.855.5081714** for Standard requests and **1.855.806.6237** for Urgent requests or by calling toll-free at **1.833.793.3767** (24 hours a day, 7 days a week Monday – Friday, 8:30 am – 5:30 pm PT).

To file a prior authorization request or formulary exception request providers can:

- Submit an ePA via your Electronic Health Record (EHR) platform
- Call PerformRx Prior Authorization line at <XXXX>
- Fill out the online form available at <XXXXXX>
- Print and submit form for Request for Medicare Prescription Drug Coverage Determination available at <XXXXXX>

PRIOR AUTHORIZATION AND EXCEPTION REVIEW PROCESS

All prior authorization and exception requests are initially reviewed by PerformRX for the Group Care line of business. Requests that cannot be approved by PerformRX are forwarded to the Alliance clinical pharmacy staff for review.

The Alliance reviews the request against the following resources:

- Drug request guidelines (approved by P&T Committee)
- Evidence of Coverage (EOC)
- Evidenced-based treatment guidelines
- External specialist review based on medical necessity
- Medical director review based on medical necessity
- Prior use of formulary alternative

PRIOR AUTHORIZATION AND EXCEPTION DENIALS

If a request for prior authorization or exception is denied, the member and requesting

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

provider will be notified by mail and have the right to appeal per the Alliance guidelines as described in Section 2249: Grievance and Appeals.

PRIOR AUTHORIZATION TURN AROUND TIMES:

In general, Alliance will make a decision about prior authorization or coverage determination requests within the timeframes in the table below. Providers can request that a request be expedited if the member's health could be seriously harmed by waiting the full timeframe for a decision. If the request is for a formulary exception, the timeframe to make a decision will start upon receipt of receiving the prescriber's supporting statement.

<u>Request Type</u>	<u>Medi-Cal</u>	<u>Group Care</u>	<u>Wellness ~~DSNPD-SNP~~</u>
<u>Urgent Medical Drug</u>	<u>72 hours</u>	<u>72 hours</u>	<u>24 hours</u>
<u>Urgent Prescription Drug</u>	<u>Submit to Medi-Cal Rx</u>	<u>24 hours</u>	<u>24 hours</u>
<u>Routine Medical Drug</u>	<u>5 business days</u>	<u>5 business days</u>	<u>72 hours</u>
<u>Routine Prescription Drug</u>	<u>Submit to Medi-Cal Rx</u>	<u>24 hours</u>	<u>72 hours</u>

EMERGENCY SUPPLY FOR DRUGS REQUIRING PRIOR AUTHORIZATION

Dispensing pharmacists can dispense up to a **three (3)-day** supply of non-formulary drug(s) using the emergency supply override while waiting to obtain prior authorization for Group Care members. Dispensing pharmacists should only utilize this override for use of alleviation of severe pain and/or treatment of unforeseen medical conditions, which, if not treated immediately, would lead to disability or death. Pharmacies can enter a universal code in the prior authorization field for the override.

For the most current override code, please contact PerformRX or consult the operating manual available online. The use of this code will be monitored.

A Prescription Drug PA Request Form must be submitted to PerformRX by the following business day for approval of the balance of the prescription.

Pharmacy Network (Rx)

The Alliance pharmacy network includes most retail pharmacies in addition to a small selection of specialty pharmacies. The pharmacy network serves Group Care members.

LOCATING A NETWORK PHARMACY

To find a nearby Alliance network pharmacy, please visit **www.alamedaalliance.org**.

Injectables (Rx)

SELF-ADMINISTERED

Self-administered injectables are dispensed by specialty pharmacies through the pharmacy benefit. The injectables are managed through the usual formulary management process. The Alliance contracts with select specialty pharmacies to provide most of the self-administered injectables and as such, claims will be denied at retail pharmacies unless there is a prior authorization. Some self-administered injectables, like insulin, are listed in the formulary and are handled by retail pharmacies. For the most current specialty pharmacies' contact information and the specialty pharmacy restricted drug list, please visit our website at www.alamedaalliance.org.

PROVIDER-ADMINISTERED DRUGS (PHYSICIAN ADMINISTERED DRUGS (PAD)

Provider-administered injectables can be processed as a medical benefit or as a pharmacy benefit through Alliance specialty pharmacies. Injectables procured directly by the provider should be billed directly to the Alliance as a medical claim. Injectables procured through specialty pharmacies are processed directly through the PBM; providers do not need to submit a separate claim. Provider-administered drugs (PAD) billed through the medical benefit may be subject to prior authorization. More information about submitting prior authorization requests may be found Section 6 Utilization Management.

Providers are encouraged to use the specialty pharmacies to order the available physician-administered injectables (refer to the specialty pharmacy restricted drug list). The specialty pharmacies can deliver directly to providers' offices. For more information on how to order from specialty pharmacies please visit our website at www.alamedaalliance.org.

Medicare Covered Medical Prescription Drugs (Medicare Part B Drugs)

Prescription drugs that are covered under Original Medicare are also covered for Alliance [DSNPD-SNP](#) members. Examples of drugs covered under Part B include:

- Drugs that usually are not self-administered by the member and are injected while receiving physician services.
- Drugs used with durable medical equipment (such as nebulizers) for use in the home.
- Clotting factors self-administered by a member that has hemophilia.
- Immunosuppressive drugs if the member had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if the member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and the member cannot self-administer the drug.
- Antigens.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

- Certain oral anti-cancer drugs and anti-nausea drugs.
- Insulin when administered via an insulin pump.
- Erythropoietin by self-injection if the member has end-stage renal disease, receives home/outpatient dialysis, and needs this drug to treat anemia.

Opioid Overutilization Monitoring Program (Drug Management Program, DMP)

CMS mandates that Part D sponsors must employ effective concurrent and retrospective drug utilization review (DUR) programs to address overutilization of medications – specifically to address opioid overutilization among its Part D members. CMS recognizes “overutilization” as: filling of multiple prescriptions written by different prescribers at different pharmacies for the same or therapeutically equivalent drugs in excess of all medically accepted norms of dosing. Members with a history of opioid-related overdose may also be included in this program. For more information about the Alliance opioid overutilization monitoring program, refer to [the CMS website at https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d](https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d). XXXX. Additional information is available <Improving Drug Utilization Review Controls in Part D | CMS>

Medication Therapy Management Program (MTMP)

The Alliance Medication Therapy Management Program (MTMP) is a no-cost program aimed at improving medication use and therapeutic outcomes. Alliance partners with Outcomes Operating, Inc. to administer the MTMP.

Certain members who have chronic diseases, take multiple medications, and have high cost for medications are enrolled in the program. Members also qualify if identified as an at-risk beneficiary (ARB) under the plan’s Drug Management Program for potential misuse of opioid medications. The Outcomes CMR is an interactive, person-to-person consultation with an MTM provider. The provider reviews the member’s medications, including prescription, non-prescription, samples, and herbals/supplements. At the conclusion of the CMR, an individualized, written summary of the interactive consultation is provided to the member, caregiver or other authorized representative (if applicable) and any drug therapy problems identified are resolved with the beneficiary and the prescriber, as appropriate. Targeted medication reviews (TMR) are also performed to help identify and resolve medication related problems. Our program complements the care patients receive from their physicians and does not interfere with the doctor-patient relationship. Additional information is available at <insert link to MTM webpage>.

Real-Time Prescription Benefit

The Real Time Benefit program by PerformRx allows providers to instantly access up-to-date prescription coverage and pricing information at the point of care, ensuring patients receive cost-effective and appropriate medication. Prescribers can see which drugs require prior authorization and evaluate therapeutic alternatives for patients. The Real-Time Prescription Benefit program can be integrated within your existing electronic prescribing workflow. For additional information please contact PerformRx at <XXXXXX>

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

~~Section 20:~~ Section 21: **Clinical Laboratory Services** **(PS)**

Alliance clinical laboratory services are contracted through Quest Diagnostics, which includes multiple testing sites throughout Alameda County. This section covers how to obtain clinical laboratory services for Alliance members.

Outpatient Laboratory Services **(PS)**

Most outpatient laboratory services must be provided through Quest Diagnostics.

Providers should send members or specimens to Quest Diagnostics for all laboratory testing except:

- Genetic, chromosomal, and alpha-fetoprotein prenatal testing
- HIV testing
- Members who are assigned to the Alameda Health System (AHS) Network*
- Renal tests performed at a dialysis center
- Tests that are included in the PCP capitation contract
- Tests that are provided through alternative sites described on the following pages

*Members with an AHS PCP assignment will use AHS outpatient laboratory facilities.

QUEST DIAGNOSTICS LAB SERVICES

Quest Diagnostics lab services and programs include:

- Two (2) four (4)-hour STAT testing services
- Client services available 24 hours a day, 7 days a week
- Courier service
- Custom ICD-10 Requisition Program
- Quest Express – Same-day testing service
- Supplies

QUEST DIAGNOSTIC LAB SERVICES

For courier service, STAT pickup, or will call, please call toll-free at **1.866.697.8378**.

QUEST DIAGNOSTICS CLIENT/PATIENT LAB SERVICES

Quest Diagnostics representatives are available Monday – Friday, 8 am – 5 pm, toll-free at **1.866.697.8378**.

Laboratory Procedures in the PCP Office **(PS)**

ASSIGNED MEMBERS

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

PCPs may perform certain, specific laboratory tests in their offices. These services need to be documented and submitted to the Alliance. All other tests must be sent to Quest Diagnostics.

NON-ASSIGNED MEMBERS

PCPs who provide laboratory services that are normally capitated to a member who is not assigned to them should submit an FFS claim when:

- Diagnosing or treating a sexually transmitted disease
- Providing family planning services
- Providing minors with consent services
- The services are for a member not assigned to any PCP
- The test has received prior authorization

Part 3. Care Management

~~Section 21:~~ Section 22: Care Management

Measuring and Improving Plan Performance (HEDIS®) (Q1)

Health Effectiveness Data Information Set (HEDIS®) measures are developed by a national group of health care experts, issued annually, and used as a standard across the country. Using HEDIS® measures, the Alliance can compare its performance against other managed care plans. HEDIS® study methodology and results are also validated and audited by an external agency.

HEDIS® studies use data submitted by providers on their claims/encounter forms and may be supplemented with data retrieved from providers' medical records. The Alliance makes every effort to request records or schedule HEDIS® data retrieval for all studies at the same time and only once each year.

Measuring and Improving Plan Performance (CAHPS and HOS)

The Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey and HOS (Health Outcomes Survey) are consumer satisfaction surveys that health plans including the Alliance are required by the Centers for Medicare and Medicaid Services to administer annually. It is required that the surveys are administered by an approved CMS vendor, with results carrying a direct impact on the CMS Medicare Part C & D Star Ratings. By thoroughly understanding the survey questions, providers and staff can better comprehend how regulating entities evaluate member experiences.

Questions in the CAHPS survey cover:

- Annual Flu Vaccine
 - Have you had your flu shot?
- Care Coordination
 - In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
 - In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
 - In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
- Getting Appointments and Care Quickly
 - In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
 - In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic?
 - Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
- Getting Needed Care
 - In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
 - In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
- Getting Needed Prescription Drugs
 - In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- Rating of Health Care Quality
 - Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months

Questions in the HOS survey cover the following categories are available by request at hosonline.org:

- Improving Bladder Control
- Improving/ Maintaining Mental Health
- Improving/Maintaining Physical Health
- Monitoring Physical Activity
- Reducing Risk of Falling

The Alliance is invested in the success of providers, experience of the members, and improvement of health outcomes. [Please connect with us at providerservices@alamedaalliance.org](mailto:providerservices@alamedaalliance.org) to learn how you might enhance members' experience and their journey to meet their wellness goals, please email providerservices@alamedaalliance.org.

QUALITY IMPROVEMENT ACTIVITIES

In addition to HEDIS® measures, the Alliance has several monitoring responsibilities for its ~~Medi-Cal~~ members. The Quality Improvement Health Equity (QIHE) Program examines data from internal studies in such areas as access (e.g., waiting times for appointments, adequacy of provider network), coordination and continuity of care, utilization, and members' rights. Providers play an important role in our QIHE Program and are required to cooperate with the Alliance quality improvement activities to improve the quality of care and services and member experience. Cooperation includes the collection and evaluation of data and participation in the organization's QIHE programs. Activities related to the QIHE Program, including the program description, work plan, and evaluation, are posted on the Alliance website at [\(https://www.alamedaalliance.org/provider/quality/\)](https://www.alamedaalliance.org/provider/quality/). Further, the QIHE Committee, which is a standing committee of the Board of Governors, has meeting materials and policies and procedures posted for review (<https://alamedaalliance.org/about/standing-committees/>).

The results of HEDIS® and internal studies for the plan's ~~Medi-Cal~~ members are the basis of planned quality improvement activities. Mandated by the Federal Balanced Budget Act for Medicaid and Medicare health plans, quality improvement activities are aimed at producing statistically significant and sustained improvement in an important aspect of health care delivery or clinical outcome.

An External Quality Review Organization (EQRO) contracted with the Department of Health Care Services validates the Alliance's quality improvement activities. This external review process may also involve requests for member medical records from providers and/or site visits. Providers are required to cooperate with the Alliance quality improvement activities to improve the quality of care and services and member experience. Cooperation includes the collection and evaluation of data and participation in the organization's QIHE programs.

Failure to comply with the Quality Improvement Health and Utilization Management Programs, including but not limited to authorization procedures, site visits, recredentialing, corrective action plans, and grievance procedures may result in actions taken by the Alliance and/or termination.

Alliance Measures of Provider Performance (QI)

Giving providers feedback about their performance in relation to their peers has proven to be a powerful tool to move behavior toward the best practice.

Alliance providers allow the plan to use provider performance data in quality improvement activities and to conduct the Alliance QIHE Program.

The Alliance QIHE Program includes systems to recognize providers based on:

- Partnership behaviors that assist the plan in the measurement and management

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

of health.

- Clinical practices that are linked to improved health outcomes for members.

The data collected from the claims and encounter data are used to measure a provider's clinical practice. The diagnoses and procedure codes documented on these forms are crucial to accurate profiling. Missing, inaccurate, or non-specific codes significantly impact systems such as the reporting of annual HEDIS® measures.

Accurate coding of diagnoses and procedures affects the quality profile.

PROVIDER QUALITY REPORT

~~As part of the QIHE Program, the~~ Alliance compiles a provider quality report for each PCP undergoing re-credentialing.

The report summarizes a range of provider statistics and activities available from the following areas:

- Member complaints
- Member satisfaction surveys
- Quality reviews
- Site review score

Care Management Programs (CMDM)

Alliance Care Management Programs coordinate with providers and community partners to improve health outcomes and the integration of care for all our members across medical and behavioral health and social services. Care Management Programs address the patient's health care needs across the continuum of care from well-being to end of life, through the identification, assessment, development, and execution of targeted, evidence-based, individualized care plans.

PROGRAM GOALS

- Improve health outcomes for the Alliance patient population
- Identify and document measurable member-specific health goals and plan of care
- Facilitate coordination of care and services to meet member health needs
- Enhance the patient-to-provider relationship
- Reduce unnecessary medical utilization
- Avoid readmissions
- Reduce avoidable emergency department visits
- Manage chronic conditions

INTERVENTIONS

Interventions include the following:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Coordinate with the providers of care about progress toward or lack thereof, the plan of care.
- Assess member needs through Health Risk Assessments (HRAs)
- Develop individualized care plans that address member health and social needs.
- Review and analyze utilization data for opportunities for improved care management and coordination.
- Work in partnership with community agencies and health practitioners who provide case/care management and services to our members.
- Assist members in obtaining measurable health outcome goals through educating and facilitating access to services and community resources.
- Select targeted members for specific Care Management Programs through predictive modeling methodologies.
- Empower and educate members with resources and information to self-manage their health conditions.
- Deliver member-centric coordination of care across the continuum.

PROGRAMS

- Care Planning Coordination: HRAs & Care Plans
- Basic Population Health Management (PHM)/Care Coordination
- Complex Case Management (CCM)
- Enhanced Care Management (ECM)
- Disease Management
- Transitional Care Services

Basic Population Health Management (CMDM)

The PCP retains primary responsibility for coordinating the member's overall health care and has the responsibility and authority to direct and coordinate the member's services. The Alliance supports the PCP in care coordination by providing the Basic Population Health Management (PHM) program to ensure that needed programs and services are made available to each member at the right time and in the right setting.

INTERVENTIONS

Interventions include, but are not limited to:

- Access to primary care
- Care coordination
- Case manager services for children under EPSDT
- Chronic disease programs
- Information sharing
- Navigation and referrals across health and social services
- Programs focused on improving maternal health outcomes
- Services provided by community health workers (CHWs)
- Wellness and prevention programs

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Care Coordination (CMDM)

The Care Coordination Program helps members identify their needs and develop a plan for meeting those needs. Members' needs are identified by HRAs and other member-centric information provided to the Alliance.

INTERVENTIONS

Interventions include, but are not limited to:

- HRAs: Assessment of the member's current health and functional status
- Care plans: Setting individualized goals and interventions.
- Self-management tools
- Mailing materials to members based on need.
- Member education
- Providing mailed and verbal coaching appropriate for the member
- Referrals to other Alliance programs when appropriate
- Coordinated care both within the Alliance and with community partners.

Complex Case Management (CCM) (CMDM)

The Complex Case Management (CCM) Program aims to intensively manage and coordinate care for members who have multiple chronic conditions, require extensive use of resources, and need help navigating the system to facilitate the appropriate delivery of care and services. CCM referrals may originate from any source including, but not limited to, self-referral, caregivers, PCPs or specialists, discharge planners at medical facilities, health information line referrals for Group Care members, and internal department referrals, including but not limited to, such as the Alliance UM Department, and the Alliance Member Services Department.

CRITERIA

CCM criteria include:

- Typically severe degree and complexity of the member's illness.
- Typically intensive level of management necessary.
- Typically extensive amount of resources required for the member to regain optimal health or improved functionality.

The Alliance's goals and intervention schedule for completion shall guide the care manager in managing the case. Additionally, the member shall be provided with the name and number of the CM to contact as needed.

The CM will perform the following:

- Evaluate cultural and linguistic needs, preferences, or limitations.
- Evaluate visual and hearing needs, preferences, or limitations.
- Address the availability of caregiver resources and their involvement with the member.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Address available benefits and any needs for community and financial resources.
- Provide the member with available programs, resources, and program requirements based upon their and their caregiver's preferences and desired level of involvement in their plan of care.
- Make and follow up on referrals to resources. Follow-up on all referrals will be scheduled at the time of the referral and can be combined as part of the next monthly contact, if not considered urgent.
- Contact the member monthly, at a minimum, or more frequently based on the needs of the member and the referrals made. Each contact includes an assessment of the member's progress toward the goals, an evaluation of the barriers to the goals, and adjusting the care plan and its goals, as needed.
- Continually update and evaluate the Care Plan based on the member's need and using information from ongoing screenings and assessments.

Community Health Worker (CHW) Services (Housing & Community)

Beginning, Friday, July 1, 2022, community health worker (CHW) services became a Medi-Cal covered benefit.

The California Department of Health Care Services (DHCS) defines CHW services as preventive health services to prevent disease, disability, and other health conditions or their progression; prolong life, and promote physical and mental health. CHWs may include individuals known by several job titles, such as promoters, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

Contracted licensed providers, hospitals, outpatient clinics, local health jurisdiction (LHJ), or community-based organizations may submit claims for CHW services as long as the supervising provider meets the credentialing requirements. This includes submitting a completed Supervising Provider Attestation for Community Health Workers Form. Please refer to Section 20: Credentialing Process.

For more information on the benefit and/or Medi-Cal billing requirements, refer to the DHCS ALL PLAN LETTER (APL) 22-016 (and any subsequent related APL).

Enhanced Care Management (ECM) (CMDM)

The Alliance covers Enhanced Care Management (ECM) services for Medi-Cal members with highly complex needs. ECM is a benefit that provides extra services to help members get the care they need to stay healthy. ECM helps coordinate primary care, acute care, behavioral health care, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to available community resources.

If a member qualifies, they may be contacted about ECM services. Members and providers can also call the Alliance to find out if a Medi-Cal member qualifies and how they can receive ECM services.

COVERED ECM SERVICES

Members who qualify for ECM will have their own care team, including a care coordinator to coordinate with members, doctors, specialists, pharmacists, case managers, social services providers, and others to make sure everyone works together. There is no cost to the member for ECM services.

ECM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

Members can be referred by their provider by calling:

Alliance Case Management Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4512**

Toll-Free: **1.877.251.9612**

[If you cannot hear or speak well](#) [People with hearing and speaking impairments](#)
(CRS/TTY): **711/1.800.735.2929**

California Integrated Care Management (CICM)

The Alliance covers California Integrated Care Management (CICM) services for [DSNPD-SNP](#) members with highly complex needs.- CICM is a benefit that provides extra services to help members get the care they need to stay healthy. -CICM helps coordinate primary care, acute care, behavioral health care, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to available community resources.

If a member qualifies, they may be contacted about CICM services. Members and providers can also call the Alliance to find out if a member qualifies and how they can receive CICM services.

COVERED CICM SERVICES

Members who qualify for CICM will have their own care team, including a care coordinator to coordinate with members, doctors, specialists, pharmacists, case

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

managers, social services providers, and others to make sure everyone works together. There is no cost to the member for CICM services.

CICM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

Members can be referred by their provider by calling:

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Toll-Free: 1.877.251.9612

If you cannot hear or speak well (CRS/TTY): 711/1.800.735.2929

Disease Management (CMDM)

The Alliance has four (4) disease management programs based on patient population needs and prevalence. These programs are offered to Alliance members with a diagnosis of asthma, diabetes, high blood pressure, or [perinatal](#) depression. These programs aim to address gaps in care, prevent complications related to chronic disease, promote health equity, and improve the health and well-being of members. The programs provide education, chronic care management, patient activation, and coordination of care.

All program interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified by claims, pharmacy, and lab data, as well as direct referrals from physicians or community partners.

Happy Lungs – Serves members who are 18 years or younger and identified with low-risk asthma based on clinical, pharmacy, and utilization data or direct referral. The members (and their caregivers) will receive an educational letter entitled “Happy Lungs” and an invitation to engage in pediatric asthma services.

Living Your Best Life with Asthma – Serves members who are 19 years or older with asthma based on clinical, pharmacy, and utilization data or direct referral. The members will receive an educational letter entitled “Living Your Best Life with Asthma” and an invitation to engage with the Alliance for additional resources.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at 1.510.747.4510. Visit us online at www.alamedaalliance.org.

Living Your Best Life with Diabetes – Serves members living with diabetes who are 19 years of age or older and identified based on clinical, pharmacy, and utilization data or direct referral. The members will receive an educational letter and an invitation to access diabetes management programs. Members identified with diabetes at a higher risk of worsening outcomes will also receive an outreach call.

Living Your Best Life with a Healthy Heart – Serves members 19 years or older with high blood pressure based on clinical, pharmacy, and utilization data or direct referral. These members will receive an educational letter and an invitation to engage with the Alliance for additional resources. Members identified with high blood pressure at a higher risk will also receive an outreach call.

BirthWise Wellbeing – Serves members between the ages of 18-50 who are pregnant or have given birth within the past year. These members will receive an educational flyer on perinatal depression and the Alliance Baby Steps educational materials for a healthy pregnancy. Members will be informed of how they can engage with the Alliance for additional resources. Members identified as higher risk for depression may also receive an outreach phone call.

Providers can refer members by completing and sending the Alliance Case and Disease Management (CMDM) – Program Referral Form. To access the form, please visit the Alliance website at- www.alamedaalliance.org/providers/provider-forms.

Alliance members may also self-refer.

Please advise Alliance members to call:

Alliance ~~Member Services~~ Case Management Department

Monday – Friday, 8 am – 5 pm

~~Phone Number: 1.510.747.4567~~

~~Toll-Free: 1.877.932.2738~~ Phone Number: 1.510.747.4512

Toll-Free: 1.877.251.9612

If you cannot hear or speak well ~~People with hearing and speaking impairments~~

(CRS/TTY): 711/1.800.735.2929

Diabetes Prevention Program (DPP) **(HCS)**

The Diabetes Prevention Program (DPP) is a Medi-Cal benefit that helps eligible members adopt healthy habits, lose weight, and significantly decrease their risk of developing type 2 diabetes. It is currently not available for Group Care members.

ELIGIBILITY

- Patient must be **18 years of age** or older
- Overweight; and
- At risk for type 2 diabetes

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

PROGRAM DETAILS

- Members are assigned a lifestyle health coach that helps them set goals and stay on track.
- The first 6 months of the program year includes 16 weekly sessions, followed by monthly sessions for the remainder of the year.
- The second year includes monthly sessions if the member achieves attendance and weight-loss goals.
- Members may receive up to \$100 in gift cards as an incentive for participation.

The DPP curriculum is approved by the Centers for Disease Control and Prevention (CDC). The program is available online only, in both English and Spanish.

The program is only available online. For more details on program eligibility or to Providers can refer members to the DPP by downloading and completing the Provider Wellness Form. This form can be found on~~view and download the referral form, please visit~~ **www.alamedaalliance.org/providers/patient-health-wellness-education.**

Alliance members may also self-refer.

Please advise Alliance members to call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**

If you cannot hear or speak well ~~People with hearing and speaking impairments~~
(CRS/TTY): **711/1.800.735.2929**

Alliance members with Medi-Cal may also take a risk quiz and enroll. Please refer them to the Alliance website at **www.alamedaalliance.org/live-healthy/dpp.** ~~The DPP curriculum is approved by the Centers for Disease Control and Prevention (CDC). The program is available in English and Spanish.~~

Medicare Diabetes Prevention Program (MDPP) (HCS)

The Medicare Diabetes Prevention Program (MDPP) is a Medicare benefit covered once in a member's lifetime by for Alameda Alliance Wellness members. It helps eligible members adopt healthy habits, lose weight, and significantly decrease their risk of developing type 2 diabetes.

ELIGIBILITY

In order to participate, all of these conditions must apply:

- Within 12 months before attending the first core session, have either a:
- Hemoglobin A1c test result between 5.7% and 6.4%;

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org.**

- Fasting plasma glucose of 110-125mg/dL; or a
- 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test).
- Have a body mass index (BMI) of 25 or more (BMI of 23 or more if the member is Asian).
- Have never been diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease.
- Have never participated in the MDPP.

PROGRAM DETAILS

- Members are assigned a lifestyle health coach that helps them set goals and stay on track.
- The first 6 months of the program includes 16 weekly sessions, followed by monthly sessions for the remainder of the year.
- The second year includes monthly sessions if the member achieves attendance and weight-loss goals.

The MDPP curriculum is approved by the Centers for Disease Control and Prevention (CDC). The program is available online via distance learning only.

Providers can refer members to the MDPP by downloading and completing the Provider Wellness Form. This form can be found on www.alamedaalliance.org/providers/patient-health-wellness-education.

Alliance members may also self-refer.

Please advise Alliance members to call:

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: 1.510.747.4567

Toll-Free: 1.877.932.2738

If you cannot hear or speak well (CRS/TTY): 711/1.800.735.2929

Alliance members with Medi-Cal may also take a risk quiz and enroll.

Please refer them to the Alliance website at www.alamedaalliance.org/live-healthy/dpp.

Transitional Care Services (HCS)

Care transitions are defined as a member transferring from one (1) setting or level of care to another, including but not limited to discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC)

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settings.

Under Population Health Management (PHM) and in line with CalAIM, the Alliance is accountable for providing strengthened Transitional Care Services (TCS) to all members, across all settings and delivery systems. Members are supported from discharge planning until they have been successfully connected to all needed services and supports. This is accomplished by ensuring that a single point of contact can assist members throughout their transition and ensure all required services are complete.

TCS HIGHLIGHTS

TCS highlights include:

- Connecting the patients to their Alliance PCPs, including facilitating discharge follow-up appointments
- Coordination of care services
- Facilitating referrals to social service organizations
- Facilitating referrals to necessary at-home services
- Medication reconciliation
- Providing education and symptom management
- SUD and ~~mental health~~ treatment referral

You can refer members to Alliance programs through the following:

Case and Disease Management

Phone Number: **1.877.251.9612**

Fax: **1.510.747.4130**

Referral Form: www.alamedaalliance.org/members/medi-cal/cmdm

Infertility Services (HCS)

STANDARD FERTILITY PRESERVATION SERVICES

Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345, and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.557. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).

For Medi-Cal members, fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.

Reconstructive Surgery (HCS)

Reconstructive surgery that is medically necessary is available to beneficiaries.

Reconstructive surgery is “surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function. (B) to create a normal appearance, to the extent possible” (Health and Safety Code § 1367.63m (c) (1) (A) (B)), or (C) to treat gender dysphoria.

Cosmetic surgery, defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance, is not a covered benefit.

Reporting Provider-Preventable Conditions (PPCs) (HCS)

BACKGROUND

~~Beginning Sunday, July 1, 2012, F~~ederal law requires that all providers report provider-preventable conditions (PPCs) that occurred during the treatment of Medi-Cal patients. Providers must report all PPCs that are associated with claims for Medi-Cal payment or with courses of treatment given to a Medi-Cal patient for which payment would otherwise be available.

Providers do not need to report PPCs that existed prior to the provider initiating treatment for the beneficiary.

The Federal Affordable Care Act section 2702 and Title 42 of the Code of Federal Regulations, sections 447, 434, and 438 also require that Medi-Cal and Medi-Cal Managed Care plans no longer reimburse providers for PPCs that occur during the treatment of Medi-Cal patients. The Alliance will investigate all reports of PPCs, including those it discovers through any means, to determine if payment adjustment is necessary.

INTERESTED PROVIDERS MAY READ THE STATE PLAN AMENDMENT FOR PPCS, WHICH TOOK EFFECT SUNDAY, JULY 1, 2012.

REPORTING REQUIREMENTS

For Alliance Medi-Cal members, providers should use the Department of Healthcare Services (DHCS) new secure online reporting portal to report PPCs to DHCS. Please see the instructions about using the portal, which includes the link to the online portal (https://www.dhcs.ca.gov/individuals/Pages/Al_PPC.aspx). Providers are required to send a copy of all PPCs submitted to the online portal to the Alliance. ~~providers must report directly to the Alliance using the PPC reporting form within five (5) working days of discovery of the PPC and confirmation that the patient is a Medi-Cal beneficiary. The PPC reporting form is attached and instructions for completing the form are included.~~

Please submit a copy of all PPCs submitted to DHCS ~~forms~~ to:

Alliance Compliance Department

Fax: **1.510.373.5999**

Email: **compliance@alamedaalliance.org**

Please Note: Reporting PPCs for a Medi-Cal beneficiary does not preclude the reporting of adverse events and health-care-associated infections (HAI) to the California Department of Public Health (DPH) pursuant to the Health and Safety Code.

~~Section 22:~~Section 23: **Grievance and Appeals** **(G&A)**

The Alliance maintains a grievance and appeals process under which members may submit their grievance or appeal to the Alliance in accordance with state and federal regulations. The Alliance does not delegate the resolution of grievances and appeals.

Providers are to comply with the grievance and appeals process in accordance with their contract. Failure to comply with our grievance and appeals process may lead to corrective action plans or a possible hold on member assignment.

DEFINITIONS

Grievance – A written or oral expression of dissatisfaction with regard to the Alliance and/or provider, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by a member or the member's representative.

PLEASE NOTE: An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include but are not limited to, questions pertaining to eligibility, benefits, or other managed care plan processes. Where the Alliance is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Adverse Benefit Determination – Defined to mean any of the following actions taken by a managed care plan (MCP):

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure to act within the required time frames for standard resolution of grievances and appeals.
- For a resident of a rural area with only one (1) managed care plan, the denial of the beneficiary's request to obtain services outside the network.
- The denial of a beneficiary's request to dispute financial liability.

Notice of Action (NOA) – Also known as a Notice of Adverse Benefit Determination.

Appeal – Defined as a review by the Alliance of an Adverse Benefit Determination:

- **Prior Authorization Appeal** – A request to change a prior authorization adverse determination for care or service that the Alliance must approve, in whole or in

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part, in advance of the member obtaining care or services.

- **Retro Authorization Appeal** – A request to change a prior authorization adverse determination for care or services that have already been received by the member.

MEMBER GRIEVANCE PROCESS

A member may file a grievance:

- Medi-Cal Members – At any time following any incident or action that is the subject of their dissatisfaction.
- Group Care Members – Within **180 calendar days** following any incident or action that is the subject of their dissatisfaction.

The Alliance does not discourage the filing of grievances. A member who files a grievance may not be discriminated against, and cannot be disenrolled from the Alliance, the provider group, the provider's office, or the facility in retaliation for filing a grievance.

Provider Assistance for Filing Member Grievances

The Alliance is responsible for processing and resolving all grievances.

When a provider has become aware that a member is dissatisfied with the delivery of care that has been provided, please provide the following information to the member:

- The member can state that they would like to file a grievance with the Alliance by calling:

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well ~~People with hearing and speaking impairments~~ (CRS/TTY): **711/1.800.735.2929**

- For D-SNP, the member can state that they would like to file a grievance with the Alliance by calling:

Alameda Alliance Wellness Customer Services (D-SNP)

Monday – Sunday We are open (seven (7) days a week), 8 am – 8 pm

Phone Number: **1.510.747.4508**

Toll-Free: **1.888.88A.DSNP1.888.882.3767**

(1.888.882.3767/1.888.88A.DSNP)

If you cannot hear or speak well, use (CRS/TTY): or call **711/**

1.800.735.2929

- Contracted provider offices or facilities are required to make member grievance

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forms and assistance readily available in accordance with the California Code of Regulations, Title 28 §1300.68 (b)(7).

- Providers can access the Alliance Grievance Forms by contacting:

Alliance Provider Services Department

Phone Number: **1.510.747.4510**

Email: **providerservices@alamedaalliance.org**

www.alamedaalliance.org/providers/provider-resources/grievances-appeals

MEMBER AUTHORIZATION APPEAL PROCESS

Members or their authorized representative (AR) may request an appeal of an adverse benefit determination. A provider may submit an appeal on behalf of a member for prior authorization and retro authorizations.

When submitting an appeal on behalf of a member, please provide the Alliance Grievance and Appeals Department with a copy of the authorization, denial notification, and all pertinent supporting documentation within:

- **60 days** from the date of denial for Medi-Cal members
- **180 days** from the date of denial for Group Care members

Please mail or fax all information to:

Attn: Grievances and Appeals Department

Alameda Alliance for Health

~~Attn: Grievances and Appeals Department~~

1240 South Loop Road

Alameda, CA 94502

Fax: **1.855.891.7258**

NON-CONTRACTED PROVIDER APPEALS

In accordance with CMS regulations, providers who are not contracted with a Medicare Advantage organization may file a standard appeal for a claim that has been denied, in whole or in part, but only if they submit a completed Waiver of Liability Statement (PDF). If you complete a Waiver of Liability Statement, you waive the right to collect payment from the member, with the exception of any applicable cost sharing, regardless of the determination made on the appeal.

If you appeal and we uphold the denial, in whole or in part, you will have additional appeal rights available to you including, but not limited to, reconsideration by a CMS contracted independent review entity.

RESOLUTION TIME FRAMES

In order to provide excellent service to our members, the Alliance maintains processes by which the member can obtain thorough investigation and timely resolution of their grievances with the following process:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Expedited Grievances

- Investigation and resolution within **72 hours for Medi-Cal and Group Care.**
- Investigation and resolution within 24 hours for D-SNP.
- Classification of expedited review will be considered for grievances involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Standard Grievances

- Acknowledgement of receipt received in writing or by telephone within **five (5) calendar days.**
- Resolution within **30 calendar days** from receipt of the complaint.

Expedited Appeals*

- Resolution and written notice within **72 hours.**

Standard Appeals

- Acknowledged in writing within **5 calendar days**; and
- Resolved within **30 calendar days** from receipt of the complaint.

~~*The Alliance may extend the time frame for an expedited appeals resolution by 14 calendar days in accordance with, and defined by, federal regulations.~~

The Alliance does not permit extensions for integrated reconsiderations (appeals) of Medicare and Medicaid services. The Plan will ensure that needed relevant information is obtained to make a decision. Plans need to ensure they are obtaining all relevant information needed to make a decision within the required timeframes.

For appeals, members have the right to continue receiving benefits pending the resolution of the appeal. Providers may be requested to continue approval of benefits/services pending the final resolution. The Alliance Grievances and Appeals Department will coordinate these requests with the Alliance Utilization Management (UM) Department or the delegate's UM Department.

RESOLUTION DETERMINATIONS

Grievances

- Resolved – The beneficiary's submitted grievance has reached a final conclusion.

Appeals

- Uphold – The investigation found the initial determination was correct.
- Overturn – The appeal investigation found the initial determination was not correct and therefore the determination is made to modify or approve the request

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in favor of the member. The Alliance or its delegate must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the Alliance reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. The Alliance or its delegate shall authorize or provide services no later than **72 hours** from the date it reverses the determination.

DELEGATE OR PROVIDER RESPONSIBILITIES

The Alliance is committed to ensuring thorough research and investigation in addition to compiling all applicable information pertinent to the complaint. As part of the Alliance's investigation, the provider will be required to respond in writing to the complaint and provide medical records if applicable. Written responses are to be received within **10 calendar days** for standard and **24 hours** for expedited cases or if otherwise specified in the request.

MEMBERS' RIGHTS – ADDITIONAL ACTIVITIES

Member Grievances

The member may also contact the Department of Managed Health Care (DMHC) if they have a grievance about an emergency, a grievance that has not been appropriately resolved by the Alliance, or a grievance that has not been resolved for more than **30 calendar days** for a standard complaint, and **72 hours** if expedited criteria were met.

The department also has a toll-free telephone number (**1.888.466.2219**) and a TDD line (**1.877.688.9891**) for the hearing and speech impaired.

Independent Medical Review (IMR)

The member has the right to contact DMHC and request an Independent Medical Review (IMR). Members may request an IMR if they have not initiated a State Fair Hearing (Medi-Cal only) and if the member has already completed the Alliance's grievance process. They may contact the DMHC Health Maintenance Organization (HMO) Help Center for further information toll-free at **1.888.466.2219** or people with hearing and speaking impairments (TDD) at **1.877.688.9891**.

The DMHC HMO Help Center is open 24/7 at no charge to the member. For complaint forms and instructions, please visit the DMHC website at **www.dmhc.ca.gov**.

Fair Hearing

Medi-Cal members have the right to file a State Fair Hearing with the California Department of Social Services, State Hearings Division. They may contact the State Hearings Division for further information toll-free at **1.800.743-8525** or people with

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

hearing and speaking impairments (TDD) at **1.800.952.8349**. Medi-Cal beneficiaries may also request a State Fair Hearing through the Alameda County Social Services Agency. State Fair Hearings must be requested within **120 calendar days** from the date of the “Notice of Appeal Resolution.” If you and the member want to continue treatment, you must ask for a State Fair Hearing within **10 days** from receiving an appeal response letter from the Alliance, or before the date your services will stop.

Ombudsman Assistance

Medi-Cal members can also request assistance with enrollment and other problems by contacting:

Medi-Cal Managed Care Division Office of the Ombudsman
Monday – Friday, 8 am – 5 pm, excluding holidays
Toll-Free: **1.888.452.8609**
Email: **MMCDombudsmanOffice@dhcs.ca.gov**

For **DSNPD-SNP**

Part C:

the If we deny (uphold) any part of enrollee's first appeal, their appeal automatically goes on to Appeal Level 2 where an independent review organization (IRE) will review enrollee's case.

Please Note: When a plan makes a fully favorable determination on a level 1 appeal less than 24 hours after the end of the adjudication timeframe, the plan should consider effectuating and notifying the enrollee of the favorable appeal decision (within the 24-hour period the appeal must be forwarded to the IRE) in lieu of forwarding the appeal to the IRE.

Forwarding Case Files to IRE Timeframes for Adverse and Untimely Decisions

Part C:

- Expedited- 24 hours of the decision.
- Standard Items and Services- 30 calendar days of receipt of request (or no later than expiration of extension).
- Standard Part B Drug- 7 calendar days of receipt of the request (no extension permitted).
- Standard Payment- 60 calendar days of receipt of request

Part D:

- Expedited- 24 hours of receipt of IRE's request for case files.
- Standard- 48 hours of receipt of IRE's request for case files.
- Untimely- 24 hours of the expiration of the adjudication timeframe.

If we say **No** to the member's Level 1 **Part D** Appeal (including dismissals), the member can accept our decision or make another appeal.

If a member decides to make another appeal, the member can use the Level 2 Appeal ~~appeals~~ process. The **Independent Review Organization (IRO)** reviews our decision when we said **No** to member's first appeal. This organization decides if we should change our decision.

The formal name for the "Independent Review Organization" (IRO) is the "Independent Review Entity", sometimes called the "IRE".

IRE- Independent Review Entity (Level 2)

Deadlines for a fast appeal at Level 2

- If a member's health requires it, they can ask the IRO for a fast appeal.
- If they agree to a fast appeal for drug coverage, they must give **the member** an answer **within 72 hours** after getting their appeal request.
- If they say **Yes** to part or all of **the member's** request, we must provide the approved drug coverage **within 24 hours** or **benefit coverage within 72** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If a member has a standard appeal at Level 2, the IRO must give the member an answer:

- ~~w~~**Within 7 calendar days** after they get the member's appeal for a drug they didn't get- and ~~w~~**Within 30 days for benefit coverage appeals (Part C).**
- ~~w~~**Within 14 calendar days** after getting the member's appeal for repayment for a drug they bought- and ~~w~~**Within 60 days for Part C payment appeals.**

If the IRO says **Yes** to part or all of a member's request:

- We must provide the approved ~~drug coverage~~ **drug coverage within 72 hours** after we get the IRO's decision- and ~~p~~**Provider service (Part C) within 14 calendar days.**
- We must pay the member back for a drug they bought within 14 calendar days after we get the IRO's decision- and ~~p~~**Pay for services (Part C) within 30 calendar days.**
 - If the IRO says **No** to the member's appeal, it means they agree with our decision not to approve ~~the member's~~**your** request. This is called "upholding the decision" or "turning down **the member's** appeal."

If the IRO says **No** to a member's level 2 Appeal, members have the right to a Level 3 Appeal if the dollar value ~~of the drug coverage the member asks for~~ meets a minimum dollar value. If the dollar value ~~of the drug coverage the member asks for~~ is less than the required minimum, the member can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends the member a letter that tells them the minimum dollar value needed to continue with a Level 3 Appeal.

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If the dollar value of the member's request meets the requirement, the member can choose if they want to take their appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to a member's Level 2 Appeal and they meet the requirement to continue the appeals process, they can:
 - Decide if they want to make a Level 3 Appeal.
 - Refer to the letter the IRO sent to the member after their Level 2 Appeal for details about how to make a Level 3 Appeal.

An **Administrative Law Judge (ALJ)** or attorney adjudicator handles Level 3 Appeals.

If a member made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of their appeals were turned down, they may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item the member appealed does not meet a certain minimum dollar amount, they cannot appeal any further. If the dollar value is high enough, they can continue the appeals process. The letter the member gets from the IRO for their Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

ALJ - Administrative Law Judge (Level 3)

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says Yes to the member's appeal, the Alliance ~~we~~ **has** the right to appeal a Level 3 decision that is favorable to the member.

- If we decide to appeal the decision, we send the member a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide not to appeal the decision, we must authorize or provide the member with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
 - If the ALJ or attorney adjudicator says No to the member's appeal, the appeals process may not be over.
- If the member decides to accept this decision that turns down their appeal, the appeals process is over.
- If the member decides not to accept this decision that turns down their appeal, they can continue to the next level of the review process. The notice the member gets will tell them what to do for a Level 4 Appeal.

MAC — Medicare Appeals Council (Level 4)

The Medicare Appeals Council (Council) reviews the member appeal and gives them an answer. The Council is part of the federal government.

If the Council says Yes to the member's Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to the member, ~~the Alliance~~ we have the right to appeal to Level 5.

- If we decide to appeal the decision, we will ~~inform~~ tell the members in writing.
- If we decide not to appeal the decision, we must authorize or provide the member with the service within 60 calendar days after getting the Council's decision.

If the Council says No or denies our review request, the appeals process may not be over.

- If the member decides to accept this decision that turns down their appeal, the appeals process is over.
- If the member decides not to accept this decision that turns down their appeal, they may be able to continue to the next level of the review process. The notice they get will tell them if they can go on to a Level 5 Appeal and what to do.

Federal Court (Level 5)

- A Federal District Court judge will review the member appeal and all of the information and decide Yes or No. This is the final decision. There are no other appeal levels beyond the Federal District Court.

~~Section 23:~~Section 24: **Credentialing (Credentialing)**

All health care providers who contract with the Alliance must have credentials verified through the credentialing process. This section covers the credentialing and re-credentialing requirements providers are expected to meet.

Credentialing Process (Credentialing)

The Alliance utilizes a credentialing process in order to ensure the participation of quality network providers. The Alliance follows National Committee on Quality Assurance (NCQA) guidelines in conjunction with special credentialing guidelines required by state regulation and policy.

DEPARTMENT OF HEALTH CARE SERVICES (DHCS) APL 22-013 SUPERSEDES APL 19-004

The Alliance follows the regulatory guidance specified in All Plan Letter (APL) 22-013, Provider Credentialing/Re-credentialing and Screening/Enrollment. The APL specifies that managed care plans are required to maintain contracts with their Network Providers (Network Provider Agreement) and perform credentialing and re-credentialing activities on an ongoing basis. The APL also requires the Alliance to perform pre- and post-enrollment site visits to medium- and high-risk providers to verify the information on the application (i.e., comprehensive outpatient rehabilitation facilities, hospice, and home health organizations, independent diagnostic laboratories, independent diagnostic testing facilities, durable medical equipment (DME) suppliers, and prosthetic and orthotic suppliers for initial and re-credentialing applicants).

CONFIDENTIALITY

The information obtained during the credentialing process, whether directly from the provider or from another source, will be treated as confidential information.

THE APPLICATION

Applicants must submit a signed application and supporting documentation to the Alliance. The Alliance then has ~~180~~**120 days** from the signature date on the attestation form to work with the applicant and Credentialing Committee (CC) to complete the credentialing process.

As part of the application process, providers will be asked to attest to statements regarding:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of disciplinary actions taken against the license

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- History of loss of license
- History of convictions
- History of loss or limitation of privileges or disciplinary activity at a facility
- History of professional liability judgments and/or claims that resulted in settlements or judgments paid by or on behalf of the applicant, or pending lawsuits
- Current malpractice insurance coverage

COMMUNITY HEALTH WORKERS (CHW) CREDENTIALING

Contracted providers may submit claims for CHW services as long as the supervising provider has submitted a completed Supervising Provider Attestation for Community Health Workers Form to the Alliance Housing and Community Services Department. The Supervising Provider must be a contracted licensed Provider, hospital, outpatient clinic, local health jurisdiction (LHJ), or a community-based organization (CBO).

ADDITIONAL CREDENTIALING STEPS

Facility Site Review

All PCP sites are reviewed by an Alliance Provider Relations representative and Quality Improvement nurse specialists prior to approval as an Alliance provider. For more information, please see Section 24: Facility Site Review (FSR).

Recommendation by the Credentialing Committee (CC)

The CC is a standing Alliance committee responsible for credentialing/re-credentialing Alliance network providers. The Peer Review Committee (PRC) is responsible for reviewing providers that are identified with quality of care issues.

The CC recommends the approval or denial of an applicant as follows:

- If the recommendation is for **APPROVAL**, the applicant receives written notification of the decision, and the number of credentialed and re-credentialed practitioners are reported monthly to the Board of Governors in the credentialing summary.
- If the recommendation is for **DENIAL**, the applicant receives written notification of the decision and supporting reasons. If the denial is due to the quality of medical care, the appeal process is included.

Practitioner Rights

Practitioners have the right to review the information submitted to support their credentialing application, correct erroneous information, receive the status of their credentialing or re-credentialing application, upon request, and receive notification of these rights. Practitioners are notified of these rights in the application cover letter.

Practitioners are allowed access to their credentialing documentation obtained by the Alliance Peer Review and Credentialing Department to evaluate their credentialing application, attestation, or curriculum vitae (CV) with the exception of National Practitioner Data Bank Reports, references, recommendations, or other peer-review protected information.

Practitioners are notified when credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples of the type of information that would cause the Alliance to alert the practitioner, if there are substantial variations from the practitioner's information, include actions on a license, malpractice claims history, and/or board certification decisions.

The Alliance Peer Review and Credentialing Department staff will contact the practitioner via written request (email or certified mail) of the discrepancy and the practitioner will be asked to submit corrections/explanations within **15 business days** by mail or fax to the Alliance Peer Review and Credentialing Department staff contact.

Right to receive status: Practitioners may contact the Alliance Peer Review and Credentialing Department at any time regarding the status of their application for appointment or reappointment. All such requests will be responded to within **four (4) business days** and the practitioner will be notified of progress in the credentialing process.

Credentialing Criteria and Basic Qualifications (Credentialing)

The following credentialing criteria are reviewed at initial credentialing and re-credentialing.

LICENSE

All providers must maintain a current license, which is applicable to the provider's scope of practice in the state of California. If providers have or had out-of-state licenses, the status of these licenses shall also be verified for the same qualifications. All initial providers must have an unrestricted license. All provider Medical Board actions are reviewed by the CC.

HOSPITAL ADMITTING PRIVILEGES

All providers must maintain current hospital admitting privileges with unrestricted clinical privileges at a hospital in the Alliance network. The Alliance may waive this requirement if the provider has admitting arrangements in writing through another provider in the Alliance network.

DEA CERTIFICATION

All providers must maintain a current Drug Enforcement Administration (DEA) certification, if applicable to the provider's scope of practice. The Alliance may waive this requirement if the provider's DEA certification is pending, and the provider presents documented evidence that another participating provider in the same office will write all prescriptions that require a DEA.

SPECIALTY BOARD CERTIFICATION

Specialists applying to the network must be board-certified in the specialty and subspecialty effective Tuesday, July 1, 2003, unless the provider was contracted with the Alliance prior to Tuesday, July 1, 2003. Specialists who have recently completed postgraduate training may be credentialed and will be expected to complete their board certification within the time frame set forth by the American Board of Specialties. If a Specialist is not board-certified in the specialty or subspecialty the practitioner will be reviewed by the CC and considered for network participation based on network needs.

NPDB AND HIPDB

The National Practitioner Data Bank (NPDB) checks medical malpractice claims and the license status for any state in which the physician has practiced. The Healthcare Integrity Protection Data Bank (HIPDB) collects information regarding licensure and certification actions, exclusion from federal and state health care programs, criminal convictions, and civil judgments related to health care.

PROFESSIONAL LIABILITY CLAIMS HISTORY

Information related to malpractice suits and settlements will be collected and reviewed.

CLEAR FROM SANCTIONS

The Alliance does not contract with providers who are excluded or sanctioned from participation in Medicare/Medicaid programs.

PROFESSIONAL LIABILITY INSURANCE

All participating providers must maintain professional liability insurance with limits of liability of at least \$1,000,000 per occurrence and \$3,000,000 aggregate at all times.

WORK HISTORY

All providers will be reviewed for work history at initial credentialing as obtained through their submitted application or CV.

CREDENTIALING AND ALLIANCE EFFECTIVE DATES

All providers will be entered into our system as a contracted provider once they have been approved through the credentialing process. The effective date is the first of the month following the month that the provider was credentialed.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Re-Credentialing (Credentialing)

Participating providers are re-credentialed in accordance with Alliance policy. Currently, re-credentialing occurs at least every **three (3) years** or more often as directed by the CC. The process is similar to the initial credentialing process as outlined earlier in this section.

The following performance areas will be reviewed for all providers, as applicable:

- Member complaints/grievances
- Results of quality reviews
- Facility site review results

DENIED RE-CREDENTIALING

If the CC determines that a provider does not meet re-credentialing criteria, the provider's participation in the Alliance network will be terminated pursuant to the terms of the provider service agreement. From that time onward, the provider may not submit claims to the Alliance for health services provided to Alliance members.

PROVIDERS WHO OPT-OUT OF MEDICARE

The Alliance complies with the provider contracting requirements as set forth by the Centers for Medicare and Medicaid Services (CMS). The Alliance monitors its provider network to ensure no providers are contracted with or paid when they are ineligible to receive payment by Medicare.

Individual providers who appear on the Medicare Opt-Out list will be not be added to the Alliance Wellness Plan as a network provider. If a provider was previously added to the Alliance Wellness Plan and then the Alliance becomes aware that the provider is now appearing on the opt-out list, the provider will immediately be removed. It is the responsibility of the provider group (contract holder) to be aware of providers within their practice that have opted out of Medicare. -Providers who Opt-Out of Medicare cannot see Alliance Wellness Plan members but can still see Medi-Cal only members.

The Alliance reviews the Medicare Opt-Out File Monthly and changes to remove any provider found on the list will be made as soon as it is identified.

There are no appeal rights for a provider on the Opt-Out file to the Alliance for reinstatement. -The provider must direct any follow up questions Medicare Opt-Out Website.

It should come as no surprise to the provider to be on the Medicare Opt-Out file as opting out is a provider decision.- Opting out of the Medicare program is for 2 years. Only providers within their first 90 days of Opt-Out status can request to change their status with CMS.

Should the provider no longer be included on the Medicare Opt-Out file, the provider may reapply for a contract with the Alliance. The provider must contact the Alliance Credentialing and Contracting Departments to begin the Credentialing process to be added as a provider.

Opt-out providers will not be paid for services rendered to D-SNP members while they are in Opt-Out status. Previous claims paid during an Opt-Out period, may be recovered or recouped.

~~Section 24:~~Section 25: Facility Site Review (FSR)

(QI)

All Alliance PCPs will receive periodic facility site reviews (FSRs). This section covers what to expect during a site review.

FSR Overview (QI)

DHCS mandates initial and periodic FSR and Medical Record Review (MRR) audits for PCP provider sites, and the Alliance complies with this DHCS mandate. The Alliance additionally conducts Physical Accessibility Review Surveys (PARS) for all PCP sites, specialist sites, ancillary services sites, and Community-Based Adult Services (CBAS) provider sites which provide care to a high volume of seniors and persons with disabilities (SPD).

The purpose of FSRs is to ensure that all contracted primary care provider sites:

- Provide appropriate primary health care services to members.
- Carry out processes that support continuity and coordination of care.
- Maintain patient safety standards and practices.
- Operate in compliance with all applicable local, state, and federal laws and regulations.

FSRs are conducted during the initial provider credentialing process. Additionally, site reviews will be conducted as part of the ongoing provider re-credentialing process. This process ensures that each provider continues to meet the Alliance's site review standards. The Alliance Quality Improvement (QI) Department is responsible for conducting site reviews.

FSR Preparation (QI)

The Alliance will help providers prepare for the review in several ways. Prior to a review, providers will receive a copy of the FSR and MRR tools and standards. To access the FSR Tool, MRR Tool, and other resources, please visit the Alliance website at www.alamedaalliance.org/providers/provider-resources.

Providers should review the tools and standards carefully to ensure a successful review. FSR nurses offer provider and office staff training prior to initial facility site reviews and/or upon the provider's request.

The Alliance has developed the Facility Site Review (FSR) and Medical Record Review (MRR) Preparation Checklist to assist you in meeting the standards of the site review. For help preparing your practice for the FSR, please call the Alliance Provider Services Department at **1.510.747.4510**.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

PROBLEMS IDENTIFIED THROUGH FSRs AND MRRs

If a facility is found to be out of compliance with Alliance and/or state requirements, the provider is notified through the Corrective Action Plan (CAP). For FSRs, a CAP is required for a total score of less than 90%, or for a total score of 90% or above if there are deficiencies in Critical Elements (CE), Pharmaceutical Services, or Infection Control.

For MRRs, a CAP is required for any score below 90%, or any section score below 80% regardless of the total score. A total score of 79% or below for FSRs and/or MRRs will result in a hold on new member assignments as well as follow-up reviews.

Per APL 22-017, the Alliance must not assign new members to providers who do not correct site review deficiencies within established CAP timelines. The Alliance must verify that the PCP site has corrected the deficiencies and that the CAP is closed.

CAP Timeline:

- CE CAP must be submitted within **10 business days** of review.
- FSR/MRR CAP is submitted within **30 calendar days** from the CAP Report. All CAPs must be closed within **90 calendar days** from the date of the FSR and/or MRR report.

The Alliance must remove any provider from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and the Alliance must expeditiously reassign that provider's members to other providers.

Participation in the Alliance network may be suspended until the facility meets compliance standards. If a provider's non-compliance issues present a clear and immediate danger to patients, the provider's members will be reassigned to another provider in the Alliance network. If problems are documented, providers are allowed time for correction. Failure to provide a timely response will result in a resurvey within **12 months** and/or reporting the provider's site review status to the Alliance's ~~CCC~~. They ~~CC~~ may suspend a provider from plan participation or recommend termination due to non-compliance to the Alliance ~~Board of Governors~~CC.

DHCS-CONDUCTED FSRs

DHCS conducts FSRs independently of the Alliance on a small sample of providers in the Alliance network. DHCS does this to monitor the Alliance's compliance with the DHCS contract and to determine how well provider sites are able to implement and meet the standards. DHCS-conducted FSRs may be conducted without prior notice. DHCS will notify Alliance of critical findings within **10 business days** following the date of the FSR and/or MRR and will provide a written report summarizing all DHCS review findings within **30 calendar days** following the review. Within **30 calendar days** from the date of Alliance receipt of the DHCS-conducted FSR report, the Alliance must provide a CAP to DHCS responding to all cited deficiencies documented in the report.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Should a DHCS inspector find a primary care site in substantial noncompliance, the Alliance may suspend that site from plan participation until the facility can meet compliance standards. If the provider's noncompliance issues present a clear and immediate danger to Alliance members, they will be reassigned to another provider in the Alliance network.

FSR Tool (QH)

The Alliance utilizes a Facility Site Review (FSR) Tool mandated by DHCS. The FSR Tool contains applicable state requirements. A copy of the full FSR Tool can be found on the Alliance website at www.alamedaalliance.org/providers/provider-resources.

The FSR Tool mandates review in the broad areas listed below:

- Access/Safety
- Personnel
- Office Management
- Clinical Services
- Preventive Service
- Infection Control

CRITICAL ELEMENTS

Within the FSR, there are 14 critical survey elements related to the potential for adverse effects on patient health or safety. These critical elements have a weighted score of two (2) points. All other survey elements are weighted at one (1) point.

Critical elements include:

- Exit doors and aisles are unobstructed and egress accessible
- Airway management equipment (i.e., oxygen delivery system, nasal cannula or mask, bulb syringe, and Ambu bag) appropriate to practice and populations served are present on-site
- The on-site availability of emergency medicine based on patient population served for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia (i.e., Epinephrine 1 mg/ml [injectable], and Benadryl 25 mg [oral] or Benadryl 50 mg/ml [injectable], Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication [solution for nebulizer or metered dose inhaler], and glucose); appropriate sizes of engineered sharps injury protection (ESIP) needles/syringes, and alcohol wipes
- Only qualified/trained personnel can retrieve, prepare, or administer medications
- Office practice procedures provide timely physician review and follow-up of referrals, consultation reports, and diagnostic test results
- Only lawfully authorized persons dispense drugs to patients
- Drugs and vaccines are prepared and drawn only prior to administration

- Personal protective equipment (PPE) for Standard Precautions is readily available for staff use
- Blood, other potentially infectious materials, and regulated wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing storage, transport, or shipping
- Needle stick safety precautions are practiced on-site
- Staff demonstrates/verbalizes necessary steps/processes to ensure sterility and/or high-level disinfection of equipment
- Appropriate PPE, exposure control plan, Material Safety Data Sheets (MSDS), and clean-up instructions in the event of a cold chemical sterilant spill are available on-site
- Spore testing of autoclave/steam sterilizer is completed (at least monthly) with documented results
- Staff adheres to site-specific protocol and/or manufacturer/product label for management of positive mechanical, chemical, and/or biological indicators of the sterilization process

CRITICAL ELEMENT DEFICIENCIES

All critical element deficiencies found during a full-scope site survey, focused survey, or monitoring visit must be corrected by the provider within **10 business days** of the survey date and verified as corrected by the plan within **30 calendar days** of the survey date.

HELPING PROVIDERS MEET STANDARDS

Sites that are non-compliant with the Alliance and/or state requirements are given a **30-day** period to correct identified deficiencies.

MRR Tool (QI)

The Alliance utilizes an MRR tool mandated by DHCS. The MRR Tool is separate from the FSR Tool.

The MRR Tool and MRR Standards can be found on the Alliance website at **www.alamedaalliance.org/providers/provider-resources**. The MRR Tool contains applicable state requirements. The MRR Tool mandates review in the broad areas listed below.

Please see the full MRR Tool for a detailed explanation of the six (6) criteria listed below:

- Format
- Documentation
- Coordination/Continuity of Care
- Pediatric Preventive Health Care

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- Adult Preventive Health Care
- Obstetric/Comprehensive Perinatal Services Program (OB/CPSP) Preventive Criteria

Alliance providers are required to have a medical record for each member. During an MRR, a minimum of 10 member records are audited per contracted provider. Reviewers may request additional records.

Help and Resources (Credentialing)

The Alliance wants to help all our providers meet the standards. The Alliance Provider Services Department staff and FSR nurses offer guidance and training or refer providers to resources that can help providers meet the established standards. To request assistance, please call the Alliance Provider Services Department at **1.510.747.4510**.

Provider Initial Review and Fair Hearing Process (Credentialing)

Physicians, ancillary professionals, and other providers shall be entitled to an Initial Review or Fair Hearing and Appeals proceeding when dissatisfied with certain adverse credentialing and/or participation decisions made by the Alliance, including those based on a medical quality concern.

The Initial Review and Fair Hearing process is divided into two (2) phases:

- Phase I – Initial Review: An Initial Review before the Peer Review Committee (PRC) to try to amicably resolve the matter; and
- Phase II – Formal Hearing: For Providers who are dissatisfied with the PRC Initial Review decision and eligible for a Phase II hearing, a formal hearing in front of an impartial Judicial Review Committee (JRC)

PROCEDURES FOR INITIAL REVIEW

The Alliance offers providers an Initial Review when the provider is dissatisfied with an adverse credentialing and/or participation decision made by the PRC. Decisions may include recommendations, such as practice restrictions, denial of the application, or participation in the Alliance network. The provider will be notified in writing of the PRC decision.

The provider may request an Initial Review within **30 days** of receipt of the notice of action or proposed action by PRC. A request for Initial Review must be in writing and must state the basis for the challenge, whether the provider would like to present evidence or oral testimony to the PRC, or both, whether the provider needs special accommodations and any preferred time or dates for the Initial Review within the next **60 days**.

The following procedures are followed for Initial Reviews:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- All credentialing and peer review issues shall be brought before the PRC for review and recommendation.
- Notice will be given to the provider stating the date of the initial review meeting and the provider shall have an opportunity to present their position.
- The decision of the PRC shall be binding and final if the decision was for any reason other than medical quality of care concern.
- If a decision of the PRC is based in whole or in part on medical quality of care concerns, the provider shall have the right to appeal the PRC decision to an impartial JRC through the Fair Hearing process.

FAIR HEARING PROCESS

Providers may request a Fair Hearing if they are dissatisfied with the PRC Initial Review decision and are eligible for a Phase II hearing, a formal hearing in front of an impartial JRC.

GROUND'S FOR A FAIR HEARING

One (1) or more of the following actions, or proposed actions, against a provider by the PRC after the Initial Review shall be grounds for a formal hearing before the JRC:

- Upholding the Alliance's reduction or failure to renew credentialing and/or participation based on medical quality concerns
- Upholding the Alliance's suspension or imposition of restrictions on credentialing and/or participation for a cumulative total of **30 calendar days** or more in any **12-month** period based on medical quality concerns
- Upholding the Alliance's denial or termination of credentialing and/or participation based on medical quality concern

Requesting an Appeal (Credentialing)

If the PRC recommends an adverse decision based on medical quality concerns of an initial application or re-credentialing that results in a mandatory reportable action, the practitioner will be notified in writing of this decision. The practitioner has the right to request a hearing before the JRC within **30 days** of receipt of the PRC notification. A provider who wishes, and is eligible, to file an appeal for an adverse credentialing or participation decision, the practitioner must deliver a written notice requesting a fair hearing before the JRC to the Alliance Chief Medical Officer within the time period specified.

The following procedures are followed for a Judicial Review process:

- Fair Hearings shall be brought before the JRC for review and recommendation
- Notice will be given to the provider stating the date of the JRC and the provider shall have an opportunity to present their position
- The decision of the JRC will be sent to the PRC and the practitioner
- The JRC will issue a written decision which shall include findings of fact and a conclusion within **30 calendar days** after the final adjournment of the hearing

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Requirements for Mid-Level Clinicians (Credentialing)

REQUIREMENTS FOR MID-LEVEL CLINICIANS

PCPs who employ or contract with mid-level clinicians in their practices are responsible for making sure that the clinicians meet the standards set forth by the clinician's licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. They must meet certain qualifications and standards in order to be credentialed by the Alliance. This helps ensure quality care for members.

DEFINITIONS OF MID-LEVEL CLINICIANS

Mid-level clinicians are non-physician medical practitioners, including:

- Certified Nurse-Midwives
- Nurse Practitioners
- Physician Assistants

DEFINITIONS OF BEHAVIORAL HEALTH CARE INTERNS AND ASSISTANTS

All non-licensed behavioral health providers must be supervised by a licensed behavioral health provider who is contracted with the Alliance and who also follows all California Licensing Board requirements for registration and supervision of non-licensed providers.

These providers include:

- Registered Psychological Associates (PA)
- Registered Associate Social Workers (ASW)
- Registered Associate Marriage and Family Therapist (AMFT) interns

CREDENTIALING

Any mid-level clinician, ASW, AMFT intern, or PA who provides care to Alliance members must be credentialed by the Alliance.

LICENSING REQUIREMENTS

To provide services to Alliance members, mid-level clinicians must have a valid, current license or registration issued by the state of California. Nurse-midwives must be certified by the ACNM Certification Council, Inc. Physician assistants must be licensed in accordance with the requirements of the Physician Assistant Examiners Committee.

INSURANCE

The supervising physician or licensed behavioral health care provider must submit proof that their liability insurance covers the mid-level or non-licensed PA, ASW, or AMFT clinician, or that the clinician has individual coverage.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

CPR AND ACLS CERTIFICATION

Mid-level clinicians must maintain CPR certification. They also are encouraged to obtain ACLS certification.

PHYSICIAN/CLINICIAN AGREEMENT

Each physician/mid-level clinician team must sign an agreement stating that the clinician will follow the practice protocols developed by the supervising physician. The agreements, also known as a Delegated Services Agreement and a Supervising Physician's Responsibility document, must be submitted at the time of credentialing and re-credentialing.

PROTOCOLS

Protocols must be reviewed and approved by the supervising physician annually. These protocols and any updates must be submitted to the Alliance at the time of credentialing and site reviews.

Organizational Providers (PS)

The Alliance is responsible for verification of the accreditation status, license, certification, and standing with regulatory bodies of all directly contracted organizational providers. This includes but is not limited to acute care hospitals, freestanding surgical centers, home health agencies, and skilled nursing homes that provide care to Alliance members at the time of contracting and a minimum every **three (3) years** thereafter.

Hospitals, facilities, and organizational providers must meet the following requirements to contract with the Alliance by submitting all licensing and specialty qualification documents to the Alliance for verification as part of the Alliance credentialing and re-credentialing process and demonstrate the ability to meet Alliance requirements as outlined in the Alliance Quality Improvement Health Equity Program Description, Assessment of Organizational Provider Policy, and contract provisions.

REQUIREMENTS

- Accreditation or certification reviewed and approved by an accrediting body. If not accredited, the organization must submit a copy of the CMS or state site survey.
- Clear of any sanctions, negative findings, or deficiencies.
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable.
- Completed Alliance application including attestations.
- Current malpractice/general professional liability insurance.
- Eligibility to participate in state and federal programs.
- Valid and current Medicare/Medicaid certification.
- Valid, current, and unrestricted health care/state and business licenses.

Part 4. Member Rights and Compliance

~~Section 25:~~Section 26: Member Rights and Responsibilities

As a member of our health plan, each Alliance member is entitled to certain rights.

Alliance Member Rights (NCQA)

1. To be treated with respect and dignity, giving due consideration to their right to privacy and the need to maintain the confidentiality of their medical information.
2. ~~To receive services without discrimination, consistent with federal and state civil rights laws, including Section 1557 of the Affordable Care Act.~~
1. ~~2.3.~~ To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
- 3.4. To receive fully translated written member information in their preferred language, including all grievance and appeals notices.
- 4.5. To make recommendations about the Alliance's member rights and responsibilities policy.
- 5.6. To be able to choose a primary care provider within the Alliance network.
- 6.7. To have timely access to network providers and to receive services without discrimination, consistent with federal and state civil rights laws, including Section 1557 of the Affordable Care Act.
- 7.8. To participate in decision-making with providers regarding their own health care, regardless of cost or benefit coverage, including the right to refuse treatment.
- 8.9. To voice grievances or appeals, either verbally or in writing, about the organization or the care they received.
- 9.10. To know the medical reason for the Alliance's decision to deny, delay, terminate, or change a request for medical care.
- 10.11. To get care coordination.
- 11.12. To ask for an appeal of decisions to deny, defer, or limit services or benefits.
- 12.13. To get no-cost interpreting services for their language.
- 13.14. To get legal help at their local legal aid office or other groups at no cost.
- 14.15. To formulate advance directives.
- 15.16. To ask for a State Hearing if a service or benefit is denied and they have

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already filed an appeal with the Alliance and are still not happy with the decision, or if they did not get a decision on their appeal after **30 days**, including information on the circumstances under which an expedited hearing is possible.

- ~~16-17.~~ 17. To disenroll from the Alliance and change to another health plan in the county upon request.
- ~~17-18.~~ 18. To access minor consent services.
- ~~18-19.~~ 19. To get no-cost written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- ~~19-20.~~ 20. To request Confidential Communications. A member may choose an alternate address, phone, fax, or email to receive mailings from the Alliance.
- ~~20-21.~~ 21. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- ~~21-22.~~ 22. To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand, regardless of cost or coverage.
- ~~22-23.~~ 23. To have access to and get a copy of their medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- ~~23-24.~~ 24. Freedom to exercise these rights without adversely affecting how they are treated by the Alliance, their providers, or the State.
- ~~24-25.~~ 25. To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside the Alliance's network pursuant to the federal law.
- ~~25-26.~~ 26. To access the Advice Nurse Line, anytime, 24 hours a day, 7 days a week. Medi-Cal members can call toll-free at **1.888.433.1876**. Group Care members can call toll-free at **1.855.383.7873**.
- ~~26-27.~~ 27. To access their medical records. They have the right to share the records of any telehealth services provided with their primary care doctor. These records will be shared with their primary care doctor unless they object.

Alliance Member Responsibilities **(NCQA)**

The Alliance is responsible for providing members with access to medically necessary covered services in a timely manner. Alliance members have certain responsibilities as well.

1. To treat all the Alliance staff and health care staff with respect and courtesy.
2. To give their doctors and the Alliance correct information (to the extent possible) needed to provide care.
3. To work with their doctor.
4. To learn about their health and help to set goals for their health.
5. To follow care plans and instructions for care that they have agreed to with their

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doctors.

6. To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
7. To always present their Alliance Member ID Card to receive services.
8. To ask questions about any medical condition, and make sure they understand their doctor's reasons and instructions.
9. To help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
10. To make and keep medical appointments and inform their doctor at least **24 hours** in advance when they need to cancel an appointment.
11. To use the emergency room only in case of an emergency or as directed by their doctor.

What Can You and Your Office Do to Protect Member Privacy? **(Compliance)**

- Keep PHI actively in mind and in your policies among your staff.
- Provide training for yourself and staff about privacy.
- Always verify the identity of the person requesting PHI before disclosing any information, including by phone or in person
- Develop a process to respond to privacy issues that arise (including notifying the Alliance of any breach).
- Limit transporting PHI out of your office.
- Use secure email when communicating about members with someone outside your office.
- Store and lock up records and documents containing PHI.
- Secure your office computers from unauthorized access.
- Shred physical documents that contain PHI when no longer needed.
- Keep appointment and registration sheets away from public view.
- Do not text PHI.
- Only access, use, or disclose the minimum necessary PHI needed to do your job.
- Do not leave PHI on voicemail unless the patient has given explicit consent.
- When speaking about, or to patients, in public areas use hushed tones so as not to be overheard by others

For more information about PHI and HIPAA compliance, please visit **www.hhs.gov**. If you have questions about how to improve the security and storage of member PHI or would like a copy of the privacy practices, please call the Alliance Provider Services Department at **1.510.747.4510**.

How to Protect the Protected Health Information (PHI) of Your Patients **(Compliance)**

As you are well aware, protecting the privacy of patients and their Protected Health

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Information (PHI) is a responsibility that we all share. The Alliance is committed to protecting every member's PHI, and we want to ensure that you do too!

The Health Information Portability and Accountability Act (HIPAA) clearly outlines how providers can use and disclose PHI. Additional federal and California state laws have been enacted governing the release of information, mandating that information be protected, creating new breach notification rules, and setting civil and criminal penalties and fines for the inappropriate release of PHI.

Written patient permission is required for most uses and disclosures of PHI. The exceptions generally are that PHI may be used and disclosed for the purpose of treatment, payment, and health care operations (and a few other specific exceptions).

~~Section 26:~~Section 27: **Fraud, Waste, and Abuse (FWA) and Protected Health Information (PHI)**

Overview of Fraud, Waste, and Abuse (FWA) (Compliance)

The Alliance has developed an Anti-Fraud Program to comply with federal and state regulations in preventing and detecting fraud in federal, state, or county-funded programs offered by the Alliance. Health care fraud includes but is not limited to, the making of intentionally false statements, misrepresentations, or deliberate omissions of material facts from any record, bill, claim, or any other form for the purpose of obtaining payment, services, or any type of compensation for health care services for which members are not entitled.

The objective of the Alliance's Anti-Fraud Program is to identify and reduce costs caused by fraudulent activities and to protect members, health care providers, and others in the delivery of health care services.

The Alliance Compliance Officer and Compliance Committee oversees its Anti-Fraud Program and manages suspected fraud and abuse reporting. The Alliance reports its fraud/abuse prevention activities and suspected fraud/abuse to regulatory and law enforcement agencies as required by law.

FWA Definitions (Compliance)

- **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.
- **Waste:** The overutilization or inappropriate utilization of services and misuse of resources.
- **Abuse:** Activities that are inconsistent with sound fiscal, business, or medical practices, and result in the following: unnecessary cost to health care programs or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary costs to health care programs.

Examples of FWA (Compliance)

In general, fraud costs the state and federal taxpayers up to \$260 billion annually.

Below are examples of fraudulent activity you may encounter as a health care provider in public programs.

MEMBER/BENEFICIARY/RECIPIENT

- Impersonation: Someone using the personal information of another person to obtain Medi-Cal or Medicare benefits for which he or she would otherwise not qualify or be entitled to receive.

PROVIDER

- Payment for referrals: When an individual or provider recruits and pays individuals money or offers gifts in exchange for referrals in the Medicare or Medi-Cal programs.
- Balance billing: A provider charging a Medicare or Medi-Cal beneficiary for the difference between the allowed reimbursement rate and the customary charge for the service.

PROVIDER BILLING AND CODING ISSUES

- Billing for services not rendered
- Billing for services at a frequency that indicates the provider is an outlier as compared with their peers
- Billing for non-covered services using an incorrect CPT, HCPCS, and/or diagnosis code in order to have services covered
- Billing for services that are actually performed by another provider
- Up-coding for services more severe or expensive than what is diagnosed or performed
- Unbundling services that should be billed together
- Billing for more units than rendered
- Services performed by an unlicensed provider yet billed under a licensed provider's name or information
- Altering records to receive covered services

How to Report Potential FWA (Compliance)

The Alliance requires its providers, members, contractors, and subcontractors to report suspected fraudulent activity to the Alliance or the appropriate regulatory and law enforcement agencies within ten working days of discovery of fraud, waste, or abuse.

Under no circumstances will the reporting of any such information or possible impropriety serve as a basis for retaliatory action to be taken against any individual making the report. No Alliance employee, provider, contractor, or member who reports suspected fraudulent activity will be retaliated against or otherwise disciplined by the Alliance or an Alliance employee for making a report in good faith.

When reporting FWA, please provide as much of the following information as possible:

- Name, address, license, or insurance ID of the suspect (if known).

- Description and details of the incident: who, what, where, when, date, and time of the incident(s).
- Any documentation you may have related to the incident(s).
- Your name and telephone number (if you would like to be contacted).

Any person may report a compliance or FWA matter through the following means:

Alliance Compliance Department
Toll-Free Hotline: **1.844.587.0810**
Email: **compliance@alamedaalliance.org**

Medi-Cal Fraud and Abuse
Toll-Free Hotline: **1.800.822.6222**
Email: **fraud@dhcs.ca.gov**

Medicare or Medi-Cal Fraud, Office of Inspector General
Toll-Free: **1.800.447.8477**

The Alliance Compliance Line is available and can receive tips 24 hours a day, 7 days a week. The Hotline is operated by a third-party vendor to maintain confidentiality for the reporter.

Health Insurance Portability and Accountability Act (HIPAA) **(Compliance)**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law that requires the Alliance and its network providers to protect and maintain the security and confidentiality of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights.

PHI is any individually identifiable health information, including demographic information. PHI includes but is not limited to the member's name, address, phone number, medical information, social security number, ID card number, date of birth, and other types of personal information.

This section of the Provider Manual seeks to guide providers on the following: 1) implementation of safeguards to protect Alliance member PHI; 2) ensure appropriate uses and disclosures of PHI; 3) ensure members are able to timely access their own PHI; and 4) how to identify and report privacy incidents and breaches to the Alliance.

Safeguarding PHI **(Compliance)**

As covered entities under the HIPAA Privacy Rule, the Alliance, and its providers must comply with HIPAA requirements.

Below are a few reminders on how to protect and secure PHI.

PHI IN PAPER FORM

- Documents containing PHI should not be visible or accessible to visitors or others who are unauthorized to have access to PHI.
- When faxing documents containing PHI, verify the recipient, the recipient's fax number, and the documents being sent.
- Ensure that outgoing faxes include a fax cover sheet that contains a confidentiality statement.
- When mailing PHI, verify the recipient, the recipient's mailing address, and the documents being sent.
- Ensure that envelopes and packages are properly sealed, ~~and secured, and if using a clear window envelope, ensure that information is not visible through the window of the envelope, and secured, and if using a clear window envelope, ensure that information is not visible through the window of the envelope~~ prior to mailing out.
- When transporting PHI, ensure that the information is protected by using binders, folders, or protective covers.
- PHI must not be left unattended in vehicles.
- PHI must not be left unattended in baggage at any time during ~~traveling~~travel.
- PHI should be locked away during non-business hours.
- PHI must be properly disposed of by shredding. Never recycle or dispose of documents containing PHI in the trash bin.

PHI IN ELECTRONIC FORM

- When transmitting PHI via email ensure that the email is encrypted. This prevents anyone other than the intended receiver from obtaining access to the PHI.
- Do not include PHI such as an individual's name or beneficiary ID number (CIN) in the subject line of the email.
- Confirm the recipient, recipient's email address, and documents or information being sent, prior to sending the email.
- Ensure all portable data storage devices (CDs, DVDs, USB drives, portable hard drives, laptops, etc.) are encrypted.

PHI IN ORAL FORM

- Do not discuss PHI in public areas such as the patient waiting room.
- Do not discuss PHI with unauthorized people.
- Always verify the identification of an individual prior to discussing PHI with the individual.
- Ensure to speak quietly when discussing PHI.

Uses and Disclosures of Member PHI (Compliance)

The HIPAA Privacy Rule allows member PHI to be used and disclosed without the member's written consent for the following reasons (not a complete list):

- Treatment
- Payment
- Health care operations

And under certain circumstances, PHI can be disclosed without written consent for the following reasons:

- Court and administrative proceedings
- Health oversight activities
- Public health activities
- Law enforcement purposes

Providers must obtain specific written consent through a HIPAA Compliant Authorization Form for all other uses and disclosures of PHI not for treatment, payment, or health care operations or otherwise permitted or required by the HIPAA Privacy Rule. The Alliance and its providers are required to maintain and distribute a Notice of Privacy Practices (NPP), which describes how PHI may be used or disclosed, and explains member rights and provider responsibilities under HIPAA.

Member Access to PHI (Compliance)

The HIPAA Privacy Rule requires the Alliance and its providers to provide members, upon request, with access to their PHI. Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever a member requests access to their PHI. Providers must also provide the member with timely access to their PHI in the form and format requested by the member. Members also have the right to request an amendment of their PHI, request restrictions on certain uses or disclosures, and to request an accounting of disclosures of their PHI, as outlined in 45 CFR §§164.526–528.

Reporting of Privacy Incidents and Breaches to the Alliance (Compliance)

The HIPAA Privacy Rule requires covered entities to provide notification to enrollees following a breach of PHI. Providers must immediately and upon discovery report both privacy incidents and breaches involving Alliance members. A privacy incident is defined as an event or situation where an individual or organization has suspicion or reason to believe that PHI may have been compromised.

Privacy incidents include but are not limited to the following:

- PHI sent to the wrong individual or organization.
- PHI sent unencrypted.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Loss or theft of documents containing PHI.
- Loss or theft of unencrypted devices (laptop, hard drives, USB drives).

A breach is defined as unauthorized access, use, or disclosure of PHI that violates either federal or state laws, or PHI that is reasonably believed to have been acquired by an unauthorized person. Timely reporting of incidents and breaches involving the PHI of our members is crucial in the response, investigation, and mitigation of incidents and breaches.

To report suspected or known privacy incidents and breaches you may contact the Alliance through any of the following means:

Alliance Compliance Department

Toll-Free Hotline: **1.888.587.0810**

Email: **deptComplianceprivacy@alamedaalliance.org**

Violations of HIPAA policies and procedures may result in disciplinary action, up to and including termination of a provider's contract or employment, in accordance with Alliance policies and applicable law.



Provider Manual

Alameda Alliance for Health
Medi-Cal, Group Care, and Medicare
Advantage Dual Eligible Special Needs
Plan (D-SNP)

October 2025

Table of Contents

Part 1. Alliance Services	8
Section 1: Introduction.....	8
Welcome to Alameda Alliance for Health (Alliance)	8
The Provider Manual	9
Getting Involved	9
Section 2: Alliance Resources.....	16
Alliance Provider Services Department.....	16
Alliance Member Services Department	16
Section 3: Eligibility and PCP Choice	19
Identifying Alliance Members	19
Verifying Member Eligibility	20
Provider Portal Instructions	21
Selecting a PCP	22
Changing PCPs.....	22
Section 4: Provider Compliance	24
Travel Time and Distance Standards	24
Hours of Operation	24
Alliance Marketing Materials	24
Approved Medi-Cal Marketing Methods	24
Discharging Members	25
Provider Directory Changes	26
Provider Data Requirements (274).....	26
Part 2. Providing Services.....	28
Section 5: Primary Care Provider (PCP) Roles and Responsibilities	28
PCP Services	28
Providing Capitated Services to Alliance Group Care Members	35
Non-Capitated Services	35
PCP Role in Supervision of Mid-Level Clinicians	36
Section 6: Utilization Management.....	40
Overview	40

Questions? Call the Alliance Provider Services Department, Monday – Friday,
 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Outpatient (Ambulatory) Services	41
Biomarkers for Cancer	42
Standing Referrals	42
Authorizations Requirements	44
Continuity of Care (CoC)	50
Doula Services	54
Enteral Nutrition Formulas for Medi-Cal Members	55
Continuous Glucose Monitor (CGM) Devices for Medi-Cal Members	56
Palliative Care Services	56
Delegation of UM to Medical Groups	59
Provider-to-Provider Communication	61
Transplant Services, including Major Organ Transplants (MOT).....	62
Minor Consent Services	64
Vision Care Services	65
Hospice Services (Medi-Cal).....	65
Hospice Services (D-SNP).....	66
Long-Term Care (LTC) (Medi-Cal Only).....	66
Community-Based Adult Services (CBAS).....	68
Community-Based Adult Services (CBAS) Emergency Remote Services (ERS)...	69
Transgender Services	71
Tertiary and Quaternary (TQ) Services	73
Second Opinions	74
Coordination of Care	74
Coordination of Services	75
Coordination of Care – California Children’s Services (CCS).....	78
Section 7: Behavioral Health Services	80
Medi-Cal Mental Health Services	80
Medi-Cal: Specialty Mental Health Services (SMHS).....	80
Medi-Cal: Non-Specialty Mental Health Services (NSMHS).....	81
Group Care Members: Mental Health	82
Substance Use Treatment Services.....	83

Behavioral Health Evaluation and Treatment for Autism for Members Under Age 21 years	84
Section 8: D-SNP Supplemental Benefits.....	90
Supplemental Benefits Overview	90
Section 9: Claims	91
Claims Overview	91
Submitting a Claim	91
Claims Receipt and Determinations	96
COORDINATION OF BENEFITS (COB).....	98
Service Specific Information	100
Code Sets	104
Electronic Visit Verification (EVV) (MEDI-CAL ONLY)	106
Section 10: Provider Dispute Resolutions (PDR)	107
Section 11: Telehealth (Medi-Cal and Group Care Only)	112
Telehealth Requirements for Medi-Cal and Group Care	112
<i>VIDEO AND AUDIO REQUIREMENTS</i>	112
<i>MODEL LANGUAGE FOR TELEHEALTH PATIENT CONSENT</i>	112
<i>REQUIREMENTS TO PROVIDE TELEHEALTH SERVICES</i>	113
<i>REIMBURSABLE TELEHEALTH SERVICES</i>	113
<i>TELEHEALTH BILLING - PLACE OF SERVICE CODES AND MODIFIERS</i>	114
<i>TELEHEALTH RESOURCES</i>	114
Telehealth Requirements for Alameda Alliance Wellness (D-SNP)	115
Section 12: Service and Referrals for Adults – Adult Clinical Preventive Services	116
OB/GYN Services	116
Cancer Screening	116
Documentation	116
Immunizations	117
Alliance Wellness (D-SNP).....	117
Family Planning Services	117
Confidential Human Immunodeficiency Virus (HIV) Testing.....	119
Abortion Services	121
Sterilization Services	121

Questions? Call the Alliance Provider Services Department, Monday – Friday,
 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)	122
Tobacco Cessation	124
Section 13: Services and Referrals for Newborns, Children, and Adolescents	126
Newborn Services	126
Clinical Preventive Services for Children – Periodic Health Assessments	127
Cognitive Health Assessments.....	128
Immunizations	129
Medi-Cal for Kids & Teens (Early Periodic Screening Diagnosis and Treatment (EPSDT) (Medi-Cal Only).....	131
Women, Infants & Children (WIC)	133
Early Intervention Services.....	133
Section 14: Perinatal Services.....	135
Perinatal Services	135
Reimbursement and Documentation of OB Services (Medi-Cal and Group Care Only)	139
Section 15: Community Supports (CS).....	141
Section 16: Out-of-Plan Services	142
California Children Services (CCS)	142
Dental Screening – Medi-Cal	144
Tuberculosis (TB) Control Services.....	145
Medi-Cal Rx – Outpatient Pharmacy Benefit (Medi-Cal Only).....	147
Section 17: Health Education	148
Health Education Services	148
Section 18: Serving Our Diverse Population	149
Documenting Staff Language Proficiency	150
Signage for Interpreter Services.....	150
Requesting Interpreter Services.....	150
Cultural and Linguistic Provider Training and Development.....	153
Monitoring Alliance Cultural and Linguistic Services Program	154
Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training ..	154
Section 19: Transportation Services.....	157
Transportation Benefits	157

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Transportation Liaison.....	161
Section 20: Formulary and Pharmacy Services.....	162
Formulary.....	162
Pharmacy Prior Authorizations and Exceptions	165
Pharmacy Network.....	167
Injectables	168
Section 21: Clinical Laboratory Services	170
Outpatient Laboratory Services.....	170
Laboratory Procedures in the PCP Office	170
Part 3. Care Management	172
Section 22: Care Management.....	172
Measuring and Improving Plan Performance (HEDIS®)	172
Measuring and Improving Plan Performance (CAHPS and HOS).....	172
Alliance Measures of Provider Performance	174
Care Management Programs.....	175
Basic Population Health Management	176
Care Coordination	177
Complex Case Management (CCM)	177
Community Health Worker (CHW) Services.....	178
Enhanced Care Management (ECM).....	178
California Integrated Care Management (CICM).....	179
Disease Management	180
Diabetes Prevention Program (DPP)	181
Medicare Diabetes Prevention Program (MDPP).....	182
Transitional Care Services	183
Infertility Services	184
Reconstructive Surgery	184
Reporting Provider-Preventable Conditions (PPCs).....	184
Section 23: Grievance and Appeals	186
Deadlines for a fast appeal at Level 2	192
Deadlines for a standard appeal at Level 2	192
ALJ - Administrative Law Judge (Level 3)	193

Questions? Call the Alliance Provider Services Department, Monday – Friday,
 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

MAC – Medicare Appeals Council (Level 4).....	194
Section 24: Credentialing	195
Credentialing Process	195
Credentialing Criteria and Basic Qualifications	197
Re-Credentialing	199
Section 25: Facility Site Review (FSR).....	201
FSR Overview	201
FSR Preparation	201
FSR Tool.....	203
MRR Tool.....	204
Help and Resources.....	205
Provider Initial Review and Fair Hearing Process	205
Requesting an Appeal.....	206
Requirements for Mid-Level Clinicians.....	207
Organizational Providers.....	208
Part 4. Member Rights and Compliance.....	209
Section 26: Member Rights and Responsibilities	209
Alliance Member Rights	209
Alliance Member Responsibilities.....	210
What Can You and Your Office Do to Protect Member Privacy?	211
How to Protect the Protected Health Information (PHI) of Your Patients	211
Section 27: Fraud, Waste, and Abuse (FWA) and Protected Health Information (PHI).....	213
Overview of Fraud, Waste, and Abuse (FWA)	213
FWA Definitions	213
Examples of FWA	213
How to Report Potential FWA	214
Health Insurance Portability and Accountability Act (HIPAA)	215
Safeguarding PHI.....	215
Uses and Disclosures of Member PHI	217
Member Access to PHI	217
Reporting of Privacy Incidents and Breaches to the Alliance	217

Part 1. Alliance Services

Section 1: Introduction

Welcome to Alameda Alliance for Health (Alliance)

Thank you for joining the Alameda Alliance for Health (Alliance) provider network! This manual is intended to provide you with the information and requirements to navigate our health plan and to assist you with offering the best possible care to our Alliance members.

ABOUT THE ALLIANCE

The Alliance is a public, not-for-profit health plan offering high quality managed care to one (1) out of every four (4) Alameda County residents through three (3) lines of business coverage programs: Group Care (Alliance Group Care), Medi-Cal (Alliance Medi-Cal), and the Medicare Advantage (MA) Health Maintenance Organization (HMO) Dual Special Needs Plan (D-SNP) (Alameda Alliance Wellness).

Alliance Health Care Coverage Programs		
Alliance Group Care	Provides coverage for health care benefits and services to In-Home Supportive Services (IHSS) workers in Alameda County.	 Alliance Alliance Group Care
Alliance Medi-Cal	Provides coverage for health care benefits and services to Medi-Cal members in Alameda County.	 Alliance Alliance Medi-Cal
Alameda Alliance Wellness	Provides coverage for health care benefits and services to members who have both Medicare and Medi-Cal and enroll in a D-SNP.	 Alliance Alliance Wellness

OUR MISSION, VISION, AND VALUES

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality, and accessible services.

Vision

The vision of the Alliance is that all residents of Alameda County will achieve optimal health and well-being at every stage of life.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Values (TRACK)

- **Teamwork:** We participate actively, support each other, develop local talent, and interact as one team.
- **Respect:** We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people's health and well-being.
- **Accountability:** We work to create and maintain efficient processes and systems that minimize barriers, maximize access and sustain high quality.
- **Commitment & Compassion:** We are empathic and care for the communities we serve including our members, providers, community partners and staff.
- **Knowledge & Innovation:** We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.

The Provider Manual

This Provider Manual describes your responsibilities to our members as a provider and is intended as a resource to help you provide them with the best possible care.

The Alliance requires that contracted practitioners, medical groups, providers, hospitals, ancillary providers, and other non-hospital facilities, together referred to as "Provider" or "Providers", fulfill the relevant specified responsibilities described in this Provider Manual and their contract.

The Alliance Provider Manual is regularly updated and reviewed at least annually and made available to in-network and out-of-network providers on the Alliance website at **www.alamedaalliance.org**.

Starting in 2024, the Alliance Provider Manual will be presented for review to the Alliance Community Advisory Committee (CAC) and Quality Improvement Health Equity Committee (QIHEC).

If you have any questions about the Alliance, our practices, or our members, please call our Alliance Provider Services Department at **1.510.747.4510**.

Getting Involved

Provider involvement helps us improve services for our members and providers.

WAYS TO PARTICIPATE:

Quality Improvement Health Equity Committee (QIHEC): The QIHEC meets at least quarterly. The Alliance Providers are encouraged to participate in the QIHEC and its peer committees. QIHEC and other committee members are paid a stipend. For more information, please call the Alliance Provider Services Department at **1.510.747.4510**.

Credentialing Committee (CC): The CC meets monthly to review new provider applications, re-credentialing information. For more information, please call the Alliance Peer Review and Credentialing Department at **1.510.747.4522**.

Peer Review Committee (PRC): The PRC reviews quality issues on contracted providers on an as needed basis. For more information, please call the Alliance Peer Review and Credentialing Department at **1.510.747.4522**.

Pharmacy & Therapeutics (P&T) Committee: The P&T Committee meets quarterly to review the drug formulary and make changes to the authorization review criteria. For more information, please call the Alliance Pharmacy Services Department at **1.510.747.4541**.

The Alliance Provider Manual: The Alliance communicates with providers through this manual and periodic provider updates. Provider suggestions have been incorporated into this manual. Feedback is always helpful in keeping the manual as up to date as possible. To share any ideas or comments, please call the Alliance Provider Services Department at **1.510.747.4510**.

The Alliance Provider Updates Bulletin: The Alliance periodically distributes provider letters, newsletters, memos, and updates with additional information to keep you informed. If you haven't received these provider communications, or if you have ideas for topics that you would like to see covered, please call the Alliance Provider Services Department at **1.510.747.4510**.

Provider Training Sessions: The Alliance conducts training sessions throughout the year for providers and their staff. If you or your staff are interested, please call the Alliance Provider Services Department at **1.510.747.4510**.

Resource	Phone Number	Address	Website
Alameda Alliance for Health	Phone Number: 1.510.747.4500 Toll-Free: 1.877.371.2222	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Behavioral Health Care Services	Toll-Free: 1.855.856.0577	1240 South Loop Rd Alameda, CA 94502,	www.alamedaalliance.org
Alliance Case & Disease Management (CMDM)	Toll-Free: 1.877.251.9612	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Compliance Hotline	Toll-Free: 1.844.587.0810	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Automated Eligibility Line	Phone Number: 1.510.747.4505	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Grievance and Appeals (G&A) Department	Phone Number: 1.510.747.4567 Fax: 1.855.891.7258	1240 South Loop Road Alameda, CA 94502	To file a grievance online, please visit: www.alamedaalliance.org
Alliance Health Education Program	Phone Number: 1.510.747.4577 Fax: 1.877.813.5151	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org/live-healthy Email: livehealthy@alamedaalliance.org
Alliance Long-Term Care (LTC) Department	Phone Number: 1.510.747.4516 Fax: 1.510.747.4191	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org Email: LTCHCS@Alamedaalliance.org

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

Resource	Phone Number	Address	Website
Alliance Member Services Department (Medi-Cal and Group Care)	Phone Number: 1.510.747.4567 Toll-Free: 1.877.932.2738 If you cannot hear or speak well (CRS/TTY): 711/1.800.735.2929	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org/contact-us Email: memberservices@alamedaalliance.org
Alameda Alliance Wellness Customer Services (D-SNP)	Toll-Free: 1.888.882.3767 (1-888-88A-DSNP) If you cannot hear or speak well (CRS/TTY): 711/1.800.735.2929	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org Email: AAWMemberSupport@alamedaalliance.org
Alameda Alliance Wellness Sales (D-SNP)	Toll-Free: 1.877.972.5373 (1-877-WSales3)	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Pharmacy Services Department	Phone Number: 1.510.747.4541 24-Hour Service: 1.855.508.1713	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Provider Services Department	Phone Number: 1.510.747.4510 Fax: 1.855.891.7257	1240 South Loop Road Alameda, CA 94502	www.alamedalliance.org/providers Email: providerservices@alamedaalliance.org

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

Resource	Phone Number	Address	Website
Alliance Utilization Management (UM) and Authorizations	Phone Number: 1.510.747.4540 Prior Authorization Fax: 1.855.891.7174 Concurrent Review: Admission Fax: 1.855.313.6306 Clinical Information Fax: 1.855.891.7409	1240 South Loop Road Alameda, CA 94502	www.alamedaalliance.org
Alliance Cultural and Linguistic Services	24-Hour Interpreter Hotline (for interpreters by phone*) 1.510.809.3986		www.alamedaalliance.org/providers/provider-resources/language-access Email: interpreters@alamedaalliance.org
ACCESS Program Alameda County Behavioral Health Care Services (Medi-Cal)	Toll-Free: 1.800.491.9099	2000 Embarcadero Cove, Suite 400 Oakland, CA 94606	www.acbhcs.org
Advice Nurse Line	Medi-Cal and D-SNP Members: 1.888.433.1876 Group Care Members: 1.855.383.7873		
Clinical Laboratory Outpatient Services: Quest Diagnostics	Toll-Free: 1.800.288.8008		www.questdiagnostics.com
Dental Services (Group Care): Public Authority	Phone Number: 1.510.577.3551		www.acgov.org

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

Resource	Phone Number	Address	Website
Dental Services (Medi-Cal): Medi-Cal Dental Program	Toll-Free: 1.800.322.6384 People with speaking impairments (TTY): 1.800.735.2922		https://dental.dhcs.ca.gov
Dental Services (D-SNP): Liberty Dental Plan	Toll-Free: 1.888.704.9838 Dental providers LIBERTY Provider Relations Toll-Free: 1.888.273.2997	PO Box 26110 Santa Ana, CA 92799	To find a dental provider: www.libertydentalplan.com/Find-a-Dentist/Find-a-Dentist.aspx
Durable Medical Equipment Provider: California Home Medical Equipment (CHME)	Toll-Free: 1.800.906.0626		www.chme.org Email: aaquestions@chme.org
Flex Card Supplemental Services (D-SNP): Nations	Toll-Free: 1.877.408.7542		www.alliancewellness.nationsbenefits.com
Hearing Supplemental Services (D-SNP): Nations	Toll-Free: 1.877.408.7542		www.Alliancewellness.nationsbenefits.com/hearing
Medi-Cal Rx administered by Prime Therapeutics	Toll-Free: 1.800.977.2273 TDD: 711		www.medi-calrx.dhcs.ca.gov
Teladoc Telehealth Provider	Toll-Free: 1.800.TELADOC (1.800.835.2362)		www.alamedaalliance.org/members/teladoc
Transportation Services	Toll-Free: 1.866.791.4158		www.alamedaalliance.org

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

Resource	Phone Number	Address	Website
Vision Services (Group Care): Public Authority	Phone Number: 1.510.577.3551		www.alamedacountyca.gov
Vision Services up to 12/31/2025 (Medi-Cal): MARCH Vision	Toll-Free: 1.844.336.2724		www.marchvisioncare.com
Vision Services starting 1/1/2026 (D-SNP): Vision Service Plan	Toll-Free: 1.855.492.9028		D-SNP Provider Directory: www.vsp.com/advantageonly
Vision Services starting 1/1/2026 (Medi-Cal): Vision Service Plan	Toll-Free: 1.800.877.7195		Medi-Cal Provider Directory: www.vsp.com/medicaid

*In-person interpreters are available for ASL and complex or highly sensitive appointments. For more information, please see “Requesting Interpreter Services” in Section 14: Serving Your Diverse Population.

Section 2: Alliance Resources

Alliance Provider Services Department

The Alliance Provider Services Department is your primary link to the Alliance. A quick phone call to an Alliance Provider Relations representative can answer many of your questions about our policies and procedures.

The Alliance Provider Services Department provides information and support to all Alliance network providers about:

- Access
- Alliance promotional materials
- Authorization status training
- Benefits
- Claims/billing status
- Contract issues
- Interpreter services
- Member eligibility
- Office address, and provider directory changes
- PCP assignment
- Peer review
- Provider bulletins
- Provider credentialing, and re-credentialing
- Provider discharges
- Provider network inquiries
- Provider portal access
- Site reviews
- Transportation services

Alliance Member Services Department

The Alliance Member Services Department helps manage member needs and concerns. The Alliance Member Services Department Call Center is specifically for members and member-related issues.

If a Medi-Cal or Group Care member has a question about their care or coverage, please encourage them to call:

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.



If an Alliance Wellness (HMO-D-SNP) member has a question about their care or coverage, please encourage them to call:

Alameda Alliance Wellness Member Services Department

Monday – Sunday (seven (7) days a week), 8 am – 8 pm

Toll-Free: **1.888.882.3767**

If you cannot hear or speak well, use TTY or call **1.800.735.2929**

The Alliance Member Services Department can assist members with:

- Changing a member's assigned primary care provider (PCP)
- Checking the status of a claim
- Checking the status of a prior authorization (PA) request
- Finding an in-network PCP, specialist, or behavioral health care provider
- Finding the location of an in-network pharmacy (For Alliance Group Care and D-SNP members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- Health education materials and resources
- Interpreter services
- Learning more about plan benefits and services
- Mail order pharmacy information (For Alliance Group Care and D-SNP members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- Reporting an issue or filing a grievance/appeal
- Requesting information on community resources
- Requesting a reimbursement for covered drugs or services (For Alliance Group Care and D-SNP members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- Requesting a replacement Alliance member ID card
- Scheduling transportation for covered services
- Updating a member's contact information (permanent contact information changes should be reported to the member's local social services agency by visiting **www.mybenefitscalwin.org**)
- Verifying a member's eligibility

The Alliance Member Services Department provides printed materials upon request for members, such as the Member Handbook or Evidence of Coverage (EOC) and Provider Directory. Members can also learn more about our services and their coverage on our website at **www.alamedaalliance.org**.

The Alliance Member Services Department can also help facilitate communication between members and providers.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.



For after-hours eligibility verification, please call the Alliance Eligibility Verification Line at **1.510.747.4505**, 24 hours a day, 7 days a week, or use the Online Provider Portal located on our website at **www.alamedaalliance.org**.

Section 3: Eligibility and PCP Choice

Identifying Alliance Members

Each Alliance member is issued an Alliance member identification (ID) card with a 9-digit member number. Providers can also use the member's Medi-Cal Client Identification Number (CIN) to identify members who are Medi-Cal beneficiaries.

ALLIANCE MEDI-CAL MEMBER ID CARD

MEMBER ID CARD	[First Name] [Last Name] Member ID: [Member ID] CIN: [CIN] Provider Group/Name: [Provider Group/Name] Primary Care Provider: [PCP Name] Phone Number: [Phone Number] Effective Date: [Effective Date] Group: [Group] Copays: MCAL OV \$0 ER \$0 RX \$0  www.alamedaalliance.org BIN: [xxxxxxxx] PCN: [xxxxxxxx]	MEMBER ID CARD
In case of emergency, call 911 or go to the nearest hospital Emergency Room (ER). Members may seek Emergency services from Out-of-Network Providers. Emergency services are covered without prior authorization, and at no cost to the member. Member Services and Behavioral Health Care: 1.510.747.4567, toll-free 1.877.932.2738 (CRS/TTY: 711/1.800.735.2929) 24-Hour Advice Nurse Line: 1.888.433.1876 Medi-Cal Rx Pharmacy Benefit Call Center: 1.800.977.2273 This card does not guarantee eligibility.		Provider Inquiries: 1.510.747.4510 Claims: PO Box 2460, Alameda, CA 94501

ALLIANCE GROUP CARE MEMBER ID CARD

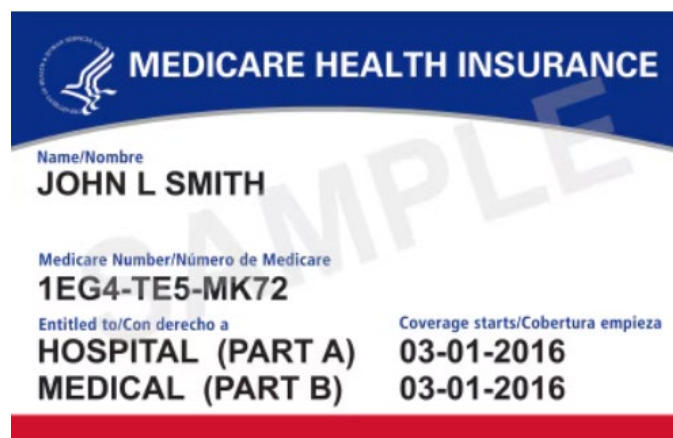
MEMBER ID CARD	[First Name] [Last Name] Member ID: [Member ID] CIN: [CIN] Provider Group/Name: [Provider Group/Name] Primary Care Provider: [PCP Name] Phone Number: [Phone Number] Effective Date: [Effective Date] Group: [Group] Copays: GC OV \$10 ER \$35 RX \$10/G \$15/B INPT \$100 ACU \$5 CHIRO \$10  www.alamedaalliance.org BIN: [xxxxxxxx] PCN: [xxxxxxxx]	MEMBER ID CARD
In case of emergency, call 911 or go to the nearest hospital Emergency Room (ER). Members may seek Emergency services from Out-of-Network Providers. Emergency services are covered without prior authorization, and at no cost to the member. Member Services and Behavioral Health Care: 1.510.747.4567, toll-free 1.877.932.2738 (CRS/TTY: 711/1.800.735.2929) 24-Hour Advice Nurse Line: 1.888.433.1876 This card does not guarantee eligibility.		Provider Inquiries: 1.510.747.4510 Claims: PO Box 2460, Alameda, CA 94501

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

MEDI-CAL BENEFITS IDENTIFICATION CARD (BIC)



MEDICARE BENEFITS IDENTIFICATION CARD



Verifying Member Eligibility

Your office is responsible for verifying member eligibility and authorization at the time of service. We encourage you to save a copy of the eligibility results for your reference.

There are several ways to verify a member's eligibility:

- State's Automated Eligibility Verification System (AEVS) – For Alliance Medi-Cal members only):
Toll-Free: 1.800.456.2387
www.medi-cal.ca.gov/eligibility/Eligibility.aspx
- Alliance Provider Services Department – For all Alliance members (Medi-Cal, Group Care, and D-SNP):
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
- Alliance Automated Eligibility Verification Line:
24 hours a day, 7 days a week
Phone Number: 1.510.747.4505

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Please have your National Provider Identifier (NPI) or Taxpayer Identification Number (TIN) available.

- Alliance Provider Portal:
- Accessed through **www.alamedaalliance.org**

Provider Portal Instructions

ONLINE PROVIDER PORTAL

The Alliance offers contracted and non-contracted providers access to our interactive website.

Through this website, you can:

- Check claims status and remittance advice statements
- Submit/check authorization status
- Submit a Provider Dispute Request (PDR)
- Submit a behavioral health care treatment report and care coordination forms (for mental health and applied behavioral analysis)
- Submit a request for interpreter services that need scheduled in advance
- Submit an Enhanced Care Management (ECM) Referral Form
- Submit professional claims electronically (including secondary claims)
- Verify member eligibility
- Verify and validate your provider directory data
- View the Alliance medication formulary (For Group Care and Alameda Alliance Wellness members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home.**)
- View the Alliance Provider Directory
- View your gap-in-care reports (PCP only)
- View your roster with assigned members (PCP only)

Information on the website is updated every 24 hours directly from our internal system.

To use the online provider portal, you must first obtain a provider account:

- Visit the Alliance website at **www.alamedaalliance.org**, select the Provider Portal link located at the top right banner, then select the “Create Account” link on the Provider Portal landing page.
- The Provider Portal Instructions Manual is available on the home page of the Provider Portal and once logged into the Provider Portal.
- For assistance, please contact:

Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
Email: **providerservices@alamedaalliance.org**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.



Selecting a PCP

The Alliance encourages members to participate in their health care by selecting a PCP from the provider network. Members can find a list of PCPs in their Alliance Provider Directories or online at **www.alamedaalliance.org**.

Members can choose a physician who is taking new members from the list of internal medicine, general medicine, family practice, pediatrics, and OB-GYNs (women can choose an OB-GYN as their PCP). An Alliance Member Services representative can help members find a PCP who knows their language or culture, or who is close to where they live or work.

Members can also choose a county or community clinic that is part of the Alliance network as their PCP. All Federally Qualified Health Centers (FQHC) in Alameda County are part of the Alliance Network. Members can go to any FQHC for medical care even if it is not part of the Alliance network.

The Alliance will mail members a new ID card with their PCP's name and phone number within **10 business days** to confirm their PCP selection (automatic or voluntary).

Members may change their PCP by calling:

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

When a member does not select a PCP in their first month of enrollment, the Alliance will assign a PCP based on member age, language, geographic location, and PCP capacity. A member's choice overrides automatic selection, and a member who has been automatically assigned will be prompted to call the Alliance Member Services Department if they prefer to be assigned to a different PCP. If the member is in a long-term care (LTC) facility and/or have Medicare (not enrolled with the Alliance D-SNP) as their primary insurance, they do not have to select a PCP.

Changing PCPs

The Alliance values member empowerment and encourages members to find an in-network provider accepting new patients with whom they can build a rewarding primary care relationship. Members can change their PCP for any reason and at any time by calling the Alliance Member Services Department at **1.510.747.4567**.



Changes will be effective on the first of the following month when the request is made. In some cases, a member may be added to a practice if the Alliance receives the assignment request before the **5th of the month**. If you have questions about a member's eligibility or assignment, please call the Alliance Provider Services Department at **1.510.747.4510**.

The Alliance Member Service Department will confirm the PCP reassignment and the effective date by sending a confirmation letter and a new Alliance member ID card with the new PCP's name and phone number to the member within **10 business days**.

If a PCP leaves their practice or is no longer able to see patients for any reason, the Alliance Member Services Department will notify any affected members as soon as possible and assist them in selecting another PCP.

Section 4: Provider Compliance

The California Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and Centers for Medicare & Medicaid Services (CMS) have established guidelines for the Medi-Cal managed care program, Group Care, and D-SNP members. Providers should familiarize themselves with these guidelines to avoid sanctions, fines, or suspension of membership.

Travel Time and Distance Standards

DHCS established Network Adequacy Standards to ensure adequate availability and accessibility of services to members. These standards include time and distance standards based on county population density.

For Alameda County, the following standards have been established based on provider type:

- **10 miles** or **30 minutes** from the member's residence for adult and pediatric PCPs, OB/GYN primary care, and pharmacies.
- **15 miles** or **30 minutes** from the member's residence for adult and pediatric specialty care, hospitals, and adult and pediatric mental health providers.

Alternative access standards may be approved by DHCS.

Hours of Operation

Alliance contracted providers are required to ensure the office hours of operation are equally accessible to all patients. This includes all Alliance members as well as Medi-Cal fee-for-service (FFS) beneficiaries.

Alliance Marketing Materials

PROMOTIONAL MATERIALS

If you are interested in obtaining brochures, newsletters, or promotional materials, please call the Alliance Provider Services Department at **1.510.747.4510**.

Approved Medi-Cal Marketing Methods

As a health care provider, you may:

- Actively encourage your Medi-Cal patients to seek out and receive information and enrollment materials that will help them select a Medi-Cal health care plan for themselves and their families.
- Provide patients with the phone number of the outreach and enrollment or Member Services Departments of the plan(s) with which you are affiliated.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Provide patients with the toll-free phone number of the DHCS, Health Care Options (HCO) enrollment contractor (toll-free: **1.800.430.4263**) and inform them of locations and times when they may receive individual or group assistance about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information, activities, presentations, and problem-resolution functions.
- Tell your Medi-Cal patients the name of the health plan or plans with which you are affiliated.

Discharging Members

The Alliance allows PCPs and specialists to request the discharge of assigned members. The Alliance will work with the member to choose another PCP or specialist who can best meet the members' needs.

HOW TO DISCHARGE A MEMBER

1. Determine the reason for the proposed discharge. Under the Medical Services Agreement, PCPs may only request the discharge of a member if medical services can no longer be successfully provided for reasons other than medical conditions. Some acceptable reasons for discharge include unruly behavior, threatening remarks, frequently missed appointments, fraud, etc. Document the reason(s) for discharge in the member's medical record. Requests to discharge a member due to medical conditions, frequent visits, or high cost of care will be denied.
2. Contact the Alliance Provider Services Department (or your Provider Relations representative) in writing to request a discharge. On the practice letterhead, please provide complete documentation regarding the nature of the problem(s) and reason(s) for the discharge. The Alliance Provider Services Department will review the request.
3. When a discharge request is granted, the Alliance Member Services Department will notify the member regarding the change in status and will work with the member to find a new PCP or specialist.
4. The PCP or specialist must maintain responsibility for the member's care until reassignment is complete. This responsibility includes giving the patient a **30-day** written notice of the discharge.

The member discharge notice must state the following:

- That the PCP will be available for emergencies and prescriptions for **30 days** or until a new PCP or specialist assignment is effective;
- That the member should contact the Alliance Member Services Department for assistance with selecting a new PCP or specialist; and
- That the PCP or specialist will make available the member's medical records to the member's new PCP or specialist upon request.

Additionally, a copy of the member discharge letter must be sent to the Alliance Provider Services Department to ensure appropriate follow-up and member assistance.

If the PCP, specialist, or member is dissatisfied with the decision, the PCP, specialist, or member may file a grievance for further review.

Provider Directory Changes

Keeping your information up-to-date and accurate is important to ensure our provider directory information is correct and that we maintain accurate information about your demographics.

Changes that should be reported include, but are not limited to, the following:

- Site name
- Site location (including suite numbers and floors)
- Phone and fax number(s)
- Hours of operation
- Accepting member status
- Member age limitations
- Languages spoken by office staff and providers
- Gender affirming care that may be offered
- Providers additions and terminations
- Telehealth or in-person availability

The Alliance requests that you notify us immediately of any updates that need to be made to the Alliance Provider Directory by calling the Alliance Provider Services Department at **1.510.747.4510**.

Provider Data Requirements (274)

The Alliance is required to report multiple provider data elements for all contracted providers to DHCS monthly. The report is called 274 and is a comprehensive and standardized file layout and protocol used by all Medi-Cal plans to submit provider network data to DHCS. The data will be used by DHCS for network assessments, data analytics, and other federal and state reporting requirements.

The preferred method to submit to the Alliance is through a file format called a Flat File. The Alliance can provide you with a Flat File template and help get you set up with how to send files electronically to allow providers to report required changes.

The required information includes, but is not limited to:

- Provider full name
- NPI

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Gender
- Date of birth
- Specialty
- Languages
- Provider license number
- DEA number
- Board certification
- Site NPI and tax ID of where the providers practice
- Site location of where the providers practice
- Hospital privileges
- Provider additions and terminations

Part 2. Providing Services

Section 5: Primary Care Provider (PCP) Roles and Responsibilities

It is the primary care provider (PCP) who acts as the primary case manager to all assigned members. This means the PCP must follow case management protocols as set forth in this section.

PCP Services

CARE MANAGEMENT PROTOCOL

As a PCP in the Alliance network, we ask that you follow care management protocols as set forth in this manual for the following areas:

- Check the rosters posted on the provider portal monthly to know which members are assigned to you as their PCP
- Coordinate and direct appropriate care for members by means of an initial diagnosis and treatment and obtain second opinions and consultation(s) with contracting specialists, as necessary
- Coordinate member discharge planning and referral to long-term care (LTC) or other services with the hospital and the Alliance
- Establish procedures to contact members when they miss appointments, require rescheduling for additional visits, or confirm referrals to a specialist for care
- Follow up on referrals made to specialists to assess the results of the care medication regimen, and special treatment, and ensure continuous care
- Provide a medical history and physical examination as appropriate:
- For new members: Provide an Initial Health Appointment (IHA) within **120 calendar days** of the member's effective date of enrollment
- Provide the specified scope of services to members
- Refer, as necessary, certain medically necessary non-emergency hospital specialty services, and diagnostic testing

OVERALL GOALS OF CARE MANAGEMENT

The Alliance will assist our PCPs in achieving these overall case management goals:

- Coordinate care of members to achieve positive care results
- Discourage inappropriate use of pharmacy and drug benefits
- Facilitate patient understanding and use of disease prevention practices and

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early diagnostic services

- Provide a structure for physicians to manage services by providing performance data on utilization, cost, and quality
- Provide National Committee for Quality Assurance (NCQA)-compliant Case and Disease Management for members
- Reduce, where appropriate, the use of emergency services as a source of nonemergency care

TIMELY ACCESS STANDARDS FOR PROVIDERS

Please see below for a table detailing the required DHCS, DMHC, NCQA, and Alliance required response times:

Appointment Wait Times	
Appointment Type:	Appointment Within:
Urgent Appointment that <i>does not</i> require PA	48 Hours of the Request
Urgent Appointment that <i>requires</i> PA	96 Hours of the Request
Non-Urgent Primary Care Appointment	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent Appointment with a Specialist Physician	15 Business Days of the Request
Non-Urgent Appointment with a Behavioral Health Provider	10 Business Days of the Request
Non-Urgent Appointment with Ancillary Services for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request
Appointments Wait Time (D-SNP)	
Appointment Type:	Appointment Within:
Urgently needed services or emergency that does not require PA	Immediately
Non-Urgent Primary Care Appointment	7 Business Days of Request
Routine or preventive care	30 Business Days of Request

All Provider Wait Time/Telephone/Language Practices	
Standard:	Within:
In-office wait time	60 minutes
Call return time	1 business day
Time to answer call	10 minutes
Telephone access – Provide coverage 24 hours a day, 7 days a week.	
Telephone triage and screening – Wait time not to exceed 30 minutes.	
Emergency instructions – Ensure proper emergency instructions.	
Language services – Provide interpreter services 24 hours a day, 7 days a week.	

LTSS Timely Access Network Standards

The Alliance's Utilization Management Department monitors our LTSS facility against the following timely access network standards.

LTSS Timely Access Network Standards	
Provider Type:	Standard:
Skill Nursing Facility	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 5 business days of request
Community Based Adult Services (CBAS)	
Initial	Within 5 business days acknowledge receipt of request from CBAS center
F2F Eligibility Assessment	Completed within 30 days
IPC by CBAS Center	Within 90 days
Reassessment	6 months

*The DMHC Timely Access Standard for an appointment with psychiatrist is **15 business days**; however, to comply with the CMS and NCQA accreditation standards of **10 business days**, the Alliance uses the more stringent standards.

PA – Prior Authorization

Urgent Care: Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care: Routine appointments for non-urgent conditions.

Triage or Screening: The assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage and determine the urgency of the member's need for care.

Shortening or Extending Appointment Timeframes: The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

Department of Health Care Services (DHCS) Timely Access Survey

About the Survey: Quarterly, the California Department of Health Care Services (DHCS) requires Medi-Cal managed care plans (MCPs) to monitor timely access to **Urgent and Non-Urgent Appointments Availability** in providers office.

Methodology: Utilizes a third party; DHCS selects and surveys a randomized sample of Alliance network providers on a quarterly basis. DHCS will make 3 attempts to each provider's office to conduct the survey.

Questions: The survey solicits answers about the next available appointment date and time for Urgent and Non-urgent appointments (*please see table above for appointment wait time*).

Minimum Performance Levels: Effective January 1, 2025 (MY2025), timely access MPLs is required for appointment wait times. Please see the table below detailing the requirements for DHCS.

Timely Access Category	MPL Effective Wednesday, January 1, 2025 to Thursday, December 31, 2026	MPL Effective Friday, January 1, 2027	MPL Effective Saturday, January 1, 2028
Urgent Adult PCP Appointment	70%	80%	90%
Urgent Pediatric PCP Appointment	70%	80%	90%
Non-Urgent Adult PCP Appointment	70%	80%	90%
Non-Urgent Pediatric PCP Appointment	70%	80%	90%
Urgent Adult Specialist Appointment	70%	80%	90%
Urgent Pediatric Specialist Appointment	70%	80%	90%
Non-Urgent Adult Specialist Appointment	70%	80%	90%
Non-Urgent Pediatric Specialist Appointment	70%	80%	90%
Non-Urgent Non-Physician Mental Health Care or SUD Provider Appointment	70%	80%	90%
Urgent Non-Physician Mental Health Care or SUD Provider Appointment	70%	80%	90%
Non-Urgent Non-Physician Mental Health Care or SUD Provider Follow-Up Appointment	70%	80%	90%
Non-Urgent Ancillary Appointment	70%	80%	90%

INITIAL HEALTH APPOINTMENT (IHA)

All new Alliance members must receive an Initial Health Appointment (IHA). The IHA consists of a history, a review of systems, a physical exam, and preventive services. For Medi-Cal members, this must be completed within **120 days** of enrollment or provider assignment. During site audits, a PCP's compliance with this standard will be assessed.

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On a regular basis, the Alliance's Quality Improvement Department conducts random audits to determine if all components of the IHA have been completed and whether the completion followed the guidelines.

The IHA should consist of an evaluation sufficient to enable the PCP to assess the acute, chronic, and preventive health needs of the member and assume responsibility for effective management of the member's health care service needs.

For children, the IHA must consist of the elements found in the most recent periodicity schedule recommended by the Bright Futures Guidelines/American Academy of Pediatrics (AAP). PCPs must provide preventive health visits for all members under **21 years of age** for Early and Periodic Screening, Diagnostics, and Treatment services at times specified by the most recent AAP periodicity schedule. The IHA must bring members up to date with all currently recommended preventive services for the lower age nearest to the current age of the child.

Codes that qualify for IHA:

Provider	Codes	Description
Behavioral Health	96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making).
OB/Gyn	59400, 59425, 59426, 59430, 59510, 59610, 59618 ----- Z1000, Z1008, Z1020, Z1032, Z1034, Z1036, Z1038	Under vaginal delivery, antepartum and postpartum care procedures, under cesarean delivery procedures, under delivery procedures after previous cesarean delivery, and under delivery procedures after previous cesarean delivery.
PCP (new patient)	99202-99205, 99461 ----- Z1016	Office or other outpatient visit for the evaluation and management of new patient.
	99381-99387	Comprehensive preventive visit and management of a new patient.
PCP (established patient)	99211-99215 ----- Z00.01, Z00.110, Z00.111, Z00.8, Z02.1, Z02.3, Z02.5	Office or other outpatient visit for the evaluation and management of an established patient with PCP but new to the Alliance.
	99391-99397	Comprehensive preventive visit and management of an established patient with PCP but new to the Alliance.

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INITIAL PREVENTIVE PHYSICAL EXAM (IPPE)

The Medicare IPPE, also known as the "Welcome to Medicare" Visit, is a one-time preventive service that should be completed within the first twelve months of a beneficiary's enrollment in Part B coverage. This visit focuses on a member's medical history, social history, and preventive education needs. Electrocardiograms are not mandatory for an IPPE but are a covered service that may be provided during the visit.

Codes	Description
G0402, G0468	The IPPE is a face-to-face visit with covered services limited to new beneficiaries during the first 12 months of Medicare enrollment Federally qualified health center (FQHC) IPPEs or AWWs include the standard bundle of Medicare-covered provided during those visits
G0403, G0404, G0405	Electrocardiogram with 12 leads; performed as a screening for the IPPE with interpretation and report Electrocardiogram 12 leads; tracing only, performed as a screening for the IPPE without interpretation and report Electrocardiogram with 12 leads; interpretation and report only, performed as a screening for the IPPE

ANNUAL WELLNESS VISIT (AWV)

The Medicare AWW is an annual visit for Medicare beneficiaries with Part B coverage. The visit is a conversation between a patient and provider to develop or modify personalized prevention and disease management plans based on history reviews, clinical screenings, and an updated health risk assessment. Advance care planning (ACP) is not mandatory but is a highly recommended element of the AWW

Codes	Description
G0438	The Initial AWW includes a personalized prevention plan and can only be billed once per lifetime after the first 12 months of enrollment in Medicare Part B
G0439	Subsequent AWWs includes a personalized prevention plan, informed by their updated health risk assessment, functional status, and screenings results
G0468	Federally qualified health center (FQHC) IPPEs or AWWs include the standard bundle of Medicare-covered provided during those visits
99497	Sixteen to thirty minutes of face-to-face advance care planning which includes the review and discussion of advanced directives with the member
99498	Each additional thirty minutes of ACP

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Providing Capitated Services to Alliance Group Care Members

SUBMISSION OF CAPITATED SERVICE ENCOUNTERS

PCPs are capitated for their Alliance Group Care members. Capitated services are the PCP's contractual responsibility. These services are covered by the monthly capitation payment. Capitated services do not require prior authorization.

PCPs must submit capitated services as claims/encounters to the Alliance with the usual and customary billed charges listed. Reported capitated services will appear along with non-capitated services (fee-for-service (FFS) claims) in a Remittance Advice to the PCP, although no payment will be associated with such services.

CAPITATED SERVICES TO A NON-ASSIGNED MEMBER

FFS billing of capitated services is limited to certain situations.

Providers who perform a capitated service for an Alliance member who is not assigned to that provider will only be paid for that service on an FFS basis during the following circumstances:

- Annual gynecological examination
- Diagnosis and treatment of a sexually transmitted disease
- Family planning services
- HIV testing and counseling
- Minor consent services
- Prenatal care (a global fee is paid for this type of care, except for specific procedures)
- The member is not assigned to any PCP
- Vaccination serum, except those covered by the Vaccines for Children (VFC) program

Non-Capitated Services

PCPs may provide services within their scope of practice that are not included in the capitation contract for their assigned members. These services are paid on an FFS basis.

Among the non-capitated services that PCPs can provide to their members on an FFS basis are preventive health care visits and inpatient care services.

All prior authorization may be submitted via the Alliance Provider Portal with supporting clinical documentation.

PCP Role in Supervision of Mid-Level Clinicians

REQUIREMENTS FOR MID-LEVEL CLINICIANS

PCPs who employ or contract with mid-level clinicians in their practices are responsible for making sure that the mid-level clinicians meet the standards set forth by the clinician's licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. They must meet certain qualifications and standards to be credentialed by the Alliance. This helps ensure quality care for members.

SCOPE OF PRACTICE

A supervising physician must define the scope of practice for each mid-level clinician working in the practice. The scope of practice may vary depending on the skills of the individual clinician, but in all cases must comply with applicable state laws.

CREDENTIALING

Any mid-level clinician who provides care to Alliance members must be credentialed by the Alliance. The effective date of a credentialed provider is the first day of the month following the month they were credentialed.

DEFINITIONS OF MID-LEVEL CLINICIANS

Mid-level clinicians are non-physician medical practitioners, including:

- Certified nurse-midwives
- Nurse practitioners
- Physician assistants

Continuing Education: All mid-level clinicians must maintain skills in their field of practice through continuing medical education programs, following the guidelines of their respective certifications. The supervising physician should monitor this process.

Supervision: All mid-level clinicians must practice under the supervision of a licensed physician and follow medical policies and protocols established by the physician.

CHARTS

Whenever care is provided by the mid-level clinician, the medical record must be reviewed and co-signed by the supervising physician in accordance with the requirements set forth by the clinician's licensing board. The Alliance will audit for compliance with this standard.

PCP/MID-LEVEL CLINICIAN RATIOS AND MEMBER CAPACITY

The number of non-physician medical practitioners who may be supervised by a single PCP is limited to the following:

- Four (4) nurse practitioners
- Four (4) nurse-midwives
- Four (4) physician assistants; or
- Four (4) of the above individuals in any combination

The ratio is based on each physician at any one-time/shift regardless of full-time equivalent status. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits.

The ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits.

AFTER-HOURS SERVICE

Mid-level clinicians may participate in the after-hours call network; however, the supervising physician must also be available for consultation when the mid-level is on-call.

The provider may also refer members to the toll-free Advice Nurse Line, accessible 24 hours a day, 7 days a week:

Medi-Cal Members (Including Alliance Wellness when dually eligible for Medi-Cal): **1.888.433.1876**

Group Care Members: **1.855.383.7873**

DISCLOSURE

Members must be informed when a practitioner is a mid-level clinician and must have the opportunity to request a physician if they wish.

QUALITY AND UTILIZATION MANAGEMENT

Contracted organizations are responsible for adherence to contractual obligations and Alliance quality standards for utilization management and quality improvement. The Alliance maintains responsibility for the overall adherence to quality and utilization standards for Alliance members.

Provider responsibilities include the following:

- Completion of corrective action plans as required to improve performance
- Prompt response to plan requests for medical records, corrective action plans, or additional information

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- Participation in provider and member satisfaction and timely access surveys
- Cooperation with Alliance annual audits such as CMS, DHCS, DMHC, NCQA, and ad hoc state and other regulatory audits
- Development, enactment, and monitoring of a utilization management and/or quality improvement plan that meets contractual requirements and Alliance standards
- Provide a representative to the Alliance Quality Improvement Health Equity Committee (QIHEC)
- Provision of encounter information and access to medical records for Alliance members
- Submission of quarterly reports, annual evaluations, and work plans
- Submission of utilization management reports based on the delegation agreement

FACILITY SITE REVIEWS (FSR) - MONITORING FSR

Facility Site Reviews (FSR) are the application of prescribed standards by the California Department of Health Care Services (DHCS)/Medi-Cal Managed Care Division (MMCD), and Centers for Medicare and Medicaid Services (CMS) for all primary care provider (PCP) sites.

All network PCP sites receive the following:

- An Initial FSR as part of the credentialing process
 - New PCP sites must pass their Initial FSR and, as applicable, correct all deficiencies to close the Corrective Action Plan (CAP) before being added to the network and receiving Alliance member assignments
- A Medical Record Review (MRR) survey is performed at the time of the FSR if Medi-Cal patient records are available; otherwise, the Alliance must complete the initial MRR of the new PCP site within **90 calendar days** of the date that the Alliance first assigns members
- A Periodic Full Scope FSR and MRR conducted every **three (3) years** thereafter
- An Interim Monitoring Review is conducted between each Periodic Full Scope FSR and MRR via an attestation form or on-site review
- A focused review (targeted review of one (1) or more specific areas of FSR or MRR) may be conducted to investigate problems identified through monitoring activities or to follow up on corrective actions
- The FSR and MRR are conducted by DHCS-certified nurse reviewers and scored with standardized DHCS guidelines and audit tools
 The purpose of the reviews is to ensure that:
 - Appropriate primary health care services are provided
 - Processes that support continuity and coordination of care are consistent
 - Patient safety standards and practices are maintained; and
 - Clinics operate in compliance with applicable local, state, and federal laws and regulations

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Regulatory agencies may conduct periodic oversight audits of the Alliance's facility site review process. It is the expectation of the Alliance that selected providers will participate in this process.

Each delegate's contract addresses the responsibility for facility site reviews. If the delegated entity is responsible for the review of their provider sites, summary reports must be provided to the plan that includes the number of sites reviewed, deficiencies, and any corrective action plans.

POTENTIAL QUALITY ISSUE (PQI)

A potential quality issue (PQI) is an individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.

The PQI review, evaluation, and monitoring process applies to all providers rendering services to Alliance members/enrollees on the plan's behalf, within all care settings. The Alliance Quality Improvement (QI) Department has the responsibility for ensuring and maintaining a timely PQI review process from the receipt of all PQI through investigation, appropriate intervention, and resolution. Providers are expected to participate in the PQI process, including submitting medical records or responding to corrective plans to complete the investigation. The Alliance considers this system process a critical component of the QIHE Program.

Section 6: Utilization Management

Overview

The Alliance Utilization Management (UM) Department helps ensure the delivery of high-quality, safe, equitable, necessary cost-effective health care for our members to improve health outcomes.

The Alliance UM Department serves to accomplish the following goals:

- Ensure that members receive the appropriate quantity and quality of health care service(s)
- Ensure that service(s) is delivered at the appropriate time
- Ensure that the care setting in which the service(s) is delivered is consistent with the medical needs of the member

The Alliance UM Department decisions are based only on the existence of coverage and appropriateness of care and service. The Alliance does not reward or incentivize practitioners or other individuals for issuing denials of coverage, service, or care. There are no financial incentives for the Alliance UM Department to make decisions that would result in underutilization.

SCOPE OF UM REVIEWS

The Alliance UM Department includes appropriately licensed health care professionals to make decisions on provider requests for authorization of services. Authorization decisions are based on eligibility, evidence of coverage, and medical necessity. The Alliance only allows a licensed physician to deny or modify requests for authorization of health care services for reasons of medical necessity. The Alliance uses a variety of sources to assist in making determinations for care.

The Alliance applies the following policies and/or guidelines, in the following hierarchy of review:

- Regulatory and contractual requirements
 - Regulatory requirements include WPATH guidelines for Transgender Care
 - Regulatory requirements include LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders.
 - National Coverage Determinations (NCD)
 - Local Coverage Determinations (LCD)
- Evidence based guidelines.
- Alliance specific guidelines
- National medical associate consensus
- Independent Medical Review
- Medical necessity/medical judgment

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

The Non-Profit guidelines for Group Care members including the American Society of Addiction Medicine (ASAM), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), Early Childhood Service Intensity Instrument (ESCI) and World Professional Association for Transgender Health (WPATH). Criteria are applied in conjunction with considering individual needs such as age, co-morbidities, complications, progress of treatment, psychosocial situations and home environment.

COMMUNICATION AND AVAILABILITY OF UM STAFF TO MEMBERS AND PRACTITIONERS

Peer-to-Peer Discussions

During the course of a utilization review, Alliance Medical Directors are available for peer-to-peer discussions with physicians to support evidence-based care for our members. Providers may contact Alliance Medical Directors for a peer-to-peer call using the Medical Directors' phone number listed on the Notice of Action.

Please Note: An adverse medical necessity determination cannot be overturned as a result of a peer-to-peer discussion. Providers may file an appeal on behalf of a member, after obtaining member consent, if they do not agree with an adverse medical necessity determination.

Outpatient (Ambulatory) Services

The Alliance provides covered medical benefits for outpatient (ambulatory) services.

These services include, but are not limited to:

- Chiropractic
- Podiatry
- Rehabilitative and habilitative (therapy) services and devices:
 - Acupuncture
 - Audiology
 - Occupational therapy
 - Speech therapy

For a list of services and authorization requirements, please refer to the Alliance Referral and Prior Authorization (PA) Grid for Medical Benefits for Directly Contracted Providers at **www.alamedaalliance.org**. Sensitive services, such as abortion, family planning, sterilization, sexually transmitted diseases, and HIV testing and counseling, do not require prior authorization.

Biomarkers for Cancer

Biomarker testing for members with advanced or metastatic stage 3 or 4 cancer does not require prior authorization. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment and expedite care.

WHAT DOES THIS MEAN FOR OUR PROVIDERS?

No prior authorization will be required for:

- Advanced or metastatic stage 3 or 4 cancer.
- Cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4 cancer.
- Biomarker testing associated with the U.S. Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
- Cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6.

Standing Referrals

The Alliance is required to provide standing referrals to specialists or Specialty Care Centers (SCC) for enrollees who require continuing specialized medical care over a prolonged period of time as part of ongoing ambulatory care or due to a life-threatening, degenerative, or disabling condition. A standing referral allows a member to see a specialist without needing a new referral for each visit when the condition may need an extended period of treatment. Standing referrals may be granted up to a maximum of **12 months**. The PCP or specialist will decide when a member meets the guidelines for a standing referral.

Services shall be authorized as a medically necessary proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and consistent with benefit coverage.

Requests can be made by a member, PCP, specialist, or SCC. A member may request a standing referral through their PCP or specialist. A standing referral made by the PCP is for more than one (1) visit to a specialist or specialty care center as indicated in an approved treatment plan for a particular diagnosis in consultation with the specialist prior to submission of the request. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the Alliance, a contracted provider, or a provider group. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the member's PCP, subject to the terms of the treatment plan.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Potential conditions for which you may want to consider a request for a standing referral when accessing out-of-network services include, but are not limited to:

- Asthma requiring specialty management
- Cancer
- Chronic obstructive pulmonary disease
- Chronic wound care
- Cystic fibrosis
- Diabetes requiring endocrinologist management
- Gastrointestinal conditions such as severe peptic ulcer, chronic pancreatitis
- Hepatitis C
- HIV/AIDS
- Lupus
- Neurological conditions such as multiple sclerosis, uncontrolled seizures
- Rehab for major trauma, extensive surgery
- Renal failure
- Significant cardiovascular disease

Potential conditions to consider for a standing referral when accessing in-network services include, but are not limited to:

- Burn care
- Chronic wound care
- Professional services that require prior authorization
- Tertiary services

Please include the following information with your request:

- Anticipated length of treatment
- Diagnosis
- Frequency of visits
- Plan of care
- Specify that you are requesting a Standing Referral

How to submit a request for a standing referral:

- Complete the Alliance Prior Authorization (PA) Request Form
- Submit the request by fax as indicated on the form or through the Alliance Provider Portal.

The turnaround time for standing referrals is **three (3) business days** from the date of receipt.

Authorizations Requirements

The Alliance requires contracted providers to obtain authorization before rendering certain services, including but not limited to:

- All out-of-network services
- Certain radiology, nuclear medicine, and outpatient services and procedures
- Elective inpatient admissions
- Emergency inpatient admissions
- Skilled nursing/rehabilitation admissions

A complete list of service types and procedures requiring authorizations is available at **www.alamedaalliance.org**.

Claims may not be reimbursed if a rendering provider does not receive authorization approval from the Alliance or one of our delegated partners before rendering services.

The Alliance will only accept a PA Request Form from the treating provider who determined the medical necessity for the requested services or procedure.

The treating provider is defined as the facility, PCP, behavioral health, or specialty clinician who is currently providing care to the member. This includes attending clinicians at a hospital or skilled nursing facility responsible for the member's discharge planning.

For services that do not require prior authorization but are associated with a service that requires prior authorization, there must be an approved authorization on file for the primary service requiring authorization for the associated code(s) to be paid. Associated service codes will not be paid separately if the primary service is denied.

NOTIFICATION REQUIREMENTS FOR ACUTE INPATIENT CARE

Contracted facilities must notify the Alliance within **24 hours** of an acute admission. Non-contracted facilities must notify the Alliance as soon as the member's medical condition has been stabilized per California Health and Safety Code Section 1262.8.

All facilities contracted and non-contracted must notify the Alliance within **24 hours** of a change in the level of care or discharge from the facility (including skilled nursing facilities).

Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.

Admission notifications for Acute Inpatient Admissions can be made using The Alliance Inpatient Authorization Request Form on the provider portal, by fax, or by sending the Admission Facesheet and supporting clinicals to the Alliance UM Department. For Facesheet Admission notifications fax to the Alliance UM Department at **1.855.313.6306**. Clinical information can be faxed to **1.855.891.7409**.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Hospitals and SNFs with electronic health records are required to comply with the Interoperability and Patient Access Final Rule (CMS-9115-F) and the California Health and Human Services Data Exchange Framework (Health and Safety section 130290), as specified in the Population Health Management Policy Guide, and provide admission, discharge, and transfer (ADT) feeds. We encourage facilities to contact the Alliance Provider Services at telephone number **1.510.747.4510** for any questions about how to set up an ADT feed.

Notifications and clinical notes received outside of the above time frames may result in a denial of the authorization for service and payments.

For D-SNP members, hospitals, facilities and/or other ancillary providers are required to issue members the appropriate notices as specified on the CMS website at **www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative**.

PROCESS FOR REQUESTING AUTHORIZATION

Unless otherwise indicated, the information provided in this section applies to both contracted and non-contracted providers providing care for an Alliance member assigned to a PCP. Providers are expected to adhere to the process below.

ELECTRONIC SUBMISSION OF PRIOR AUTHORIZATION REQUESTS

Providers can complete and submit an electronic submission of outpatient or IP elective authorization requests by using the Alliance Provider Portal.

Log in to the Alliance Provider Portal using Google Chrome and follow these steps:

- Step 1. Click 'Submit Authorizations' under the Authorization quick link.
- Step 2. Click 'Select a form' and choose from the appropriate drop-down selection
- Step 3. Enter all required fields as directed in this section.
- Step 4. Attach medical records to avoid further delays of the review or possible denial of services.
- Step 5. Click 'Submit request' once you are ready to submit.

FAX SUBMISSION OF PRIOR AUTHORIZATION REQUESTS

Providers can obtain an Authorization Request Form from the Alliance through any of the following:

- Alliance Provider Services Department: **1.510.747.4510**
- Alliance UM Department: **1.510.747.4540**
- Alliance Provider Portal: Visit **www.alamedaalliance.org** and click on the 'Provider Portal' link located at the top right banner. After you sign in, you will be able to view and download the form.
- Alliance Website: **www.alamedaalliance.org/providers/provider-forms**

IMPORTANT REMINDERS WHEN SUBMITTING AUTHORIZATION REQUESTS

1. Confirm member eligibility with the Alliance:
 - Alliance Automated Eligibility Verification System: **1.510.747.4505**
 - Online: www.alamedaalliance.org
 - Select 'Provider Portal – check member eligibility.'
 - Select an Alliance participating provider.
 - Online: www.alamedaalliance.org
 - Select 'Provider Portal – check the provider directory.'
2. Complete all required items on the Authorization Request Forms/ Home Health Form, or as indicated on the Alliance Provider Portal, for the requested service.

To ensure timely processing, please choose the appropriate level of urgency on each authorization request. The time frames for review are listed on the forms, associated with the appropriate level of urgency.

- When requesting an urgent review timeframe (within **24** hours for Part D Prescription Drugs or within **72 hours for all other types of urgent requests**), the urgency for the service being requested must be necessary due to an imminent and serious threat to the member's health, including, but not limited to, the potential loss of life, limb, or other major bodily function.
- If there is a concern raised by the UM Reviewer that any authorization request marked as urgent does not meet the definition of "urgent", the request will be reviewed by an Alliance Medical Director (physician) to make a final determination as to whether the supporting documentation for the request meets the definition of an urgent request.. If it does not, the request will be modified to a routine timeframe (**five (5) business days**) from the date of receipt. Providers will be notified of this change.

You may submit the PA Request Form to the Alliance UM Department electronically, by fax, or by mail:

Mail: Alameda Alliance for Health
Health Care Services Department
1240 South Loop Road
Alameda, CA 94502

Fax: **1.855.891.7174**

Providers may call the UM Department by phone at 1.510.747.4540 for any questions or assistance with the authorization forms or process.

Please Note: Always retain a copy of the completed Authorization Request Form in the patient's medical record.

CONCURRENT AUTHORIZATION SUBMISSION

Confirm member eligibility with the Alliance:

- Phone Number: **1.510.747.4505**
- Online: **www.alamedaalliance.org**
 - Select 'Provider Portal' and log in to check member eligibility.

Fax initial admission hospital face sheet, census report, and all relevant clinical information to **1.855.313.6306**.

Fax changes to the level of care and daily updated clinical information to **1.855.891.7409** or utilize the Provider Portal Form/ PDF version of the Inpatient Authorization Request form to indicate when a member has changed levels of care.

SKILLED NURSING AUTHORIZATION SUBMISSION

Confirm member eligibility with the Alliance:

- Phone Number: **1.510.747.4505**
- Online: **www.alamedaalliance.org**
 - Select 'Provider Portal' and log in to check member eligibility.

Use the Provider Portal/PDF version of the Post Acute Authorization Request Form.

Fax initial admission face sheet, census report, and all relevant clinical information to **1.855.313.6306**.

Fax changes to the level of care and daily updated clinical information to **1.855.891.7409** or utilize the Provider Portal Form/ PDF version of the Post Acute Authorization Request form to indicate when a member has changed levels of care.

AUTHORIZATION NOTIFICATION OF DETERMINATION DECISIONS

An authorization number, along with any quantity and date limits, will be given for all authorizations, regardless of the determination status.

Notification to members and providers/facilities are provided within **24 hours** of the review determination.

Providers are notified electronically. Members receive notifications via mail.



Medi-Cal and Group Care members with questions about their notification, or who need language assistance, may call:

Alliance Member Services Department

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well, use TTY or call **1.800.735.2929**

Alameda Alliance Wellness members with questions about their notification, or who need language assistance, may call:

Alameda Alliance Wellness Customer Services Department

Toll-Free: **1.888.882.3767 (1.888.88A.DSNP)**

If you cannot hear or speak well, use TTY or call **1.800.735.2929**

To request a copy of the criteria used in the review, providers may contact:

Alliance Authorization Department

Phone Number: **1.510.747.4540**

Provider confidentiality will be maintained regarding releasing criteria related to a specific case.

AUTHORIZATION REVIEW TIMELINESS STANDARDS

The Alliance processes authorization requests in a timely manner and in accordance with regulatory requirements.

The Alliance will make a determination within the following time frames:

Request Type	Medi-Cal	Group Care	Wellness D-SNP
Urgent	72 hours	72 hours	72 hours
Routine	5 business days	5 business days	7 calendar days
Concurrent	72 hours	72 hours	72 hours
Retrospective/Post Service	30 calendar days	30 calendar days	30 calendar days
Standing Referral	3 business days	3 business days	N/A
Major Organ Transplant	72 hours	72 hours	72 hours
Urgent Medical Drug	24 hours	72 hours	24 hours
Urgent Prescription Drug	Submit to Medi-Cal Rx	24 hours	24 hours
Routine Medical Drug	24 hours	5 business days	72 hours
Routine Prescription Drug	Submit to Medi-Cal Rx	24 hours	72 hours

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

When there is insufficient information to support a determination decision, the request will be deferred for up to **14 calendar days** from the initial date the authorization request was received, while additional information is gathered from the requesting provider. The Alliance will notify the provider and the enrollee, in writing, that a decision cannot be made within the required time frame, and specify the information needed. The Alliance will specify the anticipated date on which a decision may be rendered in accordance with regulatory timeframes. If the provider has not submitted the requested medical information by the stated deadline, the request may be denied.

A request for an elective (non-urgent) surgery or treatment submitted urgently due to the imminent date of service is not considered to be urgent. Urgent is defined by DHCS as an imminent and serious threat to the member's health, including, but not limited to the potential loss of life, limb, or other major bodily function. Therefore, requests should only be made when care is needed within **24-72 hours**, or the member is at risk of serious harm should care be delayed. Inappropriate use of the "urgent" category will be monitored.

Retrospective/Post-Service Process

Retrospective/post-service review is the process in which utilization review is used to determine medical necessity or coverage under the health plan benefit **after** health care services or supplies have been provided to a member and a prior authorization was not obtained.

The Alliance does not require prior authorization for emergency or urgent services.

Reminder: To obtain prior authorization for non-emergency or non-urgent services, the Alliance offers access to submit requests through the Alliance UM Department, 24 hours a day, 7 days a week.

Providers may contact:

Alliance Utilization Management (UM) Department

Phone Number: **1.510.747.4540**

To submit a request via E-Fax line: **1.855.891.7174**

The Alliance maintains and publishes a list of services that require prior authorization. The list is accessible at **www.alamedaalliance.org/providers/authorizations**.

Retrospective requests submitted within **90 calendar days** of the date of service will be reviewed by the Alliance UM Department for medical necessity. Determinations on retrospective requests are made within 30 calendar days of receipt of the request, per regulatory guidelines.

There are two (2) exceptions under which a retrospective request beyond **90 days** from the date of service may be considered (documentation is required):

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

1. Member eligibility – Incorrect eligibility was given or unable to validate eligibility with the Alliance at the time of service.
2. Inpatient services – The facility is unable to confirm enrollment with the Alliance.

Please Note: Retrospective/post-service requests are not considered urgent, and will not be processed as such. Requests for services that do not meet the criteria above are subject to denial, as no authorization has been obtained.

TRACKING AND MONITORING OF SERVICES AUTHORIZED

The Alliance tracks and monitors services authorized to specialists, including open or unused approved authorizations. This process is in place to ensure that authorized services are utilized within the authorized time duration. A monitoring report will be reviewed to evaluate whether there are access constraints for certain providers and specialties, as well as to identify any members who continuously do not utilize approved authorizations for possible referral to case management to help coordinate their care.

Continuity of Care (CoC)

Beneficiaries who are mandated to transition from Medi-Cal fee-for-service (FFS) and enroll as members in a managed care plan (MCP), transition from MCPs with contracts expiring, or have providers who terminate contracts with the MCP, have the right to request continuity of care (CoC) with an out-of-network Provider for a covered benefit if a verifiable pre-existing relationship exists with that Provider and the member saw the out-of-network Provider at least once for a nonemergency visit during the 12 months before the date of their initial enrollment in our plan .

CoC protections extend to the following providers:

- Primary Care Providers
- Specialists
- Select Ancillary Providers:
 - Physical Therapy
 - Occupational Therapy
 - Respiratory Therapy
 - Behavioral Health Treatment (BHT)
 - Speech Therapy
- Durable medical equipment (*allowable for at least 90 days until a new assessment/authorization is completed*)
- Prenatal services
- Surgery pre-approved within 180 days of transition

CoC protections do not extend to the following providers:

- Radiology
- Laboratory
- Dialysis Centers

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Non-Emergency Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Other Ancillary Services
- Non-enrolled Medi-Cal Providers

Members, authorized representatives (AOR), or providers may request **up to 12 months** of CoC with a provider, unless other timelines specified below. CoC requirements include:

- The Alliance determines the Member has a pre-existing relationship with the provider (a pre-existing relationship means the member has seen the OON provider for a non-emergency visit, at least once during the 12 months prior to the date of their initial enrollment in the MCP)
- The provider is willing to continue to see the member
- The provider is willing to accept the Alliance's contract rates or Medi-Cal FFS rates
- The provider meets the Alliance's applicable professional standards and has no disqualifying quality of care issues; and
- The provider is a California State Plan approved provider (a list of suspended or ineligible Providers is available at <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/sandi>)

12-month CoC Period Restart:

- After a mandatory transition into the Alliance, if a member changes MCPs by choice following the initial enrollment with the Alliance during the 12-month CoC period, the 12-month CoC period for a pre-existing provider **may start over one time**
Example: If a member enrolls in an MCP on January 1, 2023, but then later changes MCPs by choice on April 1, 2023, then the 12-month Continuity of Care may start over one time and the Member may see the Provider until April of the following year
- After a mandatory transition into the Alliance, if a member loses and then later regains MCP eligibility during the 12-month CoC period, then the 12-month CoC period for a pre-existing provider **may start over one time**
- If the Member changes MCPs or loses and then later regains MCP eligibility a second time (or more), the CoC period **does not start over** and the member does not have the right to a new 12 months of CoC
- If the member returns to Medi-Cal FFS (if applicable) and later re-enrolls in an MCP, the CoC period **does not start over**

Additionally, if a member has one of the conditions listed below in the Health and Safety Code (HSC) section 1373.96, CoC is provided for the completion of a course of treatment for that specific condition by a terminated or out-of-network provider, at the member's request.

Health condition	Time period
Acute conditions (a medical issue that needs fast attention)	For as long as your acute condition lasts
Serious chronic physical and behavioral conditions (a serious health care issue you have had for a long time)	For an amount of time required to finish your course of treatment and to safely move you to a new doctor in the Alliance network
Pregnancy and postpartum (after birth) care	During your pregnancy and up to 12 months after the end of pregnancy
Maternal mental health services	For up to 12 months from the diagnosis or from the end of your pregnancy, whichever is later
Care of a newborn child between birth and 36 months old	For up to 12 months from the start date of the coverage or the date the provider's contract ends with the Alliance
Terminal illness (a life-threatening medical issue)	For as long as the illness lasts. A member may still get services for more than 12 months from the date they enrolled with the Alliance or the time the provider stops working with the Alliance
Performance of a surgery or other medical procedure from an out-of-network provider as long as it is covered, medically necessary, and authorized by the Alliance as part of a documented course of treatment and recommended and documented by the provider	The surgery or other medical procedure must take place within 180 days of the provider's contract termination date or 180 days from the effective date of a member's enrollment with the Alliance

Please Note: If the Alliance is not able to come to an agreement with the terminated provider or out-of-network provider, or if the member, authorized representative, or provider does not submit a request for the completion of covered services by said provider, the Alliance is not required to continue the provider's services.

CONTINUITY OF CARE FOR COVERED SERVICES AND PRIOR TREATMENT AUTHORIZATIONS

For members who mandatorily transition from Medi-Cal FFS to the Alliance with active prior treatment authorizations for services, those services must be honored for **90 days** from the date of enrollment without a request by the member, authorized representative or provider. Services authorized under the active treatment authorization should be arranged with an **in-network provider**, or **if there is no in-network provider to provide the service, with an OON provider**. The active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment, whichever is shorter. A new assessment is considered complete if the member has been seen in-person and/or via synchronous Telehealth by a network provider and this provider has reviewed the member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

A. Durable Medical Equipment (DME) rentals and medical supplies:

Members who mandatorily transition from Medi-Cal FFS to the Alliance are allowed to keep their existing DME rentals and medical supplies from their **existing** providers under the previous prior authorization for a minimum of **90-days** following MCP enrollment and until the MCP can reassess, the new equipment or supplies are in possession of the member, and ready for use. Continuity of DME and medical supplies must be honored without request by the member, authorized representative or provider. After 6 months, the Alliance may reassess the member's authorization at any time and require the member to switch to an in-network DME provider.

Please Note: If DME or medical supplies have been arranged for a transitioning member, but the equipment or supplies have not been delivered, the Alliance must allow the delivery and for the member to keep the equipment or supplies for a minimum of 6 months following MCP enrollment and until reassessment.

B. Non-Emergency Medical Transportation and Non-Medical Transportation:

Members who mandatorily transition from Medi-Cal FFS to the Alliance must be allowed to keep the **modality** of transportation under the previous prior authorization with an in-network provider until the MCP is able to reassess the member's continued transportation needs.

Additional information on CoC for Medi-Cal members can be found at www.dhcs.ca.gov/services/Pages/Continuity-of-Care.aspx#coc.

CoC for Group Care is available in the following scenarios:

- Acute condition – Completion of covered services shall be provided for the duration of the acute condition
- Pregnancy (including care after the birth) – Completion of covered services shall be provided for the duration of the pregnancy when (1) the pregnancy is high-risk, or (2) the member is in their second or third trimester
- Serious chronic condition – Completion of covered services shall be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the member and the non-participating provider, and consistent with good professional practice
 - a. Completion of covered services shall not exceed **12 months** from the time of enrollment with the Alliance
- Surgeries and/or procedures – Performance of surgeries and/or other procedures that the member's previous plan authorized as part of a documented course of treatment, and that had been recommended and documented by the non-participating provider to occur within **180 days** of the time the member enrolled with the Alliance

- Terminal illness – Completion of covered services shall be provided for the duration of the terminal illness
 - a. Completion of covered services may exceed **12 months** from the time of enrollment with the Alliance

Specific provider requirements for coverage are:

- The provider has had a pre-existing relationship within the last **12 months** for non-urgent services
- The provider is willing to continue to see the member
- The provider is willing to complete a letter of agreement for payment

Doula Services

Doulas services are covered for prenatal, perinatal, and post-partum members as preventive services and are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants. Doulas are birth workers who provide person-centered, culturally competent health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doulas are not licensed and do not require supervision. Doulas offer various types of support, including health navigation, lactation support, the development of a birth plan, and linkages to community-based resources.

Services can be provided virtually or in-person with various locations including, but not limited to:

- Homes
- Office visits
- Hospitals
- Alternative birth centers

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure. Doulas are required to enroll as Medi-Cal providers.

The California Department of Health Care Services (DHCS) issued a statewide standing recommendation for doula services. The recommendation covers all Medi-Cal members who are pregnant or have been pregnant within the past year and would benefit from doula services.

Services include:

- One (1) initial visit
- Up to eight (8) additional prenatal and postpartum visits
- Support during labor and delivery (including stillbirth, abortion, or miscarriage)

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Up to two (2) three-hour postpartum visits after the end of a pregnancy

Providers do not need to complete a recommendation form for the initial nine doula visits.

Members may receive up to nine (9) additional postpartum visits with a written recommendation from a physician or other licensed practitioner of the healing arts (LPHA) acting within their scope of practice. The recommending practitioner does not need to be enrolled in Medi-Cal or be a network provider with the Plan.

An LPHA may include any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), or licensed-eligible practitioner working under the supervision of a licensed clinician.

The recommendation for additional doula services can be found on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

The Alliance will work with network hospital/birthing centers as needed to ensure that doulas will not have any barriers to accessing these providers when accompanying members for delivery, regardless of the outcome.

Alliance members can access doula services by:

- Calling the Alliance Member Services Department at **1.510.747.4567**
- Searching the Alliance Provider Directory at **www.alamedaalliance.org/help/find-a-doctor** and contacting a doula directly

Enteral Nutrition Formulas for Medi-Cal Members

Enteral nutrition formula for Medi-Cal members is covered by Medi-Cal Rx as a pharmacy benefit. No changes will occur to how enteral supplies such as pumps, tubing, or general enteral nutrition products are submitted. The Alliance or delegate group will still authorize these supplies.

A list of covered enteral nutrition products can be found on the Medi-Cal Rx Covered Product List **<https://medi-calrx.dhcs.ca.gov/provider/forms>**. Providers may call Medi-Cal Rx toll-free at **1.800.977.2273**.

Parenteral services will continue under the medical benefit and be reviewed by the Alliance or assigned delegate group.

Enteral nutrition for Group Care will remain with the Alliance or assigned delegate group and follow the general prior authorization processes and form for submission.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Continuous Glucose Monitor (CGM) Devices for Medi-Cal Members

Continuous glucose monitors (CGM) for Medi-Cal members are covered by Medi-Cal Rx as a pharmacy benefit.

A list of covered CGM products and coverage criteria can be found on the Medi-Cal Rx Covered Product List at <https://medi-calrx.dhcs.ca.gov/provider/forms>. Providers may call Medi-Cal Rx toll-free at **1.800.977.2273**.

CGM products for Group Care members are covered by the Alliance or assigned delegate group and follow the general prior authorization processes and form for submission.

Palliative Care Services

The Alliance authorizes palliative care services to its Medi-Cal members when these services are medically necessary. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the Alliance's contracts and does not affect a member's ability to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302.

ELIGIBILITY CRITERIA

Member must meet at least one (1) of the following:

- Member is likely to or has started to use hospital or emergency department to manage their advanced disease (excluding elective procedures)
- Member has advanced illness, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment
- Clinician feels that member's death within a year would not be unexpected based on clinical status
- Member has either received appropriate patient-desired medical therapy or is a member for whom patient-desired medical therapy is no longer effective
- Member is not in reversible acute decompensation
- Member, and if applicable, family/patient designated support person agrees to:
 - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
 - b. Participate in advance care planning discussions

DISEASE-SPECIFIC ELIGIBILITY CRITERIA

The member has one (1) of the following conditions:

- Congestive heart failure (must meet both of the following):
 - New York Heart Association class 3 or higher or at least one (1) hospitalization for heart failure with no further invasive interventions planned; and
 - Ejection Fraction <30% for systolic failure or significant comorbidities
- Chronic obstructive pulmonary disease (COPD) (must meet either of the following):
 - Forced Expiratory Volume (FEV) 1 less than 35% and 24-hour oxygen requirement of less than 3L; or
 - 24-hour oxygen requirement of greater than or equal to 3L per minute
- Advanced cancer (must meet both of the following):
 - Stage 3 or 4 solid organ cancer, lymphoma, or leukemia; and
 - A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy)
- Liver disease (must meet either of the following):
- Evidence of irreversible liver damage, serum albumin <3 and INR >1.3 and ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
 - Evidence of irreversible liver damage and a Model of End Stage Liver Disease (MELD) score of greater than 19
- Advanced dementia and Alzheimer's dementia (must meet four (4) out of the five (5) criteria indicated below for coverage):
 - Decreased oral intake and/or significant weight loss in the last six (6) months
 - Functional impairment (ADL dependencies)
 - Malnutrition
 - Minimal communication
 - Profound memory deficits
- Other serious and advanced illnesses, as diagnosed by a doctor

Palliative care services may be authorized while the member is also receiving curative care and until the condition improves, stabilizes, or results in death.

The Alliance, as part of its palliative care network development, contracts hospitals, long-term care (LTC) facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals.

Palliative care services include, at a minimum, the following seven (7) services when medically necessary and reasonable for the management of a qualified serious illness:

- Advance care planning: Advance care planning for beneficiaries enrolled in Medi-Cal palliative care includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally recognized decision-maker
 - a. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms
- Palliative care assessment and consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations.
 - a. Topics may include, but are not limited to:
 - i. Advance directives, including POLST forms
 - ii. Emotional and social challenges
 - iii. Legally recognized decision maker
- Pain, symptoms, and medicine side effects
 - iv. Patient goals
 - v. Spiritual concerns
 - vi. Treatment plans, including palliative care and curative care
- Plan of care: A plan of care is developed with the engagement of the member and/or their representative(s) in its design
 - a. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion
 - b. A member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care
- Palliative care team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of members and their families and can assist in identifying sources of pain and discomfort of the member
 - a. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc.
 - b. The palliative care team will also address other issues such as medication services and allied health needs
 - c. The team members must provide all authorized palliative care
 - d. DHCS recommends that the palliative care team includes, but is not limited to the following team members, a Doctor of Medicine or osteopathy (PCP if MD or DO), a registered nurse, a licensed vocational nurse or nurse practitioner (PCP if NP), and/or a social worker
- Care coordination: A member of the palliative care team provides coordination of care, ensures continuous assessment of the member's needs and implements the plan of care

- Pain and symptom management: Adequate pain and symptom management is an essential component of palliative care
 - a. Prescription drugs, physical therapy, and other medically necessary services may be needed to address beneficiary pain and other symptoms
 - b. The member's plan of care includes all services authorized for pain and symptom management
- Mental health and medical social services: Counseling and social services are available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process
 - a. Counseling services facilitated by the palliative care team may include, but are not limited to psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate
 - b. The provision of medical social services does not duplicate specialty mental health services (SMHS) provided by county Mental Health Plans (MHPs) and does not change the Alliance's responsibility for referring to and coordinating with county MHPs for Medi-Cal and D-SNP members.

Delegation of UM to Medical Groups

Members may be assigned to a PCP who is not directly contracted with the Alliance and who belongs to one (1) of the following medical groups which performs utilization management:

1. Children First Medical Group (CFMG) – Medi-Cal only
2. Community Health Center Network (CHCN) –Medi-Cal and Group Care

Our medical groups adhere to the same regulatory standards for UM as outlined above. With some exceptions, a provider serving an Alliance member as part of a medical group must verify authorization rules and obtain any required authorizations from the medical group. Providers can verify a member's group assignment by using one (1) of the Alliance's eligibility verification methods.

Behavioral Health Services are not delegated. The Alliance directly manages mental health services for Medi-Cal members with mild-moderate mental health conditions only. The Alliance directly manages all behavioral health services for Group Care members and D-SNP members.

For Medicare Advantage Dual Eligible Special Needs Plan (Alameda Alliance Wellness), utilization management will not be delegated.

DURABLE MEDICAL EQUIPMENT (DME)

The Alliance contracts with California Home Medical Equipment (CHME) for authorization management and servicing certain durable medical equipment (DME) services to all members.

CHME manages the following service categories:

- Breast pumps
- Continuous glucose monitoring (CGM) services for Group Care and Alliance Wellness only
- Blood pressure cuff services for Group Care only
- Diabetic Shoes
- Home respiratory equipment
- Hospital beds /decubitus care equipment
- Incontinence supplies
- Lymphedema products
- Medical supplies; wound care, ostomy, and urological supplies
- Nutritional supplements and feeding supplies
- Other home medical supply needs
- Wheelchairs, walkers, canes, and other ambulatory aids

PA requests for DME should be directed to CHME for processing. A complete list of service codes managed by CHME is available in the Alliance prior authorization grid under DME at www.alamedaalliance.org.

Please ensure that CHME has the following information to promptly review the request:

- Delivery address (equipment cannot be delivered to a PO Box)
- Diagnosis for equipment
- Member's height and weight
- Order/prescription from the prescribing provider
- Progress notes related to the equipment
- Settings for oxygen and PAP devices
- Test results such as oxygen saturation and/or arterial blood gas (ABGs)

For services excluded from CHME's service categories, the Alliance contracts with a select group of DME providers. Providers should submit a PA request directly to the Alliance UM Department or a member's assigned delegated group for these excluded services.

DIVISION OF UM RESPONSIBILITY WITH ALLIANCE MEDICAL GROUPS AND VENDORS

This grid is meant to direct providers to submit prior authorizations to the correct entity.

Delegated Medical Group	Line Of Business/ Plan	Phone Number	Website
Children First Medical Group (CFMG)	Medi-Cal	Phone Number: 1.510.428.3154 Fax: 1.510.450.5868	www.childrenfirstmedicalgroup.org
Community Health Center Network (CHCN)	Medi-Cal and Group Care (D-SNP is not delegated)	Phone Number: 1.510.297.0220 Fax: 1.510.297.0222	www.chcnetwork.org
California Home Medical Equipment (CHME)	Medi-Cal, Group Care, and D-SNP	Phone Number: 1.650.357.8550 Fax: 1.650.931.8928	www.chme.org To send orders by email: orders@chme.org

Provider-to-Provider Communication

To ensure coordinated care when referring members for specialty services, the following communication and documentation guidelines must be followed.

PCPS

Provide the specialist with the following information:

- Condition/reason for referral
- Document the referral in the member's medical record
- Member name/Alliance member ID number
- Member's preferred language
- PCP's name
- Provide the member with the referral information
- Refer to network providers only – check the most recent online provider directory for a complete listing of current Alliance specialists
- Relevant clinical information

SPECIALISTS

Please complete the following:

- Document the referral information in the member's medical record
- Provide regular feedback to the PCP
- Verify the member's eligibility at the time of service
- Verify the referral from the member's PCP or obtain authorization from the Alliance for services requiring prior authorization

Transplant Services, including Major Organ Transplants (MOT)

Effective Sunday, January 1, 2022, the Alliance covers the Major Organ Transplant (MOT) benefit for adult and pediatric transplant recipients and donors.

Medi-Cal and D-SNP members identified by Alliance providers as potential candidates for MOT/ Bone Marrow Transplants (BMT) procedures should be promptly referred to a Medi-Cal-approved Center of Excellence (COE) for transplant evaluation. For D-SNP the organ transplant must be in a Medicare-approved facility.

The Alliance will cover all medically necessary services for transplant recipients and both living donors and cadaver organs for the following major organs:

- Bone marrow
- Heart
- Heart-lung
- Kidney
- Liver
- Intestine
- Lung
- Kidney-pancreas
- Pancreas
- Heart-lung
- Heart-kidney
- Liver-small bowel
- Liver-kidney
- Intestine-small bowel

Medi-Cal and D-SNP members for whom a transplant procedure authorization is denied will continue to receive primary care and treatment services from the Alliance.

All beneficiaries previously disenrolled to fee-for-service (FFS) and who were approved for a transplant prior to Sunday, January 1, 2022, will remain in FFS Medi-Cal until they receive a transplant.

TRANSPLANT AUTHORIZATION PROCESS FOR PCP AND SPECIALISTS

The PCP or attending specialist must send an authorization request to the Alliance Utilization Management (UM) Department for a member seeking an evaluation as a potential candidate for a transplant.

The Alliance must directly refer adult beneficiaries or authorize referrals to a transplant program for an evaluation within **72 hours** of a beneficiary's PCP or specialist identifying the beneficiary as a potential candidate for transplant and receiving all the necessary information to make a referral or authorization.

The Alliance must refer pediatric beneficiaries to the County California Children's Services (CCS) program for CCS eligibility determination within **72 hours** of the beneficiary's PCP or specialist identifying the beneficiary as a potential candidate for transplant. The County CCS program will be responsible for referring the CCS-eligible beneficiary to the transplant Special Care Centers (SCC).

If the CCS program determines that the beneficiary is not eligible for the CCS program, but the transplant is medically necessary, the Alliance maintains complete responsibility for the medical care of that member.

TRANSPLANT CENTERS

If the transplant program confirms that the beneficiary is a suitable transplant candidate, the Alliance will be required to authorize the request for the transplant. The transplant program is responsible for placing beneficiaries on the National Waitlist maintained by the Organ Procurement and Transplantation Network (OPTN), administered by the Health Resources and Services Administration (HRSA), once it has determined that the beneficiary is a suitable transplant candidate.

COORDINATION OF CARE

The Alliance Health Care Services Department must ensure care management for all covered services and coordination of care for beneficiaries between all providers, organ donation entities, and transplant programs to ensure the transplant is completed as expeditiously as possible. The Alliance, Centers of Excellence (COE), or CCS will be responsible for providing care management and care coordination services to the transplant recipients as well as the living donors.

TRANSPLANT APPROVED

If the member is approved for transplant by CCS or the COE, then the member will not be disenrolled from the plan. The Alliance-contracted PCP and/or specialist will continue to be responsible for transferring the member's medical records directly to the COE or CCS as requested.

TRANSPLANT NOT APPROVED – ALL DENIALS FOR TRANSPLANT SERVICES MUST BE REVIEWED BY THE CHIEF MEDICAL OFFICER

If the member is not approved for the transplant, the Alliance will continue case management of the member in coordination with the PCP for ongoing care. The member's eligibility will continue with the Alliance until deemed otherwise.

Minor Consent Services

Children under age 12 may get certain confidential services without parental approval.

Minor consent services are services related to:

- Diagnosis and treatment of sexually transmitted diseases
- Family planning services
- Medical care after a sexual assault
- Pregnancy and pregnancy-related services

Children ages 12 years or older may access the following services without parental consent:

- Pregnancy and pregnancy-related services
- Family planning services
- Sexual assault services
- Infectious, contagious, or communicable disease diagnosis and treatment
- Sexually transmitted disease prevention, diagnosis and treatment
- Drug and alcohol use treatment/counseling (age 16 or older may consent to opioid disorder from a narcotic treatment program)
- Outpatient mental health treatment and counseling
- Residential shelter services and other support services on a temporary or emergency basis
- Intimate partner violence services

*Children must be **12 years of age** or older to receive drug and alcohol abuse services and outpatient mental health care services without parental approval.

Mental health providers must evaluate minors who are seeking mental health services without involving parents or guardians to ensure the minor is able to benefit from and intellectually engage in services. A mental health provider who determines that they will provide mental health services to a minor without parental or guardian involvement must notify the Alliance by completing and submitting the Initial or Follow Up treatment plan and coordination of care form on the Alliance provider portal to notify the Alliance and ensure notifications related to the minor's mental health care are not sent to the minor's parents or guardians.

Providers can call the Alliance Member Services Department to find out how to coordinate minor consent services. Members can also receive minor consent services from a non-Alliance provider that accepts Medi-Cal. PCPs do not have to authorize these services.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Vision Care Services

Starting January 1, 2026, the Alliance contracts with Vision Service Plan (VSP) to provide routine eye care services to Alliance Medi-Cal and Alliance Wellness members.

For Medi-Cal coverage includes:

- Routine eye exam once every **24 months**
- Eyeglasses (frames and lens) once every **24 months**; contact lens when required for medical conditions such as aphakia, aniridia, and keratoconus

Prior authorization is not needed for appointments.

Medi-Cal Members may access VSP Services at:

Telephone number: **1.800.877.7195**

Medi-Cal Provider Directory: **www.vsp.com/medicaid**

For Alameda Alliance Wellness (D-SNP HMO), coverage includes one (1) pair of eyeglasses with standard frames (or one (1) set of contact lenses) after each cataract surgery that implants an intraocular lens as a Medicare-covered benefit.

Alliance Wellness members also have supplemental benefit coverage that includes:

- One (1) routine eye exam every year
- Allowance of up to \$150 for one pair of routine eyeglasses (frames) or contact lenses every two (2) years. Standard lenses (single vision, lined bifocals, or lined trifocals) are covered in full.

Alliance Wellness Members may access VSP services at:

Telephone number: **1.855.492.9028**

Alliance Wellness Provider Directory: **www.vsp.com/advantageonly**

Up to December 31, 2025, MARCH Vision Care will continue to provide the Medi-Cal vision services to Medi-Cal members listed above.

For questions or to request a provider directory, please contact:

MARCH Vision Care

Toll-Free: **1.844.336.2724**

To request online: **www.marchvisioncare.com**

Group Care members have access to vision care services through their specific plans. Members should contact their vision plan for more information.

Hospice Services (Medi-Cal)

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

The Alliance will provide reimbursement for hospice care for members who are certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

A member who elects to receive hospice care must file an election statement with the hospice providing the care.

The election statement must include:

- Identification of the Hospice
- The member's or representative's acknowledgment that:
 - a. A member or representative may:
 - i. Execute a new election for any remaining entitled election period at any time after revocation
 - ii. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit
 - b. A member's voluntary election may be revoked or modified at any time
 - i. The member must file a signed statement with the hospice revoking the member's election for the remainder of the election period
- The effective date of the election
- The signature of the member or representative
- They have a full understanding that the hospice care given as it relates to the member's terminal illness will be palliative rather than curative in nature

Hospice Services (D-SNP)

The Medicare hospice benefit provides comprehensive end-of-life care for beneficiaries with a terminal illness and a life expectancy of six months or less if the disease runs its normal course. It emphasizes palliative care, not curative treatment, and is covered under Original Medicare Part A, even for D-SNP enrollees.

Hospice services are carved out of the D-SNP benefit package and are provided and billed directly through Medicare by Medicare-certified hospice agencies, not the D-SNP plan.

The D-SNP plan will continue to cover and coordinate non hospice related care, Part D prescription drugs unrelated to the terminal condition, as well as Medi-Cal benefits such as LTSS.

Long-Term Care (LTC) (Medi-Cal Only)

The Alliance is responsible for long-term care (LTC) services for Alliance Medi-Cal and D-SNP members. LTC may be provided in facilities, including Skilled Nursing facilities providing custodial care, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes, and Subacute Facilities.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

If an Alliance member requires LTC placement, facilities need to request authorization prior to admission. If that is not possible due to an urgent need of an admission, the Alliance must be notified within 24 hours of admission. All out-of-network admissions also require a prior authorization (PA) request. To extend an authorization, a reauthorization should be submitted to the Alliance as early as 60 days, but no later than one (1) week prior to the expiration of the existing authorization for the member. For authorization turnaround timeframes, please see the following table.

Request Type	Turn Around Time
Urgent	72 hours
Routine	5 business days
Retrospective/Post Service	30 calendar days

The facility is responsible for notifying the Alliance of any change in the level of care within 24 hours of the change (such as being transferred to the hospital). The facility must request a new authorization any time the member's level of care changes. The facility must also notify the Alliance of any member admissions to the hospital (need for a bed hold), transfer to other levels of care, discharges, and expirations.

The facility is responsible for communicating any discharge plans or needs for members transitioning back into the community, prior to the discharge.

For more information, facilities may contact:

Alliance LTC Department
Phone Number: **1.510.747.4516**
Fax: **1.510.747.4191**
Email: **LTCHCS@alamedaalliance.org**

DOCUMENTATION

Providers must send the Alliance a complete history of the illness, including diagnostic tests, procedures, and treatments from all physicians involved in the member's care. Documentation must include a statement from the provider that verifies that the member will be an LTC resident, and all required documentation based on care level (i.e., Physicians order, HS 231, IPP, PASRR, MDS, etc.). To Access the Alliance Prior Authorization (PA) Request Form, please visit the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

LTC CLAIMS

Claims must be submitted utilizing the UB-04 claim form. Medi-Cal has issued the code sets to be used on the UB-04 claim form for each accommodation code and its related revenue and value codes. The only current acceptable accommodation codes that the Alliance accepts for billing are for NF-B & NF-A regular patient room & board (R&B), leave of absence days, and bed holds for custodial care.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

For more information on accommodation codes, please visit https://files.medi-cal.ca.gov/pubsdoco/hipaa/crosswalks/ltc_accommodation_code_to_revenue_code_value_code_and_value_code_amount_crosswalk.pdf.

ADDITIONAL COSTS FOR LTC MEMBERS

Medi-Cal Share of Cost

Some Medi-Cal subscribers must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). A Medi-Cal subscriber's SOC is similar to a private insurance plan's out-of-pocket deductible. It is expected the provider will collect this SOC prior to billing the Alliance and show the collected amount in the Value Code section of the UB-04 claim form.

Community-Based Adult Services (CBAS)

Community-Based Adult Services (CBAS) is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to Alliance members. The Alliance authorizes CBAS based on a referral from the member's PCP and an eligibility assessment completed by a CBAS provider.

CBAS MEDICAL NECESSITY CRITERIA

Except for those residing in an Intermediate Care Facility, Developmentally Disabled-Habilitative ICF/DD-H members must meet all of the following medical necessity criteria to qualify for CBAS:

- A high potential exists for the deterioration of the member's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS are not provided
- The member has one (1) or more chronic or post-acute medical, cognitive, or mental health condition(s) identified by the member's personal health care provider as requiring monitoring, treatment, or intervention, without which the member's condition(s) will likely deteriorate and require emergency department (ED) visits, hospitalizations, or other institutionalization
- The member has at least one (1) of the following:
 - a. Mild cognitive impairment
 - b. Organic, acquired, or traumatic brain injury
 - c. Chronic mental illness
- The member suffers from moderate to severe dementia
- The member has a developmental disability

- The member's condition(s) require all core CBAS performed on each day of attendance to be individualized and designed to maintain the ability of the member to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization
- Core services include:
 - a. Meal service/transportation
 - b. Personal care services/social services
 - c. Professional nursing services (which include observation, assessment, and monitoring of member's health status and medications; communication with member's health care providers regarding changes in health status; supervision of personal care services; and/or skilled nursing care and intervention)
 - d. Therapeutic activities
- The participant's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one (1) of the following:
 - a. The member has family or caregivers available, but those individuals require respite to continue providing sufficient and necessary care or supervision to the member
 - b. The member lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision
 - c. The member resides with one (1) or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the member

Community-Based Adult Services (CBAS) Emergency Remote Services (ERS)

Community-Based Adult Services (CBAS) Emergency Remote Services (ERS) services ensure each member's needs continue to be met if the member is unable to return physically to a CBAS center for services. The goal is to support seniors and persons with disabilities (SPD) and their families and caregivers where and when services are needed. This expands access to home and community-based services to support individuals remaining in their homes and communities. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings in the community, the participant's home, or via telehealth to allow for immediate response during CBAS participant emergencies.

CBAS ERS is available only to CBAS participants.

A CBAS participant is defined as a member who:

- Is eligible for CBAS by the Alliance
- Has completed a person-centered care plan
- Has an approved authorization on file; and
- Signed a CBAS participation agreement at the CBAS Center

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

There are two (2) unique circumstances that may result in the need for ERS services.

The provision of ERS supports and services is temporary and time-limited:

- **Short-term:** Members may receive ERS for an emergency occurrence for up to **three (3) consecutive months**. CBAS providers and MCPs must coordinate to ensure the duration of ERS is appropriate during the member's current authorized period and, as necessary, for reauthorization into a new period; or
- **Beyond three (3) consecutive months:** ERS for an emergency occurrence may not exceed **three (3) consecutive months**, either within or crossing over an authorized period, without assessment and review for the possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan
 - a. CBAS providers and MCPs must coordinate requests for authorization of ERS that exceed **three (3) consecutive months**

The two (2) types of circumstances for ERS are:

- Public emergencies, such as state or local disasters, regardless of whether formally declared
 - a. These may include but are not limited to earthquakes, floods, fires, power outages, and epidemic/infectious disease outbreaks such as COVID-19, tuberculosis, norovirus, etc.
- Personal emergencies, such as serious illness or injury, crises, or care transitions, as defined below
 - a. Specific personal emergencies may include:
 - i. Serious illness or injury - The illness or injury is preventing the member from receiving CBAS within the facility and providing medically necessary services and supports that are required to protect life, address or prevent significant illness or disability, and/or alleviate pain
 - ii. Crises – The member is experiencing, or threatened with, intense difficulty, trouble, or danger. Examples of personal crises include the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
 - iii. Care transitions – Transitions to or from care settings, such as returning to the home or another community setting from a nursing facility or hospital. ERS provided during care transitions should address service gaps and the member/caregiver needs and not duplicate responsibilities assigned to the intake or discharging entities

Members may choose to cease receipt of ERS at any time. The Alliance will cover ERS as part of the CBAS benefit when a member meets the criteria established as outlined above.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

SERVICES FOR MEMBERS WITH DEVELOPMENTAL DISABILITIES

Developmental Disability Referrals

The Alliance coordinates referrals to the Regional Center of the East Bay (Regional Center) for members with developmental disabilities.

Referral Guidelines

Providers or family members may refer directly to the Regional Center. The family must make the intake appointment with the Regional Center. Prior authorization is not required.

Providers must:

- Document the referral to the Regional Center in the member's medical record; and
- Provide necessary medical evaluations and obtain written consent prior to releasing any medical information directly to the Regional Center

For more information, please contact:

Regional Center of the East Bay
Creekside Plaza
500 Davis Street, Suite 100
San Leandro, CA 94577
Phone Number: **1.510.618.6100**
Fax: **1.510.678.4100**

Transgender Services

The Alliance covers medically necessary care for transgender members, consistent with the state Medi-Cal benefit APL 20-018, federal CMS benefits and following the World Professional Association of Transgender Health (WPATH) Standard of Care for Gender Dysphoria. All services require prior authorization.

Examples of services may include:

- Gender confirmation surgery, including facial feminization surgery
- Hair removal services
- Hormone therapy for adults over 18 years of age
- Hormone therapy or pubertal suppression for children under 18 years of age
- Reconstructive surgery
- Voice/communication therapy services related to transgender care
- Voice feminization/modification surgery

State law defines “medically necessary” as follows:

- For Medi-Cal members **21 years of age** or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. (Welfare and Institutions Code section 14059.5.)
- For Medi-Cal members under **21 years of age**, a service is “medically necessary” or a “medical necessity” if the service corrects or ameliorates defects and physical and mental illnesses and conditions. (Title 42 USC 1396d(r)(5).)
- For Group Care members, “Medically necessary treatment of a mental health or substance use disorder” means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
 - i. In accordance with the generally accepted standards of mental health and substance use disorder care.
 - ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.
 - iii. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider (HSC 1374.72(a)(3)(A)).
- For D-SNP members, the Centers for Medicare & Medicaid Services (CMS) defines “medically necessary services as those that are; proper and needed for the diagnosis and treatment of your medical condition, provided for the diagnosis, direct care and treatment of your medical condition, and meet accepted standards of medical practice in the local area and are not mainly for the convenience of the member or the provider.

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

1. Behavioral health services
2. Hormone therapy
3. Psychotherapy
4. Surgical procedures that bring primary and secondary gender characteristics into conformity with the individual’s identified gender

Tertiary and Quaternary (TQ) Services

The Alliance requires prior authorization for referrals and transitions to tertiary and quaternary (TQ) academic centers to ensure that members are accessing the right level of care at the right time for efficient and expedient access to services. All physician-based services (office visits and consultations) to a TQ center require prior authorization (initial and ongoing). To minimize the need for ongoing submission, please follow the Standing Referral process. The prior authorization process will make certain that a standardized process is utilized in reviewing the appropriateness of referrals and transitions to TQ centers. This will establish consistency of all reviews, both internally and externally (delegates, hospitals, clinics), resulting in highly specialized care prevention that will impact illness and restore health to the highest physical or psychological function. The Alliance makes utilization management decisions only on the appropriateness of care and the existence of coverage. The Alliance maintains a network of providers that is sufficient to provide adequate access to care.

TQ care referrals may be appropriate in the following situations:

- When a higher level of care in the form of a specialized diagnostic approach, treatment, and/or procedure is warranted.
- When a member is new to the Alliance (within the last **12 months**) and has been receiving acute care management from a TQ-level provider.
- When redirection may result in the delay of necessary medical treatment.
- Referrals to secondary sub-specialists when the member is being managed for a primary diagnosis to allow for multi-disciplinary collaboration for the member's overall plan of care.
- Services not available in the community or of limited availability.
- Ancillary requests (radiology, lab, etc.) may be considered to prevent potential delays in treatment decisions.

The information below should be included along with the PA request:

- Indicate the reason(s) why the member requires tertiary-level service
- Primary diagnosis driving TQ-level care
- Any information or records from community specialists
- Plan of care if applicable
- Anticipated length of treatment

All other services that currently require prior authorization will remain the same. For delegated members, the PA request will be submitted to the delegated medical group.

Second Opinions

PCPs, specialists, and members (if the practitioner refuses) have the right to request a second opinion from a qualified health professional, at no cost to the member, from the Alliance regarding proposed medical or surgical treatments from an appropriately qualified participating health care professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition, or conditions associated with the request for a second opinion.

Second opinions from contracted providers do not require authorization and are arranged through the member's assigned PCP.

The Alliance provides a second opinion from a qualified health care professional in the network or arranges for the member to obtain one out of network, at no cost to the member.

A prior authorization from the Alliance is required to receive a second opinion from an out-of-network provider. The time frames for processing second opinions follow the standard authorization time frames.

The second opinion authorization or denial will be provided expeditiously appropriate to the member's condition, after the Alliance's receipt of the request.

Coordination of Care

The Alliance provides comprehensive medical case management to all members. Comprehensive medical case management includes care coordination for medically necessary services provided to members within and outside of the Alliance's provider network based on the individual member's needs.

PRIMARY CARE PROVIDER (PCP) ROLE

Continuity and coordination of care are ensured through the PCP who is formally designated as having primary responsibility for coordinating the member's overall health care. The PCP has the responsibility and authority to direct and coordinate the member's services. For D-SNP the PCP is considered a member of the interdisciplinary care team (ICT).

These responsibilities include:

- Act as the primary case manager for all assigned members
- Assess the acute, chronic, and preventive needs of each member
- Employ disease management protocols to manage a member's chronic health conditions.
- For D-SNP (Alameda Alliance Wellness), the case manager serve as the lead case manager for the member, ensuring direct and frequent collaboration with the PCP

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- For D-SNP (Alameda Alliance Wellness), the PCP or their representative is encouraged to participate in all ICT meetings to ensure members receive appropriate care and services to meet their needs

DELIVERY OF PRIMARY CARE

The establishment of an ongoing relationship between the member and their chosen PCP is crucial to the member achieving optimal health. Members are encouraged to make an appointment with their PCP immediately upon selection of their PCP. Primary care services will be available according to the health plan's established access and availability standards.

Coordination of Services

The PCP has primary responsibility for evaluating the member's needs before recommending and arranging the services required by the member and facilitating communication and information exchange among the different providers/ practitioners treating the member.

Members are included in the planning and implementation of their care, with special emphasis on those members with mental health or substance use problems, co-existing conditions, and chronic illnesses, or those members at the end of life. Members who are unable to fully participate in their treatment decisions (i.e., minors, incapacitated adults) may be represented by parents, guardians, other family members, or conservators, as appropriate, and in accordance with the member's wishes.

The Alliance offers care coordination for the following services:

- Alcohol and substance use disorder treatment services
- Behavioral health care
- California Children's Services (CCS)
- Children with special health care needs
- Dental services
- Directly observed therapy (DOT) for the treatment of tuberculosis (TB)
- Early intervention service with the Early Start Program
- Emergency department (ED) follow-up
- Excluded services requiring member disenrollment
- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver program
- Local Education Agency services (LEA)
- Services for people with developmental disabilities (Regional Center)
- Services with out-of-network providers
- Waiver Program
- Women, Infants, and Children (WIC) Supplemental Nutrition Program

ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES

PCPs are responsible for identifying members with active or potential substance use problems. Once members are identified, PCPs are responsible for providing services for the substance use problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical workup given the nature of the substance use problem. PCPs are also responsible, with the assistance of the Alliance, for referring members with substance use problems to an appropriate treatment practitioner or county department.

BEHAVIORAL HEALTH CARE

The Alliance collaborates with its behavioral health providers to identify opportunities to improve the coordination of behavioral health care with general medical care that may include but is not limited to collaboration between the organization and behavioral health providers. Additionally, Mental Health providers are required to complete and submit Initial and follow-up treatment and coordination of care forms via the Alliance Provider Portal. The Alliance sends these treatment summary to co-treating providers including the member's PCP to facilitate coordination of care between co-treating providers.

Behavioral health care coordination is provided by the Alliance Behavioral Health Care Department. For more information, please visit the Alliance website at www.alamedaalliance.org.

CALIFORNIA CHILDREN'S SERVICES

PCPs and specialists are responsible for the early identification of members who may have eligible CCS conditions. Medically necessary health care services will be administered throughout the referral process with the Alliance, regardless of whether the child is accepted into the CCS Program (e.g., Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for Medi-Cal members). The Alliance will consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The Alliance will assist with referrals/authorizations and care coordination to ensure that members receive the care appropriate for their medical, mental, or physical condition.

DENTAL SERVICES

For Medi-Cal, dental services are not covered by Medi-Cal managed care. However, the Alliance will ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.

For Alameda Alliance Wellness, dental services are offered as a supplemental benefit. Please refer to the D-SNP Supplemental Benefits section for more information.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

DIRECT OBSERVED THERAPY (DOT) FOR TREATMENT OF TUBERCULOSIS (TB)

DOT is offered by the local health departments (LHDs) and is not covered by Medi-Cal managed care. PCPs will assess the risk of non-compliance with drug therapy for each member who requires placement on anti-tuberculosis therapy.

EARLY INTERVENTION SERVICE WITH THE EARLY START PROGRAM

PCPs are responsible for assessing children's developmental status during well-child exams or at other medical encounters as appropriate. Children from birth to 36 months identified at risk for or suspected of having a developmental disability or delay must be referred to the Regional Center of the East Bay (RCEB) for evaluation for the Early Start Program. The Alliance will collaborate with RCEB or the local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start Program.

EXCLUDED SERVICES REQUIRING MEMBER DISENROLLMENT

For services related to incarceration, the Alliance will initiate the disenrollment process.

HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS) WAIVER PROGRAM

Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered by Medi-Cal or D-SNP managed care. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer Medi-Cal and D-SNP managed care members to an HIV/AIDS waiver program if they meet the criteria.

LOCAL EDUCATION AGENCY SERVICES (LEA)

Services provided by Local Education Agencies (LEA) as called for in the LEA's Individual Education Plan (IEP) are not covered benefits under Medi-Cal managed care. In compliance with the Children and Youth Behavioral Health Initiative (CYBHI), the Alliance covers behavioral health services provided by school-based providers who are approved to provide mental health services under the CYBHI program. On an as-needed basis, the Alliance will work with the PCP to coordinate care for a member to ensure the provision of all medically necessary covered diagnostic, preventive, and treatment services identified in the Individual Education Program (IEP) developed by the LEA, with the PCP's participation. The Alliance is working in collaboration with LEAs to expand behavioral health care services in and near schools.

SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (REGIONAL CENTER)

Contracted PCPs and specialists (practitioners) are responsible for the identification and referral of members with developmental disabilities/ behavioral health disorders outside their scope of practice. The Alliance implements and maintains systems to identify members with developmental disabilities who may meet requirements for Regional Center Services.

SERVICES WITH OUT-OF-NETWORK PROVIDERS

The Alliance identifies members who may need or who are receiving services from out-of-network (non-contracted) providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management.

WAIVER PROGRAM

Members who may qualify for one (1) of the Waiver Programs will be identified by their PCP, with Alliance UM Department support, based on their diagnosis and need for a specific level of care. Authorization of services should be medically necessary and recommended by the PCP or the specialty care provider (SCP). Members have a right to request any covered services, whether or not the service has been recommended by the PCP/SCP. Members who may qualify for one of the Waiver Programs can be identified by their PCP, the Alliance Case Management Department, or Alliance Utilization Management Department based on the member's diagnosis and need for a specific level of care. Authorization of services should be medically necessary and recommended by the PCP or specialty care provider (SCP). Members have a right to request any covered services, whether or not the service has been recommended by the PCP/SCP. The authorization for services must be approved through a utilization management system (either the health plan or the delegated medical group/IPA) based on medical necessity.

WOMEN, INFANTS, AND CHILDREN (WIC) SUPPLEMENTAL NUTRITION PROGRAM

The Alliance PCP, obstetrical (OB), and pediatric practitioners will inform members of the availability of Women, Infants, and Children (WIC) services and make appropriate referrals to the local WIC program for their assigned members who are potentially eligible for WIC services. Eligibility is based on income. Members that have active Medi-Cal eligibility may qualify for WIC.

Alliance providers may refer pregnant women to WIC by having them call toll-free at **1.800.852.5770** or by visiting **myfamily.wic.ca.gov**.

Coordination of Care – California Children's Services (CCS)

PCPs and specialists are responsible for:

- Early identification and referral of children with potentially eligible conditions to California Children's Services (CCS)
- Notifying the Alliance Utilization Management (UM) Department of members referred to CCS
- Administering medically necessary health care throughout the referral process, with the Alliance, regardless of whether or not the child is accepted into CCS
 - a. For example, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for Medi-Cal members

CCS is responsible for:

- Treatment for CCS-eligible conditions
- Reimbursement of CCS-paneled providers and CCS-approved hospitals
- Covering EPSDT services related to the CCS condition for Medi-Cal members

Section 7: Behavioral Health Services

Medi-Cal Mental Health Services

Medi-Cal members can access mental health care in two (2) ways:

- Through Alameda County Behavioral Health (ACBH) for severe conditions or
- Through the Alliance for mild-to-moderate conditions

Medi-Cal members with severe mental health needs receive what are called "specialty mental health services" (SMSHS). On the other hand, the Alliance offers "non-specialty mental health services" (NSMH) to Medi-Cal members with mild to moderate mental health needs.

Medi-Cal members are screened using a Department of Health Care Services (DHCS) tool to determine which system of care they will receive services. To access the tool, please visit **www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx**.

The screening is completed by Alameda County Behavioral Health (ACBH) ACCESS or the Alliance. Providers are not required to complete the screening.

If a member who is currently in mental health treatment requires a higher level of care beyond outpatient visits, providers should complete the DHCS required transition of care form at **www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf**. This form can be forwarded directly to ACBH ACCESS.

Medi-Cal: Specialty Mental Health Services (SMHS)

Medi-Cal members are eligible to receive specialty mental health services (SMHS) from the Alameda County Behavioral Health (ACBH). SMHS services focus on treating severe conditions that require treatment beyond outpatient visits.

Providers may also contact ACCESS for urgent conditions to receive a triaged consultation. For crisis resources available in Alameda County please visit **www.crisissupport.org/get-help-now/alameda-county-crisis-referrals/**.

These referrals can be made 24 hours a day, 7 days a week, by calling the ACCESS helpline for Medi-Cal members:

Phone Number: **1.510.346.1000**
Toll-Free: **1.800.491.9099**

If a member's mental disorder is outside the scope of the provider's practice, or requires a higher level of care beyond outpatient visits, the provider may also refer the Medi-Cal member to specialty mental health care by calling ACCESS and completing the Department of Mental Health Services (DHCS) required transition of care form which can be accessed at www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf.

ACBH ACCESS serves all ages. Medi-Cal members seeking mental health services for themselves or their minor children may directly access specialty mental health care by calling ACCESS. The county will provide consultations by phone to Alliance PCPs. Consultations are available Monday – Friday, 8 am – 5 pm, through the ACCESS helpline.

Medi-Cal: Non-Specialty Mental Health Services (NSMHS)

Alliance Medi-Cal members are eligible for NSMHS with Alliance Network Providers in the following situations:

- The members screen as mild to moderate based on the DHCS mental health screening tool (score less than 6) or
- The member is receiving SMHS, but the outpatient services are not available within SMHS

The Alliance covers the following medically necessary non-specialty mental health services:

- Dyadic therapy
- Family therapy
- Group therapy
- Individual therapy
- Psychiatric consultation and medical management
- Neuropsychological and Psychological testing
- Transcranial Magnetic Stimulation
- Esketamine/Spravato

Prior Authorization for NSMHS – Alliance Provider Network

No prior authorization is required for an initial mental health evaluation and ongoing outpatient visits with contracted mental health providers.

Prior authorization is required for the following outpatient services:

- Psychological/neuropsychological testing
- Transcranial magnetic stimulation (TMS)
- Outpatient electroconvulsive therapy (ECT)
- Ketamine/Spravato drug treatment

All prior authorization requests may be submitted with supporting clinical documentation demonstrating medical necessity.

Intensive outpatient, partial hospitalization and inpatient care is not a covered benefit under the NSMH benefit through the Alliance. However, comparable services are available to members via the SMHS offered by ACBH.

If a member's mental disorder is outside the scope of the provider's practice, or requires a higher level of care beyond outpatient visits, the provider may also refer the Medi-Cal member to specialty mental health care by calling ACCESS and completing the Department of Mental Health Services (DHCS) required transition of care form which can be accessed at www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf.

Group Care Members: Mental Health

For Group Care members, the Alliance offers a non-exhaustive list of behavioral health care services that evaluate and treat mental health and substance use disorders regardless of severity.

Prior authorization is not required for routine outpatient behavioral health care services with contracted Alliance providers. Members can self-refer to most services.

Prior authorization is required for medically necessary higher levels of care beyond outpatient services such as intensive outpatient programs (IOP), residential treatment and inpatient psychiatric treatment. In addition, the following outpatient services require prior authorization:

- Psychological/neuropsychological testing
- Transcranial magnetic stimulation (TMS)
- Electroconvulsive therapy (ECT)
- Esketamine/Spravato drug treatment

All prior authorization requests must be submitted with supporting clinical documentation demonstrating medical necessity.

D-SNP Members: Mental Health (Behavioral Health)

For D-SNP members, the Alliance covers the following medically necessary services:

- Crisis Services
- Mental health evaluation and treatment, including individual, couples, group, and family psychotherapy
- Outpatient services that include lab work, drugs, and supplies*
- Outpatient services to monitor drug therapy.
- Psychiatric consultation
- Psychological and neuropsychological testing to evaluate a mental health condition*

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

- Transcranial Magnetic Stimulation (TMS)*
- Spravato/Esketamine*
- Electroconvulsive Therapy*
- Intensive Outpatient Programs for mental health and substance use*
- Partial Hospitalization Programs for mental health and substance use*
- Residential Mental Health Services*
- Inpatient psychiatric care*

**Services require prior authorization.*

No prior authorization is required for outpatient most visits with contracted mental health providers.

Substance Use Treatment Services

For Medi-Cal members, all substance use treatment is managed by Alameda County Behavioral Health Plan (ACCESS):

Phone Number: **1.510.346.1000**
Toll-Free: **1.800.491.9099**

For Group Care members, the Alliance covers a non-exhaustive list of medically necessary substance use treatment.

These include but are not limited to:

- Crisis Services
- Outpatient substance use recovery services
- Outpatient services that include lab work, drugs, and supplies*
- Outpatient services to monitor drug therapy
- Psychiatric consultation
- Medication Assisted Treatment (MAT)
- Intensive Outpatient Programs for substance use*
- Partial Hospitalization Programs for substance use*
- Residential*
- Inpatient and outpatient detox services*

**These services are available to members. It is the responsibility of the treatment provider to seek authorization.*

For D-SNP Members, the Alliance covers the following substance use treatments:

- Crisis Services
- Outpatient substance use recovery services
- Outpatient services that include lab work, drugs, and supplies*
- Outpatient services to monitor drug therapy

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Psychiatric consultation
- Medication Assisted Treatment (MAT)
- Intensive Outpatient Programs for substance use*
- Partial Hospitalization Programs for substance use*
- Inpatient and outpatient detox services*

**These services are available to members. It is the responsibility of the treatment provider to seek authorization.*

Alameda County Behavioral Health provides coverage for residential substance use treatment. The Alliance does not cover residential substance use treatment for D-SNP. Members may receive these services through Alameda County Behavioral Health by contacting ACCESS 1.800.491.0900.

Behavioral Health Evaluation and Treatment for Autism for Members Under Age 21 years

PCP REFERRAL REQUIREMENTS FOR APPLIED BEHAVIORAL ANALYSIS (ABA) OR COMPREHENSIVE DIAGNOSTIC EVALUATION (CDE)

Members who may need an autism evaluation can be referred by completing the Alliance Behavioral Health (BH) Care – Autism Evaluation, BHT/ABA Referral Form. To access the form, please visit www.alamedaalliance.org/providers/provider-forms.

Below are sample scenarios to determine the next steps for referrals.

SCENARIO #1	SCENARIO #2	SCENARIO #3
a. You or a member's family suspects the member has autism. b. The member has never had a psychological assessment to rule out autism, there are behavioral health concerns, and you are unsure of what type of BHT member may need (ABA or other types of BHT).	a. You determine that other behavioral health or mental health services may be medically necessary (you are not recommending ABA either due to lack of supporting documentation or ABA is not clinically indicated).	a. You have conducted your own assessment/screening, are familiar with ABA treatment, and deem that the member can benefit from ABA treatment. b. A licensed psychologist has diagnosed the member with autism or another diagnosis, and you deem that a referral for ABA treatment is medically necessary.
↓	↓	↓
Refer for Diagnostic Evaluation	Next Steps: Referral for Mental Health	Next Steps: Referral for ABA

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

SCENARIO #1	SCENARIO #2	SCENARIO #3
A diagnostic evaluation for autism is administered by a licensed psychologist. This assessment is conducted to rule out autism (evaluation of child/adolescent with indications from screening of possible autism but no formal diagnosis has been given). It will either yield a diagnosis of autism or not and will provide recommendations as needed. Please complete the Behavioral Health (BH) Care – Autism Evaluation, BHD/ABA Referral Form, and check the box for Diagnostic Evaluation/ Psychological Assessment to rule out autism.	Mental health services include all evidence-based services for the treatment of mental and/or substance use disorders that may include depression, post-traumatic stress, anxiety disorders, phobias, ADHD, mood disorders, attachment disorders, and more. Treatments may include individual and group counseling, medication, and other supportive services. Please complete and submit the Behavioral Health (BH) Care Referral Request Form.	ABA treatment is a specific type of behavioral health treatment that addresses socially significant behaviors (e.g., maladaptive behaviors, social interactions, communication, and self-help skills) through the application of behavioral strategies. ABA was first implemented with individuals with autism and intellectual disability; therefore, empirical research has mostly been concentrated on efficacy with these populations. Please complete the Behavioral Health (BH) Care – Autism Evaluation, BHD/ABA Referral Form, and check the box for Applied Behavioral Analysis (ABA) Treatment and complete Section 4: Evaluation/ Referral Information within the form. If the PCP has information regarding the member or family's availability for services (times of day and days of the week), please include it in Section 5: Additional Information.

AUTHORIZATION REQUIREMENTS FOR ABA

Members must have a recommendation for ABA treatment from a licensed physician or licensed psychologist. Medi-Cal members must also meet the criteria outlined in the California Department of Health Care Services (DHCS) All Plan Letter 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

The Alliance Behavioral Health team will help link members to ABA providers for the initial assessment. Members can also seek out preferred in-network providers once they obtain a referral from a licensed physician/licensed psychologist. ABA providers can also submit a prior authorization (PA) request for the initial ABA assessment/Functional Behavioral Assessment (FBA) if they have the member's referral/recommendation from a licensed physician/licensed psychologist.

The initial assessments/FBA and subsequent treatment reports with all treatment plan elements and requests for authorization must be completed on the Alliance treatment plan web form and submitted through our Provider Portal . For more information, please refer to the most current Applied Behavior Analysis (ABA) Treatment Plan (TP) Report Guidelines for Providers. These can be found on the provider portal, or in the provider section of The Alliance's website.

RE-AUTHORIZATION REQUIREMENTS FOR ABA

All PA requests and treatment plans for the continuation of ABA treatment must be completed using the Alliance treatment plan web form and submitted through our Provider Portal. Treatment plans are reviewed by the Alliance behavioral health team and may be sent to the member's PCP or Pediatrician to facilitate coordination of c

The treatment plans must contain all of the following elements as required by DHCS:

- Description of patient information, the reason for referral, brief background information (e.g., demographics, living situation, or home/school/ work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services
- Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors
- Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation
- Include outcome measurement assessment criteria that will be used to measure the achievement of behavior objectives

The member's current level of need (baseline, expected behaviors the guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria (the objective goal), date of introduction, estimated date of mastery, specify a plan for generalization and report goal as met, not met, or modified (include explanation)

- Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member

- Clearly identify the service type, number of hours of direct service(s), observation and direction, guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services
- Include care coordination that involves the guardian, school, state disability programs, and other programs and institutions, as applicable
- Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision
 - a. However, the Alliance must not reduce the number of medically necessary BHT hours that a member is determined to need by the hours the member spends at school or participating in other activities.
- Deliver BHT services in a home or community-based setting, including clinics BHT intervention services provided in schools, in the home, or in other community settings, must be clinically indicated, medically necessary, and delivered in the most appropriate setting for the direct benefit of the member
 - a. BHT service hours delivered across settings, including during school, must be proportionate to the member's medical need for BHT services in each setting
- Include an exit plan/criteria
 - a. However, only a determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services

To avoid a lapse in treatment and backdating of authorizations, please submit the updated treatment plan/progress report two (2) weeks before the current ABA treatment authorization ends.

PLEASE NOTE: ABA treatment requires prior authorization before services are rendered. Providers must have an approved authorization for the dates of service as indicated in the PA request.

ABA PROCEDURE CODE AND UNITS

For each procedure code, please enter the total number of units for the authorization period (e.g., 6 months). The number of units must be in whole numbers.

To convert the total number of treatment hours for the 6 months to units, please use the following formula:

Total number (#) of hours for 6 months x 4 units = Total # of units (for the authorization period)

Example: If requesting 100 total hours of H2019, it would be submitted as:

$$100 \times 4 = 400 \text{ units.}$$

To convert the number of hours per week to the total number of units for the 6-month authorization period, please use the following formula:

Number of hours per week $\times$ 26 (weeks) $\times$ 4 (units) = Total # of units (for the authorization period)

Example: If requesting 10 hours per week of H2109, it would be submitted as:

$$10 \times 26 \times 4 = 1,040 \text{ units}$$

PROCEDURE CODES AND DESCRIPTIONS FOR ABA TREATMENT

H0031 – Behavior identification assessment. This will be utilized for the initial assessment/FBA and treatment plan development.

H0032 – Observational behavioral follow-up assessment. This will be included in the initial ABA services authorization letter and will be utilized for the progress report and re-assessment.

H2012 – Adaptive behavior treatment with protocol modification. This will be utilized for program supervision (direct and indirect).

Examples of direct and indirect supervision activities:

Direct Supervision	Indirect Supervision
Directly observe treatment implementation to determine if any changes are needed. Sometimes treatment plans need to be modified more frequently.	Analyze and summarize direct observation data to evaluate the member's progress toward goals. Typically done weekly (depending on member's needs/response to treatment).
Provide direction/guidance to staff and/or caregivers in the implementation of the treatment plan (with the member present). Typically done during treatment sessions.	Engage in care coordination with other service providers.
Observe and monitor treatment reliability to ensure implementation of treatment plan/protocols by behavior interventionist (BI)/staff. This will be important if there are staff changes or revisions to a member's treatment plan.	• Develop treatment plans and data collection systems. • Develop transition/discharge plans. • Make adjustments/revise treatment plans and protocols.

H2019 – Adaptive behavior treatment with one (1) patient. This is utilized for direct/1:1 ABA services provided to the member (member must be present).

H2014 – Adaptive behavior treatment social skills group with multiple patients. This is utilized for social skills groups with members and other peers. Typically, there are four (4) children/clients/members to one (1) adult/provider in the group setting.

S5111 – Family adaptive behavior treatment guidance. This is utilized for parent/caregiver training targeting parent/caregiver goals.

Section 8: D-SNP Supplemental Benefits

Supplemental Benefits Overview

DENTAL SERVICES PROVIDED THROUGH LIBERTY DENTAL

The Alliance contracts with Liberty Dental Plan for authorization management and a dental network that is available to members who enroll in the Alliance Wellness Plan.

Liberty Dental Plan
Toll-Free: **1.888.704.9838**
PO Box 26110
Santa Ana, CA 92799

To find a dental provider: <https://www.libertydentalplan.com/Find-a-Dentist/Find-a-Dentist.aspx>.

FLEX CARD PROVIDED THROUGH NATIONS

The Alliance contracts with Nations to provide a flex card to members who enroll in the Alliance Wellness Plan that can be used to buy a variety of eligible OTC products, such as cough and cold medicine, vitamins, pain relievers, bandages, and other eligible products.

Alliance Wellness Members may contact Nations toll-free at **1.877.408.7542**.

HEARING AID (SUPPLEMENTAL SERVICES) PROVIDED THROUGH NATIONS

The Alliance contracts with Nations to provide additional supplemental hearing aid services that is available to members who enroll in the Alliance Wellness Plan and can be used for prescription hearing aids.

- Member contacts Nations to schedule a hearing exam.
- Member visits provider for hearing exam at no charge.
- If the member is a candidate for hearing aids, they can order hearing aids utilizing their benefit allowance.
- The provider programs and fits the member with their hearing aids.
- The member receives a 60-day evaluation period, 3 follow-up visits, and a 3-year comprehensive warranty to ensure quality of care and total satisfaction

Alliance Wellness Members may contact Nations toll-free at **1.877.408.7542**.

Section 9: Claims

Claims Overview

Effective January 1, 2026, Medicare Advantage (MA) Health Maintenance Organization (HMO) Dual Special Needs Plan (D-SNP) (Alameda Alliance Wellness) will be implemented.

CLAIM REQUIREMENTS

The Alliance has established requirements for filing a claim for payment consideration. These requirements include that the claim is valid and complete, furnished within a prescribed time, and delivered to the correct business address. Failure to comply with these requirements may jeopardize the claim for reimbursement.

To be accepted as a valid claim, the submission must meet the following criteria:

- Must be submitted on a standard current version of a CMS 1500, CMS-1450 (UB04), or the ANSI X12-837-5010 (current version electronic format).
- Must contain appropriate information in all required fields.
- Must be a claim for an Alameda Alliance Wellness (D-SNP) member eligible at the time of service. (Always verify eligibility; for more information, please refer to “How to verify eligibility” in Section 3: Eligibility and PCP Choice).
- Must be an original bill.
- Must contain correct national standard coding, including but not limited to CPT, HCPCS, NDC (as published by the Food and Drug Administration (FDA), Revenue, and ICD-10 codes).
- Must not be altered by handwritten additions to procedure codes and/or charges.
- Must be signed by the rendering provider, if submitted as a paper claim.
- Must be printed with dark ink that is heavy enough to be electronically imaged, if submitted as a paper claim.
- Must be received within **180 days** from the service date for contracted providers unless otherwise indicated in your agreement and **365 days** for non-participating (non-contracted) providers.
- Must submit attachments on an 8 ½ x 11-inch sheet of paper and be legible.

Submitting a Claim

HEALTH INSURANCE CLAIM FORM (CMS 1500) – PROFESSIONAL CLAIMS

The Centers for Medicaid and Medicare Services (CMS) form 1500 or the electronic equivalent 837p must be used to bill the Alliance for medical services. This form is used by physicians and allied health professionals to submit claims for medical services.

HEALTH INSURANCE CLAIM FORM (CMS 1450) – FACILITY CLAIMS

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

A CMS 1450 (UB-04) or the electronic equivalent 837i is the only acceptable claim form type for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by the Alliance. In addition, a CMS 1450/837i is required when billing for nursing home services, swing bed services with revenue and occurrence codes, inpatient hospice services, Ambulatory Surgery Centers (ASC), and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

PAPER CLAIMS SUBMISSION

Paper claims for Alliance members should be submitted for payment as follows:

Claim Type	Responsible Entity
Professional Medical Service Claims	Medi-Cal and Group Care members: If the member/patient is assigned to an Alliance PCP: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460 If the member/patient is assigned to a CHCN PCP: Community Health Center Network 101 Callan Ave., 3rd Floor San Leandro, CA 94577 If the member/patient is assigned to a CFMG PCP: Children's First Medical Group PO Box 99680 Emeryville, CA 94662-9680 For Alameda Alliance Wellness members effective January 1, 2026: If the member/patient is assigned to an Alliance, CHCN, or CFMG PCP: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460
Institutional (Hospital, SNF, Long-Term-Care, etc.) Services Claims	Hospital/facility claims for all Alliance members: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460
Behavioral	For Medi-Cal members and if the services are moderate-to-

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Claim Type	Responsible Entity
Health Claims (Includes mental health and applied behavioral analysis)	severe, such as specialty mental health/severe mental illness and all substance use treatment: ACCESS, Alameda County Behavioral Health Care Services Toll-Free: 1.800.491.9099 For Medi-Cal members, and if the services are mild-to-moderate: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460 For Group Care members: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460 For Alameda Alliance Wellness members effective January 1, 2026: Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460
Vision Claims	Medi-Cal members up to December 31, 2025: MARCH Vision Care Attn: Claims Department 6701 Center Drive West, Suite 790 Los Angeles, CA 90045 www.marchvisioncare.com For Medi-Cal and Alameda Alliance Wellness members effective January 1, 2026: Attn: Claims Department Vision Service Plan PO Box 997100 Sacramento, CA 95899-7100
Dental Claims	Medi-Cal members: Medi-Cal Dental California Medi-Cal Dental Program PO Box 15609 Sacramento, CA 95852-0609

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Claim Type	Responsible Entity
	Alameda Alliance Wellness members effective January 1, 2026: Attn: Claims LIBERTY Dental Plan PO BOX 15149 Tampa, FL 33684-5149

ELECTRONIC CLAIMS SUBMISSION

The Alliance offers providers the speed, convenience, and lower administrative costs of electronic claims filing, also known as Electronic Data Interchange (EDI). Providers interested in submitting claims electronically should call the Alliance Provider Services Department at **1.510.747.4510**.

Claims that require attachments may not be sent electronically. They must be submitted using the appropriate paper claim forms with the attachments.

TIME FRAME FOR CLAIMS SUBMISSION

All claims must be submitted on time for consideration of payment. Claims submitted after the appropriate filing deadline will be denied unless documentation substantiating the delay in billing is provided. Claims submitted prior to the actual date of service (or date of delivery for supplies and DME) will also be denied.

Timely filing rules are as follows:

- When the Alliance is the primary payer on the claim:
- Participating (contracted) providers must submit claims post-service within the timely filing time frame identified in your agreement with the Alliance
- Post-service is defined as after the date of service for professional or outpatient institutional providers, or after the date of discharge for inpatient institutional providers
- Unless otherwise indicated in your agreement, contracted providers must submit claims within **180 calendar days** post-service
- Non-participating (non-contracted) providers must submit claims within **365 calendar days** post-service
- When the Alliance is not the primary payer under Coordination of Benefits (COB):
- Providers must submit a claim to the Alliance within **180 days** from the date of payment or date of denial notice from the primary payer
- Effective January 1, 2026, claims for Alameda Alliance Wellness (D-SNP) members will be automatically processed under the both the D-SNP and Medi-Cal lines of business. Providers do not need to submit a separate claim for the Medi-Cal line of business.

- For Medi-Cal only members: Providers must also submit a copy of the Remittance Advice (RA)/ Explanation of Benefits (EOB) from the primary payer which indicates the date of resolution by the primary payer, whether paid, contested, or denied
- When an Alliance member does not present accurate insurance information, and another payer or the member is billed for the service:
- The provider must also submit proof that the member or another payer has been billed
- Claims or any portion thereof previously denied by the Alliance as an incomplete claim due to missing or invalid information:
- For Medi-Cal and Group Care members: A corrected claim must be submitted for reconsideration of payment within **180 days** from the date of the original denial by the Alliance. A corrected claim may be mistaken as a duplicate claim submission unless it is clearly identified as such
- Effective January 1, 2026, for Alameda Alliance Wellness (D-SNP) members: A corrected claim must be submitted for reconsideration of payment within **365 days** from the date of the original denial by the Alliance for Contracted and Non-Contracted Providers. A corrected claim may be mistaken as a duplicate claim submission unless it is clearly identified as such
- Effective January 1, 2026, for Alameda Alliance Wellness (D-SNP) members: For certain claim related issues, Non-Contracted Providers will be sent a formal request for additional information needed to complete a claim. This request will be issued within 60 days of receiving the claim. Not all denials result in this request for additional information.

CLAIMS STATUS AND INQUIRY

Claim status can be verified for providers using our Online Provider Portal. Contact the Alliance Provider Services Department at **1.510.747.4510** for information regarding the use and how to obtain a Provider Portal account if you do not already have one.

Providers should call the Alliance Provider Services Department at **1.510.747.4510** for more complex claim status questions or submission requirements. Alliance Provider Services Representatives can assist with the resolution of complex claims issues and arrange for the adjustment of claims, if necessary.

PROOF OF TIMELY FILING

If a claim has been denied for timely filing, the following are acceptable forms of documentation for payment reconsideration:

- Certified mail receipt proving claims were received by the Alliance.
- Copy of the Remittance Advice (RA) or Explanation of Benefits (EOB) from the primary payer indicating the date of resolution (payment, date of contest, denial, or notice) if the claim was denied for untimely filing.
- Copy of the Alliance Electronic Data Interchange (EDI) Preprocessing

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Acceptance or Error Report for claims originally submitted electronically.

- Copy of the Alliance RA indicating the date and reason for the original denial for unclear claim denials.

MISDIRECTED CLAIMS

For Medi-Cal and Group Care members: When a claim is incorrectly sent to the Alliance that should have been sent to one (1) of its delegated partners (e.g., CHCN, CFMG, etc.), the Alliance will forward the claim to the appropriate delegated partner within **10 working days** of receipt of the claim.

The provider will also receive a notice of denial with instructions to bill the delegated partner.

Claims Receipt and Determinations

ACKNOWLEDGEMENT OF CLAIM RECEIPT

The Alliance will acknowledge the receipt of an electronic claim within **2 working days** from receipt of the claim or within **15 working days** of receipt of the claim if it was submitted on paper.

CLEAN CLAIM

A clean claim is defined as a claim that, when it is originally submitted, contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability and make timely payment.

CLEAN CLAIM PROCESSING TIME

- The Alliance will adhere to the following claims processing guidelines until December 31, 2025: 90% of clean claims within **30 calendar days** from receipt
- 95% of clean claims within **45 working days** from receipt
- 99% of clean claims within **90 calendar days** from receipt

The Alliance will adhere to the following claims processing guidelines as of January 1, 2026:

- 100% of clean claims within **30 calendar days** from receipt

INTEREST ON CLAIMS

For claims processed and paid through Wednesday, December 31, 2025: The Alliance will calculate and automatically pay interest, in accordance with Assembly Bill (AB) 1455 requirements, to all providers of service who have not been reimbursed for payment, within **45 working days** after the receipt of a clean claim.

Effective Thursday, January 1, 2026: For Medi-Cal and Group Care members, the Alliance will calculate and automatically pay interest, in accordance with Assembly Bill (AB) 3275 requirements, to all providers of service who have not been reimbursed for payment, within **30 calendar days** after the receipt of a clean claim.

Effective Thursday, January 1, 2026: For Contracted Providers submitting claims for Alameda Alliance Wellness (D-SNP) members, the Alliance will calculate and automatically pay interest in accordance with the terms outlined in the Provider contract.

Effective Thursday, January 1, 2026: For Non-Contracted Providers submitting claims for Alameda Alliance Wellness (D-SNP) members, clean claims will incur interest if paid greater than 30 calendar days from the claim received date or the date the requested additional information is received

BILLING MEMBERS

Providers are prohibited from billing Alliance members for covered services. Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California, it is illegal to bill a member who is enrolled in a state program for which services were provided. Alliance members are never responsible for paying participating providers any amount for covered medical services, other than approved co-insurance, deductibles, or co-payment amounts as a part of the member's benefit package. d

Providers may not seek reimbursement from the member for a balance due. Providers may not bill Alliance members for covered services, open bills, or balances in any circumstance, including when the Alliance has denied payment. In some cases, providers may bill members for co-payments, non-benefits, and non-covered services.

Effective Thursday, January 1, 2026: For Alameda Alliance Wellness (D-SNP) members, In Network Providers may not seek reimbursement from the member for a balance due. Providers may not bill Alliance members for covered services, open bills, or balances in any circumstance, including when the Alliance has denied payment. In some cases, providers may bill members for co-payments, non-benefits, and non-covered services.

Effective Thursday, January 1, 2026: For Alameda Alliance Wellness (D-SNP) members, Out of Network Providers cannot bill members for the remaining balance after the plan has paid their portion of the claim, except in specific cases like non-covered services.

OVERPAYMENTS AND RECOUPMENTS

Overpayments can happen for many reasons, including, but not limited to:

- Alliance claim processing error
- Another party paid for covered services (i.e., coordination of benefits)

- Duplicate payment made by the Alliance when covered services are payable, in part or full, to another provider
- Retroactive change to eligibility

For Medi-Cal and Group Care members: A written overpayment request will be sent to the provider within **365 days** of the date the original claim was paid. The provider must either dispute or refund the requested monies within **30 working days** from receipt of the notification of overpayment. If the provider does not dispute or refund the requested monies within **30 working days**, the Alliance may offset the requested amount against future claim payments, as documented in the contractual agreement or when a non-contracted provider has agreed in writing.

Effective Thursday, January 1, 2026: For Alameda Alliance Wellness (D-SNP) members, a written overpayment request will be sent to the provider within **365 days** of the date the original claim was paid. The provider must either dispute or refund the requested monies within **30 working days** from receipt of the notification of overpayment. If the provider does not dispute or refund the requested monies within **30 working days**, the Alliance may offset the requested amount against future claim payments, as documented in the contractual agreement or when a non-contracted provider has agreed in writing.

COORDINATION OF BENEFITS (COB)

For Medi-Cal members, the Order of Benefit Determination Rule is used to determine the order of payment responsibility when an Alliance member is covered by more than one (1) health plan or insurer. The Alliance is always the payer of last resort for Medi-Cal members and all other coverage is primary. State and federal laws require providers to bill other health insurers prior to billing the Alliance.

Effective Thursday, January 1, 2026: For Alameda Alliance Wellness (D-SNP) members, the Order of Benefit Determination Rule is used to determine the order of payment responsibility when an Alliance member is covered by more than one health plan or insurer.

For D-SNP members who also have a Commercial (COMM) plan, the order of payment is as follows:

- COMM Plan – Primary payer
- D-SNP Plan – Secondary payer
- Medi-Cal – Payer of last resort, covering any remaining eligible balance

COORDINATING BENEFITS

For Medi-Cal members: All claims must be submitted to the Alliance within **180 days** from the date of payment on the primary payer's RA/EOB. A copy of the RA/EOB must accompany the claim. If the primary payer denies services asking for additional information, the information must be submitted to the primary payer and the claim finalized prior to submitting the claim to the Alliance. Since a copy of the primary payer's RA/EOB must be submitted along with the claim, these claims must be submitted on paper. Claims submitted electronically where the member has other coverage will be denied with instructions to resubmit as a paper claim with the RA/EOB attached.

When the Alliance is the primary payer, providers are reimbursed at their full contracted reimbursement rate or based on Medi-Cal rates for non-participating (non-contracted) providers.

When the Alliance is the secondary payer under COB rules, the Alliance will generally pay the lesser of the following amounts for covered services:

- The actual charge made by the provider less the amount paid by the other coverage up to the patient responsibility portion (co-insurance, deductible, or co-pay amounts).
- Up to the amount the Alliance would have paid if the individual did not have other coverage.

If the primary insurance payment exceeds the fully allowed contracted rate, neither the Alliance nor its member is financially responsible for any additional amount.

THIRD-PARTY LIABILITY

Providers may often learn of a possible Third-Party Liability (TPL) case before the Alliance. Therefore, providers must assist with recovery by promptly notifying the Alliance when a TPL case is discovered.

Notification and TPL information may be either mailed or faxed to:

Attn: Claims Department
Alameda Alliance for Health
PO Box 2460
Alameda, CA 94502-0460
Fax: **1.877.747.4506**

Providers must promptly notify the Alliance Claims Department of a TPL case when:

- The patient has filed or intends to file a claim or lawsuit against a third party for injuries
- A third party that caused or allegedly caused the patient's injury has insurance that will cover the expenses

Below are some situations where a possible TPL case may exist:

- Member involved in an auto accident
- Member injured on premises owned by another (e.g., slip-and-fall)
- Member injured on the job (worker's compensation)
- Member injured by another's negligence

TPL SUBMISSION REQUIREMENTS

When a TPL case is identified, the provider's staff should obtain the following information from the member and forward it with the TPL Notification Form to the Alliance:

- Patient name, social security number, address, and telephone
- Date of injury
- Attorney's name, address, and telephone number (if any)
- Third party's insurance carrier or attorney's name, address, and telephone number (if known)

Service Specific Information

AMBULANCE, EMERGENCY, URGENTLY NEEDED, AND POST-STABILIZATION CARE SERVICES

The Alliance is responsible for ambulance, emergency, urgent, and post-stabilization care services, whether services are obtained in or out of network.

During Business Hours: A contracted or non-contracted hospital can call the Alliance Authorization Unit when the hospital determines that a member is stable for transfer or to obtain authorization for post-stabilization care. The hospital only needs to make one (1) call to the Alliance to request prior authorization for post-stabilization care. If the Alliance does not respond to the request within one-half hour (30 minutes), the post-stabilization care shall be deemed as approved. The Alliance Authorization Unit coordinator will confirm the member's eligibility and forward the information to an Alliance Utilization Management (UM) nurse. The Alliance UM nurse will perform a telephonic review of the member's current medical conditions and coordinate any necessary post-stabilization care.

To contact the Alliance Authorization Unit, please call:

Alliance Authorization Unit
Phone Number: **1.510.747.4540**
Toll-Free: **1.855.891.9161**



After Business Hours, Weekends, and Holidays: Contracted and non-contracted hospitals can call the Alliance On-Call nurse when the hospital determines that a member is stable for transfer or to obtain authorization for post-stabilization care. The hospital only needs to make one (1) call to the Alliance to request prior authorization for post-stabilization care. If the Alliance does not respond to the request within one-half hour (30 minutes), the post-stabilization care shall be deemed as approved. The first day of post-stabilization will be authorized if the member is eligible with the Alliance on the date of service. The Alliance will follow up with the hospital on the next business day with the authorization number.

To contact the Alliance On-Call Nurse, please call:

Alliance On-Call Nurse
Phone Number: **1.510.326.5271**

To provide medically necessary post-stabilization care services within 30 minutes of the request, the services are deemed authorized. This requirement applies to requests submitted directly to the Alliance and/or its delegates.

The Alliance will make a prompt determination and reasonable payment to, or on behalf of, the member for the service(s) when the financial responsibility is that of the Alliance.

FAMILY PLANNING SERVICES AND SENSITIVE SERVICES (MEDI-CAL AND GROUP CARE ONLY)

Sensitive services are those services designated by the state Medi-Cal program as available to members without a referral or authorization to protect patient confidentiality and promote timely access. Sensitive services include family planning, screening and treatment for sexually transmitted diseases, HIV testing, and abortions. All Alliance Medi-Cal members may go outside of their medical group's network for sensitive services, which does not include prenatal care. Authorization is not required for prenatal care, but members must stay within their medical groups.

Family planning and sensitive services may be billed fee-for-service. All PCPs or OB-GYNs rendering family planning and sensitive services must be documented on the claim form. For Medi-Cal members, family planning and sensitive services may be obtained in or out of network without any prior authorization requirements. For Group Care members, family planning and sensitive services obtained in network do not require prior authorization, but services obtained out of network will require prior authorization.

STERILIZATION SERVICES (MEDI-CAL AND GROUP CARE ONLY)

Written informed consent must be obtained from all members seeking sterilization services. This applies to tubal sterilization, vasectomy, and hysterectomy. For Medi-Cal members only, regulations require that a copy of the signed PM-330 consent form be submitted to payers before payment can be released. Consequently, the Alliance will not reimburse professional or facility fees associated with tubal sterilizations, vasectomies, or hysterectomies, unless an appropriately completed PM-330 consent form is submitted by the primary surgeon.

HIV TESTING AND COUNSELING (MEDI-CAL AND GROUP CARE ONLY)

PCPs rendering HIV counseling and testing to assigned members may bill fee-for-service for those procedures.

Providers, other than the assigned PCP, who render HIV counseling and testing services, may bill the Alliance fee-for-service (FFS).

MINOR CONSENT SERVICES (MEDI-CAL AND GROUP CARE ONLY)

Minor Consent Services, described below, may be billed fee-for-service when rendered by a PCP to their assigned Medi-Cal members. Minor Consent Services include:

- Abortions
- Confirmation or rule out pregnancy
- Family planning
- HIV testing
- Sexual assault
- Sexually transmitted diseases

VACCINES (MEDI-CAL AND GROUP CARE ONLY)

Administration of routine pediatric immunizations is paid on a fee-for-service basis to the PCP. The appropriate administration codes must be submitted on the CMS 1500 form or the electronic equivalent 837p.

For Medi-Cal members, PCPs have access to free vaccines through the Vaccines for Children (VFC) Program. To enroll, call the VFC Program directly. Community and county clinics should call **1.510.267.3230**. Private providers should call **1.510.704.3750**. Vaccines not covered by the VFC Program should be billed directly to the Alliance for reimbursement. If a claim is received and the provider is registered with VFC, the claim will be denied.

LABORATORY: CLINICAL, CYTOPATHOLOGY, AND PATHOLOGY

Quest Diagnostics is the Alliance's contracted partner for most outpatient clinical laboratory services. Apart from emergency, urgent, PCP-covered labs, sensitive services, or labs specifically identified as reimbursed fee-for-service, laboratory services are carved out to the Alliance's capitated laboratory provider, Quest Diagnostics. Pathology services, identified as CPT-4 procedure code range 88300- 88399, are payable by the Alliance only when performed in conjunction with emergency or urgent care services, or surgical services performed in an inpatient hospital, outpatient hospital, or freestanding surgical facility setting.

Members who are assigned to Alameda Health System (AHS) are capitated for lab services and will receive laboratory services through one (1) of the following AHS clinics:

AHS Clinic	Phone Number	Address
Eastmont Wellness	1.510.567.5700	6955 Foothill Blvd. Oakland, CA 94605
Hayward Wellness	1.510.266.1700	664 Southland Mall Dr. Hayward, CA 94545
Highland Wellness	1.510.437.5039	1411 East 31st St. Oakland, CA 94602
Newark Wellness	1.510.505.1600	6066 Civic Terrace Ave. Newark, CA 94560

The Alliance also contracts with Foundation Laboratory.

They provide on-site lab services to members who are seen by these Oakland providers:

Clinic	Phone Number	Address
MacArthur Gastroenterology	1.510.562.7467	10520 MacArthur Blvd. Oakland, CA 94605
Roots Community Health Center – Main Clinic	1.510.777.1177	9925 International Blvd. Oakland, CA 94603
Roots Community Health Center – Headquarters Clinic	1.510.533.1248	7272 MacArthur Blvd. Oakland, CA 94605

OFFICE-BASED INJECTABLES

Except for injectables administered in an inpatient setting, claims for injectables administered in the office must be billed with the appropriate HCPCS code and include the corresponding National Drug Code (NDC) for each drug. Claims that do not include NDCs, invalid NDCs, or NDCs that do not correspond to the procedure code billed will be denied.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Code Sets

BILLING CODES

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete or invalid codes will result in a potential denial of the claim and a subsequent delay in payment.

All providers need to bill with approved Medicare code for D-SNP members or Medi-Cal codes for Medi-Cal and Group Care members. Using non-approved Medicare or Medi-Cal codes will result in a denial of services.

For Medi-Cal and Group Care claims, if you use unlisted or miscellaneous approved Medi-Cal CPT-4 or HCPCS codes, notes and/or a description of services rendered must accompany the claim. The use of unlisted or miscellaneous codes will delay claims payment and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

Providers will also improve the efficiency of their reimbursement through proper coding and reporting of a member's diagnosis. We require the use and reporting on a claim of valid ICD-10 diagnosis codes, to the appropriate specificity, for all claims. This means that ICD-10 codes must be carried out to the fifth, sixth, or seventh digit when indicated by the coding requirements in the ICD-10 manual. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

Effective January 1, 2026: For Alameda Alliance Wellness (D-SNP) members, it is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete or invalid codes will result in a potential denial of the claim and a subsequent delay in payment.

All providers need to bill with approved Medicare codes. Using non-approved Medicare codes will result in a denial of services.

If you use unlisted or miscellaneous approved Medicare CPT-4 or HCPCS codes, notes and/or a description of services rendered must accompany the claim. The use of unlisted or miscellaneous codes should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

Providers will also improve the efficiency of their reimbursement through proper coding and reporting of a member's diagnosis. We require the use and reporting on a claim of valid ICD-10 diagnosis codes, to the appropriate specificity, for all claims. This means that ICD-10 codes must be carried out to the fifth, sixth, or seventh digit when indicated by the coding requirements in the ICD-10 manual. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

CODE AUDITING AND EDITING

The Alliance utilizes code-auditing software for automated claims coding verification, and to ensure that the Alliance is processing claims in compliance with general industry, Medicare, and Medi-Cal standards.

The code-auditing software takes into consideration the conventions set forth in the health care insurance industry, such as regulatory state and federal standards, the National Correct Coding Initiative (NCCI), Medicare guidelines, and Medi-Cal guidelines.

Using a comprehensive set of rules, the code auditing software:

- Accurately applies coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology, and anesthesiology, as outlined by the American Medical Association's (AMA) CPT-4 manual
- Evaluates the CPT-4 and HCPCS codes submitted by detecting, correcting, and documenting coding inaccuracies, including, but not limited to, unbundling, up-coding, fragmentation, duplicate coding, invalid codes or modifiers, and mutually exclusive procedures
- Incorporates historical claims auditing functionality that links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service
- The Alliance reviews providers' claim billing patterns and requests medical records for review when needed. Providers are responsible for submitting the requested medical records to the Alliance
- Failure to comply with the request may lead to corrective action plans or a possible hold on payments

Effective January 1, 2026, the above process also applies to Alameda Alliance Wellness (D-SNP) claims in accordance with the National Correct Coding Initiative (NCCI), and Medicare guidelines

Electronic Visit Verification (EVV) (MEDI-CAL ONLY)

Effective Sunday, January 1, 2023, the Electronic Visit Verification (EVV) requirements established by the California Department of Health Care Services (DHCS) required providers who offer Personal Care Services (PCS) and Home Health Care Services (HHCS) in a member's home to capture and transmit six (6) mandatory data components to DHCS' vendor, Sandata. Sandata supplies the visit verifications required by DHCS to process claims for services. Claims for unverified visits that have not been logged through Sandata may be subject to claim denials.

Below are the six (6) mandatory data components:

- The type of service performed
- The individual receiving the service
- The date of service
- The location of the service
- The individual providing the service
- The time the service begins and ends

Provider types who are required to comply with EVV requirements are:

- Day habilitation program providers
- Home health providers
- Personal care and homemaker providers
- Respite providers

Registration link and/or training resources:

- Registration: **www.dhcs.ca.gov/provgovpart/Documents/CalEVV-Provider-Self-Registration-QRG.pdf**
- Training: **<https://sandata.zendesk.com/hc/en-us/articles/8614759432211--CalEVV-New-Provider-Self-Registration-and-Onboarding-Video>**
- Provider/Claim Types: **www.dhcs.ca.gov/provgovpart/Documents/EVV-Provider-Types-and-Codes-November.pdf**

Section 10: Provider Dispute Resolutions (PDR)

For Medi-Cal and Group Care Members: The Alliance offers a fair, fast, and cost-effective dispute resolution mechanism to process and resolve provider disputes. A PDR request may be submitted in writing using the PDR Request Form. Dispute requests must be submitted within **365 calendar days** of the Alliance's most recent action on the disputed claim.

A contracted or non-contracted provider dispute is a provider's written notice challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted, or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim or appeal of medical necessity/utilization management decision.

Corrected claims are not accepted through the PDR process. For more information on how to submit a corrected claim, please refer to "Submitting a Claim" in Section 8: Claims.

Note: The Provider Dispute Resolution (PDR) process should not be used to request retroactive authorization. Instead, retrospective authorization requests, even if a claim denial is already on file, must be submitted to the Alliance Utilization Management (UM) Department for medical necessity review. These requests must be submitted within 90 calendar days from the date of service.

Alliance Utilization Management (UM) Department
Phone Number: **1.510.747.4540**
To submit a request via E-Fax line: **1.855.891.7174**
www.alamedaalliance.org/providers/authorizations.

Each contracted provider dispute must contain, at a minimum, the following information:

- Provider name
- Provider NPI/TIN
- Member name and identification number
- Provider identification number
- Provider contact information
- Claim number
- Supporting documentation
- Reason for the dispute, including a clear explanation of the issue and the provider's position thereon

- If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim – A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
- If a dispute is about a claim – Must have a processed (paid or denied) claim
- If the dispute involves a member or group of members – Must include the individual claims numbers, name(s) and identification number(s) of the member(s), and a clear explanation of the disputed item, including the date of service and the provider's position thereon

Providers can access the Provider Dispute Resolution (PDR) Form on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

Provider disputes can be submitted by mail or through the Alliance Provider Portal:

Mail:

Attn: Provider Dispute Resolution (PDR) Unit
Alameda Alliance for Health
PO Box 2460
Alameda, CA 94501-0460

Provider Portal:

To submit the form through the Alliance Provider Portal:

- Visit the Alliance website at **www.alamedaalliance.org**.
- Click on the 'Provider Portal' link in the upper right-hand corner and log in.
- Select 'Claims Submission Form.'

Provider disputes that do not include all required information may be returned to the submitter for completion. An amended dispute which includes the missing information may be submitted within **30 working days** of your receipt of a returned provider dispute.

PDRs submitted by mail will be acknowledged within **15 working days** of the receipt date and PDRs submitted electronically (through the Alliance Provider Portal) will be acknowledged within **two (2) working days**; either submission type will be resolved within **45 working days** of the receipt date of the dispute.

A determination from the Alliance is the final decision and will not be reconsidered if resubmitted.



Effective January 1, 2026: For Alameda Alliance Wellness (D-SNP) claims:

For Contracted Providers, the Alliance offers a fair, fast, and cost-effective dispute resolution mechanism to process and resolve provider disputes. A dispute request may be submitted in writing using the provider dispute Request Form. Dispute requests must be submitted within **120 calendar days** of the Alliance's most recent action on the disputed claim. Contracted Providers do not have appeal rights.

Non-contracted providers may only dispute a claim payment when reimbursement is less than what the provider would have expected under Original Medicare.

Providers can access the Provider Dispute Resolution (PDR) Form on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

Provider disputes can be submitted by mail or through the Alliance Provider Portal:

Mail:

Attn: Provider Dispute Resolution (PDR) Unit
Alameda Alliance for Health
PO Box 2460
Alameda, CA 94501-0460

Provider Portal:

To submit the form through the Alliance Provider Portal:

- Visit the Alliance website at **www.alamedaalliance.org**.
- Click on the 'Provider Portal' link in the upper right-hand corner and log in.
- Select 'Claims Submission Form.'

Non-contracted providers may submit an appeal for claim denials along with a Waiver of Liability (WOL) statement to the Alliance's Grievance and Appeals Department. Please refer to Section XX, Grievance and Appeals, for information on submitting an appeal. Appeals requests must be submitted within **120 calendar days** of the Alliance's most recent action on the claim.

Alameda Alliance Wellness Customer Services
Monday – Sunday (seven (7) days a week), 8 am – 8 pm
Phone Number: **1.510.747.4508**
Toll-Free: **1.888.88A.DSNP (1.888.882.3767)**
If you cannot hear or speak well use TTY or call **1.800.735.2929**

Corrected claims are not accepted through the PDR process. For more information on how to submit a corrected claim, please refer to "Submitting a Claim" in Section 9: Claims.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Please Note: The Provider Dispute Resolution (PDR) process should not be used to request retroactive authorization. Instead, retrospective authorization requests, even if a claim denial is already on file, must be submitted to the Alliance Utilization Management (UM) Department for medical necessity review. These requests must be submitted within 90 calendar days from the date of service.

Alliance Utilization Management (UM) Department

Phone Number: **1.510.747.4540**

To submit a request via E-Fax line: **1.855.891.7174**

www.alamedaalliance.org/providers/authorizations.

Each provider dispute must contain, at a minimum, the following information:

- Provider name
- Provider NPI/TIN
- Member name and identification number
- Provider identification number
- Provider contact information
- Claim number
- Supporting documentation
- Reason for the dispute, including a clear explanation of the issue and the provider's position thereon
- If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim – A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
- If a dispute is about a claim – Must have a processed finalized (paid or denied) claim
- If the dispute involves a member or group of members – Must include the individual claims numbers, name(s) and identification number(s) of the member(s), and a clear explanation of the disputed item, including the date of service and the provider's position thereon

Providers can access the Provider Dispute Resolution (PDR) Form on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

Provider disputes can be submitted by mail or through the Alliance Provider Portal:

Mail:

Attn: Provider Dispute Resolution (PDR) Unit
Alameda Alliance for Health
PO Box 2460
Alameda, CA 94501-0460

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Provider Portal:

To submit the form through the Alliance Provider Portal:

- Visit the Alliance website at **www.alamedaalliance.org**.
- Click on the 'Provider Portal' link in the upper right-hand corner and log in.
- Select 'Claims Submission Form.'

The Alliance Dispute team will make attempts to work with the Contracted Provider for disputes that do not include all required information to make a final determination. If the information is not received by the 60th calendar day, the case will be closed.

Contracted Provider Submissions shall be resolved within 60 calendar days of the receipt date of the dispute. Non-Contracted Provider Submissions shall be resolved within 30 calendar days of the receipt date of the dispute.

If an investigation shows that a claim was originally denied or paid incorrectly due to the Alliance's error, any interest and penalty due for late payment will be included in the claim payment. Payment will be made within five (5) working days from the issuance of the Alliance's determination

A determination from the Alliance is the final decision and will not be reconsidered if resubmitted. For further instructions on how to submit a PDR request, please call:

Alliance Provider Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4510**.

Section 11: Telehealth (Medi-Cal and Group Care Only)

This section details telehealth requirements for providers who may provide services via audio or visual telehealth modality as required by state and federal regulations.

Telehealth Requirements for Medi-Cal and Group Care

VIDEO AND AUDIO REQUIREMENTS

Effective Monday, January 1, 2024, all providers conducting telehealth via audio-only synchronous interactions must also offer those same services via video synchronous interactions.

Providers furnishing services through video or audio-only synchronous interaction must also do one (1) of the following:

- Offer those same services via in-person, face-to-face contact
- Arrange for a referral to and facilitation of in-person care that does not require a member to independently contact a different provider to arrange for that care
- Document member consent prior to the initial delivery of covered services via telehealth
- Inform the member that telehealth is voluntary, and consent for telehealth may be withdrawn at any time without affecting their ability to access Medi-Cal-covered services in the future
- Inform the member about the availability of non-medical transportation (NMT) to in-person visits
 - Please direct Alliance members to call the Alliance Transportation Services toll-free at **1.866.791.4158**
- Inform the member of the potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable

MODEL LANGUAGE FOR TELEHEALTH PATIENT CONSENT

The California Department of Health Care Services (DHCS) has created a document with model language that providers may use as part of their Telehealth Policy Implementation Patient Consent. To view or download the document, please visit the DHCS website at www.dhcs.ca.gov/provgovpart/Documents/Patient-Consent-Model-Written-Verbal-Language.pdf. Providers are not required to use the DHCS language but may be used as a resource.

Please Note: Providers must also document when a member consents to receive covered services via telehealth before the initial delivery of the services. Member consent can be obtained verbally or in writing and then documented by the provider.

REQUIREMENTS TO PROVIDE TELEHEALTH SERVICES

Telehealth modality may only be provided and reimbursed if all the following criteria are satisfied:

- The treating provider at the distant site believes the covered services being provided are clinically appropriate to be delivered via telehealth based on evidence-based medicine and/or best clinical judgment
 - The member has provided verbal or written consent
 - The medical record documentation substantiates that the covered services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service
- Providers are not required to:
- Document a barrier to an in-person visit for covered services provided via telehealth (WIC section 14132.72(d)); or
 - Document the cost-effectiveness of telehealth reimbursement for covered services provided via a telehealth modality
- The covered services provided via telehealth meet all state and federal laws regarding confidentiality of health care information and a member's right to their medical information

REIMBURSABLE TELEHEALTH SERVICES

Certain types of covered services cannot be appropriately delivered via telehealth. These include covered services that would otherwise require the in-person presence of the member for any reason, such as those that are performed in an operating room or while the member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

The provider must assess the appropriateness of the telehealth modality to the member's level of acuity at the time of the service. The provider is not required to be present with the member at the originating site unless determined medically necessary by the provider at the distant site.

All providers, with the exception of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs), are allowed to be reimbursed for consultations provided via a telehealth modality. These electronic consultations (e-consults) are permissible using the appropriate CPT-4 code, modifier(s), and medical record documentation defined in the Medi-Cal Provider Manual.

Members cannot initiate e-consults as they are interprofessional interactions, and therefore only permissible between providers. Providers, including FQHCs, RHCs, and THPs are permitted to be reimbursed for brief virtual communications that consist of a brief communication with a member who is not physically present (face-to-face) at the fee-for-service (FFS) rate.

The virtual communications reimbursement for FQHCs, RHCs, and THPs was discontinued with the end of the COVID-19 Public Health Emergency on Thursday, May 11, 2023.

TELEHEALTH BILLING - PLACE OF SERVICE CODES AND MODIFIERS

Telehealth visits may ONLY use CPT codes for an office visit with the appropriate place of service and/or modifier option, regardless of the modality. Providers will continue to be reimbursed at the contracted rate for office visits for these services and are responsible for determining the appropriate place of service code and modifier option to use based on the visit and guidance by DHCS.

Place of Service Code	Modifier Options	Modifier Description
02 – Telehealth Provided Other than in Patient's Home.	95	For services or benefits provided via synchronous, interactive audio and visual telecommunications systems . Synchronous means a real-time interaction between a patient and a health care provider located at a distant site.
Or	GQ	For services or benefits provided via asynchronous store and forward telecommunications systems . Asynchronous store and forward means the transmission of a patient's medical information from an originating site to the health care provider at a distant site.
10 – Telehealth Provided in Patient's Home.	93	For services or benefits provided via synchronous telephone or other real-time interactive audio-only telecommunications systems . Synchronous means a real-time interaction between a patient and a health care provider located at a distant site.

TELEHEALTH RESOURCES

- DHCS website www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
- DHCS Telehealth Resource Page for Providers
www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx
- California Code, Business and Professions Code - BPC § 2290.5
- Senate Bill 184

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Telehealth Requirements for Alameda Alliance Wellness (D-SNP)

Dual Eligible Special Needs Plans (D-SNP), Alameda Alliance Wellness will become effective January 1, 2026.

CMS guidance for telehealth is valid through September 30, 2025, you can get telehealth services at any location in the U.S., including your home.

CMS guidance for telehealth starting October 1, 2025, you must be in an office or medical facility located in a rural area (in the U.S.) for most telehealth services.

If you aren't in a rural health care setting, you can still get certain Medicare telehealth services on or after October 1, including:

- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis
- Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit

Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder (including a substance use disorder) in your home.

Section 12: Service and Referrals for Adults – Adult Clinical Preventive Services

This section details the services for adults receiving benefits as required by state and federal regulations. The Alliance requires PCPs to follow uniform guidelines for adult periodic health examinations in accordance with the US Preventive Services Task Force’s “A” and “B” recommendations in the *Guide to Clinical Preventive Services*.

The preventive guidelines can be found on the U.S. Preventive Services Taskforce website at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations. PCPs are required to provide preventive health services to their assigned members.

In addition, all Alliance members over the **age of 21** are required to receive an Initial Health Appointment (IHA) from their PCP, including a complete physical examination, history, and risk assessment. (see www.alamedaalliance.org/providers/initial-health-assessment).

For assistance, providers may contact the Alliance Provider Services Department at **1.510.747.4510**.

OB/GYN Services

Alliance members have open access to services provided by in-network OB/GYNs and qualified family practice physicians. Gynecological services provided to a member in the provider’s office do not require prior authorization or a referral from their PCP.

Cancer Screening

All generally medically accepted cancer screening tests are covered by the Alliance.

Screening and diagnosis of breast cancer is a covered benefit. Mammograms do not require prior authorization. Treatment for breast cancer includes prosthetic devices or reconstructive surgery for a patient incident to mastectomy.

Documentation

Documentation of all clinical preventive service encounters must be included in the member’s medical record. The medical record will be reviewed for completeness during site reviews conducted by the Alliance.

Providers should report all adult preventive health encounters, whether capitated or fee-for-service, to the Alliance using the CMS 1500.

For more information on adult preventive health services, providers can visit www.ahrq.gov/prevention/guidelines/index.html.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

Immunizations

Vaccinations provided to Alliance members over **age 18** do not require prior authorization. Providers may bill the Alliance for administering the vaccine and submitting a CMS 1500 claim form.

Alliance Wellness (D-SNP)

Vaccines for DSNP members may be covered under Part B (medical) or Part D (pharmacy) benefit. Part D covers vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) at no cost to the member. Vaccines administered in office will require the member to pay and submit a reimbursement request to Alliance. ACIP recommended Part D vaccines obtained at a network pharmacy have no cost share to the member. For specific vaccines covered under Part D refer to the Alliance D-SNP formulary at **www.alamedaalliance.org/alliancewellness**.

Family Planning Services

Medi-Cal members are entitled to timely, convenient, and confidential access to the full range of family planning services. In accordance with federal regulations, Medi-Cal members are allowed freedom of choice in selecting a family planning provider. Therefore, Medi-Cal members may receive such services from a PCP, non-PCP, or an out-of-plan provider, without prior authorization. Members enrolled in other Alliance product lines may see Alliance-contracted providers for family planning services.

SCOPE OF SERVICES

The following family planning services (Medi-Cal members only) are covered for both in-network and out-of-plan providers:

- Abortions
- Diagnosis and treatment of STDs if medically indicated
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider, if provided in an ambulatory setting
- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Laboratory tests if medically indicated as part of the decision-making process for the choice of contraceptive methods
- Limited history and physical examination
- Pregnancy testing and counseling
- Provision of contraceptive pills/devices/supplies
- Screening, testing, and counseling of members at risk for HIV; referral for treatment
- Tubal ligation
- Vasectomies

TYPES OF PROVIDERS WHO MAY RENDER FAMILY PLANNING SERVICES

The following types of contracted providers may provide family planning services, as listed previously, within their scope of practice, to Alliance members:

- Assigned PCPs
- Family and general practitioners
- Pediatricians
- County and community clinics
- Obstetricians/Gynecologists and Certified Nurse Midwives
- Family planning clinics
- STD clinics

Nurse practitioners and physician assistants may provide family planning services through a contracted physician.

REFERRALS

If the member's family planning needs exceed the provider's scope of practice, the member should be referred to an appropriate family planning provider. This referral does not require prior authorization and can be made to a provider within or outside the Alliance provider network (Medi-Cal only).

Providers should assist members in identifying family planning providers. Refer to the Provider Directory or encourage the member to call the Alliance Member Services Department at **1.510.747.4567**. The Alliance Member Services Department can provide referrals for family planning services.

INFORMED CONSENT

Providers must obtain signed informed consent for any invasive procedure done during a family planning visit, such as the insertion of a Norplant or an intrauterine device (IUD) and for sterilization. Although signed consent is not required for all family planning methods, providers must document that members have been informed of the full range of contraceptive choices.

OUT-OF-PLAN FAMILY PLANNING SERVICES FOR MEDI-CAL

Covered Out-of-Plan

Medi-Cal members may access family planning services out-of-network but are encouraged to choose a plan provider in order to promote continuity of care. Out-of-network family planning providers must be qualified to provide family planning services based on their licensed scope of practice. Medi-Cal members seeking care from an out-of-network provider should be advised that services are limited to those listed under Scope of Services in this section.

Excluded Out-Of-Plan

Out-of-plan providers will not be reimbursed for the following family planning services:

- Hysterectomy
- Reversal of voluntary sterilization
- Routine infertility studies or procedures
- Transportation, parking, and childcare

Confidential Human Immunodeficiency Virus (HIV) Testing

The Alliance's policy is to ensure members receive information regarding access to confidential HIV counseling and testing. Alliance Medi-Cal members have the right to confidential HIV counseling and testing within and outside of the Alliance's provider network. Members enrolled in other Alliance product lines may see any Alliance-contracted provider for HIV services.

IDENTIFICATION

The following procedures should be followed for the identification of patients who may need confidential HIV counseling and testing:

- All hemophiliacs
- Any other STD (i.e., syphilis, gonorrhea, human papillomavirus, chlamydia, pelvic inflammatory disease)
- Behavior/history Indications
- Behavior resulting in other blood-to-blood contact, sadomasochism (S&M), tattooing, piercing, etc.
- Cervical cancer
- Child of an HIV-infected woman
- Hepatitis B or C
- Herpes zoster outbreak in a person under 50 years old
- Inquire about illicit drug use to identify members who may need HIV counseling and testing
- Medical indications
- Men who have had sex with men
- Perform a thorough history and physical exam, including taking a sexual history
- Persistent, recurrent, or refractory vaginal candidiasis
- Persons who have had anal intercourse
- Received blood/blood transfusion before 1985 or in a country where blood was not tested for HIV
- Received drugs for sex
- Received money for sex
- Refer members for HIV counseling and testing under the following conditions:
 - Sex with a prostitute/sex partner

- Tuberculosis, active disease in a U.S. native, and TB patients unresponsive to treatment
- Unexplained, persistent weight loss, diarrhea, or fever
- Use of intravenous drugs or other substances

All pregnant women should be offered and encouraged to have HIV counseling and testing whether or not they seem to be at risk for HIV infection, in accordance with California law.

For a complete list of test sites, please call the County Office of Acquired Immune Deficiency Syndrome (AIDS) at **1.510.873.6500**.

REFERRAL

Providers may refer a patient requesting confidential HIV testing to a confidential test site, family planning, or a sexually transmitted disease provider within the Alliance provider network for all product lines. Referrals to in-plan sites are encouraged; however, Medi-Cal members do have the option of seeking HIV testing through non-contracted providers.

Providers should advise any member who chooses to go to an out-of-plan confidential test site to sign a release of information form to allow their name to be submitted on the claim. If the claim is submitted without a name to determine eligibility for services, the Alliance will not reimburse the provider.

ALLIANCE-CONTRACTED HIV TEST SITES

The following test sites are within the Alliance's network:

Test Site	Phone Number	Address
Alameda County Medical Center - Highland Hospital	1.510.437.4800	1411 E. 31st St. Oakland, CA 94602
Asian Health Services	1.510.986.6800	818 Webster St. Oakland, CA 94607
Axis Community Health Center	1.925.462.1755	5925 W. Las Positas Blvd. #100 Pleasanton, CA 94566
Berkeley Public Health Clinic	1.510.981.5350	830 University Ave. Berkeley, CA 94710
East Oakland Health Center	1.510.430.9401	7450 International Blvd. Oakland, CA 94621
Eastmont Wellness Center	1.510.577.5668	6955 Foothill Blvd. Oakland, CA 94605
La Clínica de la Raza - Clínica Alta Vista	1.510.535.4000	3451 E. 12th St. Oakland, CA 94601

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Test Site	Phone Number	Address
Native American Health Center	1.510.535.4460	3124 International Blvd. Oakland, CA 94601
Planned Parenthood, Hayward	1.510.733.1819	1866 B St. Hayward, CA 94541
San Antonio Health Center	1.510.238.5400	1030 International Blvd. Oakland, CA 94606
Bay Area Community Health	1.510.770.8133	39500 Liberty St. Fremont, CA 94538
West Oakland Health Center	1.510.835.9610	700 Adeline St. Oakland, CA 94607

Please remember to report all AIDS cases to the County Communicable Disease Division at **1.510.267.3240**.

Abortion Services

The following guidelines apply to Alliance abortion services:

- In-network and out of network abortion services are available to all members without a referral or prior authorization
- The Alliance will not reimburse for abortions provided by out-of-plan providers for Group Care members without prior authorization
- Every effort shall be made to assist members seeking abortion services
 - This includes providing timely and appropriate counseling, education, information, and referral
- Providers shall assist members in identifying abortion service providers
 - Providers should refer to the Provider Directory or encourage the member to call the Alliance Member Services Department at **1.510.747.4567**

Sterilization Services

Written informed consent must be obtained from all members seeking sterilization procedures in accordance with state law. This applies to all members regardless of the product line in which they are enrolled and includes services for tubal ligations, sterilization, vasectomies, and hysterectomies.

A copy of the signed sterilization consent form must be maintained in the member's medical records. For Medi-Cal members, a copy of the consent must also be submitted to the Alliance in order to be reimbursed (see below). Consent submission to the Alliance only applies to Medi-Cal members. Providers do not need to submit a copy of the consent to the Alliance for members in other product lines.

Prior authorization is not required for tubal ligations or vasectomies. Prior authorization is required for hysterectomies.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

REQUIREMENTS REGARDING CONSENT

The legal requirements listed below apply to the provision of sterilization services. Sterilization is covered only if all applicable requirements are met at the time the procedure is performed. If the member obtains retroactive coverage, previously provided sterilization services for tubal ligations and vasectomies are not covered unless all applicable requirements and California State Law, including the timely signing of an approved sterilization consent form, have been met.

MEDI-CAL MANAGED CARE REQUIREMENTS

Alliance members enrolled in Medi-Cal Managed Care must meet the requirements of the law specific to Medi-Cal-funded members. This means that a member cannot waive the **30-day** waiting period between the date of written consent and the actual performance of the procedure unless an emergency is documented in accordance with Title 22 CCR 51305.1.

When submitting claims for Medi-Cal members, a copy of an appropriately completed PM-330 must be submitted with a claim for vasectomies and tubal ligations. Failure to submit the PM-330 will result in the denial of payment to all providers involved in the delivery of the service until a properly completed PM-330 is submitted. If the PM-330 has not been properly completed in accordance with Medi-Cal guidelines, payment may be denied.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Providers must provide alcohol and drug screening, assessment, brief interventions and referral to treatment (SABIRT) to members **11 years of age** and older, including pregnant women. Unhealthy alcohol and drug use screening must be conducted using validated screening tools. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use, alcohol use disorder (AUD), or substance use disorder (SUD) is present. Assessment can be done without first using screening tools.

Brief misuse counseling should be offered for unhealthy alcohol use. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered for patients with probable AUD or SUD.

Brief interventions must include the following:

- Discussing negative consequences and the overall severity of the problem
- Supporting the patient in making behavioral changes
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated

Member medical records must include the following:

- The service provided
- The name of the screening instrument and score
- The name of the assessment instrument and score
- If and where a referral to an AUD or SUD program was made

VALIDATED SCREENING AND ASSESSMENT TOOLS

Below are resources for validated screening and assessment tools.

Screening tools:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID): **www.pedagogyeducation.com/Main-Campus/Resource-Library/Correctional-Nursing/CAGE-AID-Substance-Abuse-Screening-Tool.aspx**
- Tobacco Alcohol, Prescription medication and other Substances (TAPS): **www.drugabuse.gov/taps**
- National Institute on Drug Abuse (NIDA) Quick Screen for adults – The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening: **archives.drugabuse.gov/nmassist**
- Drug Abuse Screening Test (DAST-10) (fee required): To use this tool, please email Dr. Harvey Skinner at **hskinner@yorku.ca**
- Alcohol Use Disorders Identification Test (AUDIT-C): **www.hepatitis.va.gov/alcohol/treatment/audit-c.asp**
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents: **www.ntiupstream.com/4psabout**
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFT) for non-pregnant adolescents: **www.crafft.org**
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population: **hign.org/sites/default/files/2020-06/Try_This_General_Assessment_17.pdf**

Assessment tools:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST): **<https://archives.drugabuse.gov/nmassist/>**
- Drug Abuse Screening Test (DAST-20) (fee required): To use this tool, please contact Dr. Harvey Skinner at **hskinner@yorku.ca**
- Alcohol Use Disorders Identification Test (AUDIT): **auditscreen.org**

BILLING FOR SERVICES

SABIRT Billing Codes and Frequency Limits Table

Billing Code	Description	When To Use	Frequency Limit
G0442	Annual alcohol misuse screening, 15 minutes	Alcohol use screening	One (1) per year, per provider
H0049	Alcohol and/or drug screening	Drug use screening	One (1) per year, per provider
H0050+	Alcohol and/or drug services, brief intervention, per 15 minutes	Alcohol misuse counseling or counseling regarding the need for further evaluation/treatment	One (1) per year, per provider

REFERRALS FOR TREATMENT

For Alliance Medi-Cal members:

Alameda County Behavioral Health Substance Use Treatment and Referral Helpline
Toll-Free: **1.844.682.7215**
www.acbhcs.org/substance-use-treatment

For Alliance Group Care:

Alameda Alliance Member Services
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**

For Alliance D-SNP members:

Alameda Alliance Wellness Member Services
Toll-Free: **1.888.882.3767**

Tobacco Cessation

Alliance providers are responsible for tobacco use tracking, counseling, and referrals. Providers should ask all patients about tobacco use at every visit and have a tobacco user identification system to track use.

Below are various ways to track:

- Record in your electronic health record (EHR)
- Use ICD-9 codes for pregnancy-related tobacco use
- Use ICD-10 codes for nicotine dependence
- Use CPT codes for tobacco cessation counseling

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

TOBACCO CESSATION COUNSELING

The Alliance covers the following types of tobacco cessation counseling and referrals:

- **Individual Counseling:** Providers can bill for tobacco cessation counseling.
- **Group Counseling:** Refer patients to Alliance Health Programs at **1.510.747.4577** for group classes
- **Telephone Counseling:** Refer patients to Kick It California. Patients can call toll-free at **1.800.300.8086** or visit **kickitca.org**. Kick It can help people quit smoking, vaping, and smokeless tobacco

For additional training and resources on tobacco cessation counseling, please visit **www.alamedaalliance.org/providers/provider-resources/tobacco-provider-guide**.

Section 13: Services and Referrals for Newborns, Children, and Adolescents

This section describes the health care services that children in the Alliance are entitled to receive. Like adults, children are entitled to some services outside of the scope of a provider's practice. In such cases, providers should make assessments and, as appropriate, referrals for the conditions covered in this section.

Newborn Services

ELIGIBILITY

Babies born to mothers who are Alliance members are covered by the Alliance during the "newborn period."

The newborn period is not the same for all lines of business, and is calculated as follows:

- Medi-Cal Newborns – Covered for the calendar month of birth and the month after
- If the mother does not apply for the baby to receive their own insurance benefits, the baby will not be eligible for services, including Alliance services, after the newborn period
 - When this occurs, providers will not receive reimbursement or capitation for the baby from the Alliance
- The Alliance sends reminders regarding newborn eligibility to the mother and can assist by providing enrollment information
 - However, providers are encouraged to also remind the parent/guardian to obtain separate benefits for the newborn and to choose a health plan and a PCP for continuity of care
- Group Care Newborns – Covered from the date of birth through the first **30 days** of life only
- Dependents are not eligible to enroll in the Alliance Group Care Program

BILLING

Pediatric care will be paid on a fee-for-service basis for attending the delivery, routine newborn care, and sick newborn care during the newborn period. It is important to verify the mother's eligibility before providing service to the newborn.

PHENYLKETONURIA (PKU) TESTING & TREATMENT

Testing and treatment of phenylketonuria (PKU), including formulas and special food products, are a covered benefit based upon the following guidelines:

- Part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Alliance; and
- Provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU

Clinical Preventive Services for Children – Periodic Health Assessments

This section outlines the PCP's responsibilities for preventive care services for children.

Periodic health assessments must be provided by PCPs for all members under **21 years of age**, according to the periodicity schedule and content of the most current Bright Futures/American Academy of Pediatrics (AAP) recommendations for preventive pediatric health care.

If the provider sees a child for urgent care and that child is not yet assigned to a PCP, the provider will be reimbursed at the base Medi-Cal fee-for-service rate for care, including preventive care provided at that visit.

BLOOD LEAD SCREENING

The PCP must provide oral or written anticipatory guidance to a parent or guardian of the child that, at minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from **six (6) months** until **72 months** of age. This guidance must be performed at each periodic health assessment, starting at **six (6) months** of age and continuing until **72 months** of age.

Blood lead screening is required for all children at **12 months** and **24 months** of age. If the provider performs a periodic health assessment and becomes aware that a child between **12 months** and **72 months** has no documented blood lead testing at either the **12-month** or **24-month** interval, the provider performs blood lead testing, or blood lead testing is completed anytime it is requested by the parent or guardian. The blood lead level test is not required if the parent or guardian refuses to consent or the PCP determines it poses a risk to the child's health that is greater than the risk of lead poisoning. Any reason for not screening must be documented in the child's medical record. In cases where consent has been withheld, the medical record must include a signed statement of voluntary refusal or documentation of the reason for not obtaining one. Blood lead screening encounters should be identified using the appropriate CPT codes.

PCPs must follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidance when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up. CLPPB guidelines can be found at www.cdph.ca.gov/Programs/ccdphp/deodc/clppb/pages/prov.aspx.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

WRITTEN RESULTS

For Medi-Cal members, PCPs must provide written results to the member (or the member's parent or guardian, as appropriate) of the initial or periodic health assessments.

FOLLOW-UP ON MISSED OR CANCELED APPOINTMENTS

Providers must follow up on missed or canceled appointments for preventive care. At least three (3) attempts to contact the member should be made and documented in the medical record.

DOCUMENTATION OF PREVENTIVE SERVICES

The DHCS Facility Site Review (FSR) requirements include outreach from the provider when members have missed appointments.

The process established on-site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult Initial Health Appointments (IHA), specialty care and appointments, and follow-up of missed or canceled appointments. Systems, practices, and procedures used for making services readily available to patients will vary from site to site.

Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record.

For all Alliance members, preventive services including visits and immunizations must be billed to the Alliance, using the CMS 1500 billing form.

Cognitive Health Assessments

Cognitive health assessments are covered directly by the Alliance for members who are **65 years of age** and older and who do not have Medicare coverage. Providers must obtain Dementia Care Aware training approved by the Department of Health Care Services (DHCS) on conducting the assessment before administering and billing for the assessment. Cognitive health assessment training is available at www.dementiacareaware.org.

BILLING

To appropriately bill and receive reimbursement for conducting an annual cognitive health assessment, providers must do all of the following:

- Complete the DHCS Dementia Care Aware cognitive health assessment training.
- Be a contracted and credentialed provider with the Alliance.
- Bill in accordance with Medi-Cal billing requirements Current Procedural Terminology (CPT) code 1494F and quantity limits.
- Administer the annual cognitive health assessment as a component of an E&M

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

visit including, but not limited to an office visit, consultation, or preventive medicine service.

- Document all the following in the member's medical records and have such records available upon request:
- The screening tool or tools that were used (at least one (1) cognitive assessment tool listed below is required)
- Verification that screening results were reviewed by the provider
- The results of the screening
- The interpretation of results; and
- Details discussed with the member and/or authorized representative and any appropriate actions taken regarding screening results

At least one (1) cognitive assessment tool listed below is required. Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

- Cognitive Assessment Tools or patient assessment tools
- General Practitioner assessment of Cognition (GPCOG)
- Mini-Cog
- Informant tools (family members and close friends)
- Eight-item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly

Immunizations

STANDARDS

The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC) and other medical associations, regardless of member's age, sex, or medical condition, including pregnancy. Immunization information is available from the CDC at **www.cdc.gov/vaccines**. ACIP-recommended immunizations are viewed as preventive services, these services are not subject to Prior Authorization.

PROMOTION

Pediatric immunizations must comply with the most recent standards of the Pediatric Immunization Practices (U.S. Public Health Service and AAP) and the Recommended Childhood Immunization Schedule (ACIP and AAP). These schedules are accessible via the Alliance website at **www.alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines**. Additional information is available on the CDC website at **www.cdc.gov/vaccines/index.html**.

Adult vaccines recommended by the U.S. Food and Drug Administration (FDA) and ACIP are covered by the Alliance, without cost sharing.

Additional information is available on the CDC website at www.cdc.gov/vaccines.

To increase immunization rates, all PCPs are encouraged to:

- Use the California Immunization Registry (CAIR), ideally with a bi-directional interface between CAIR and the practice's electronic health record (EHR) Resources for practices can be found at <http://cairweb.org/how-cair-helps-your-practice>
- Establish or update electronic medical record (EMR)/EHR templates to accurately reflect coding for visit reason and diagnosis
- Utilize “flag” alerts in the EMR/EHR system for staff to identify and communicate with members/parents/guardians that immunization is due at every member encounter
- Appoint a vaccine coordinator
- Use huddle time to brief/communicate member/patient needed service(s)
- Use all visits, as appropriate, to provide immunizations
- Create immunization-only services or walk-in immunization clinics
- Communicate with families when vaccinations are due (reminders) or late (recall) via portals, texts, and/or calls
- Train staff on immunization schedule and how to address vaccine hesitancy

VACCINES FOR CHILDREN (VFC) PROGRAM (MEDI-CAL ONLY)

PCPs have access to free vaccines for Medi-Cal members **0-18 years of age** through the Vaccines for Children (VFC) Program. The administration fee for routine pediatric immunizations is paid on a fee-for-service basis for Alliance directly contracted providers. When the VFC Program does not provide the vaccine for the Medi-Cal program or other Alliance product lines, the PCP may bill the Alliance without prior authorization for the vaccine by submitting an invoice with the CMS 1500 claim form. Providers who would like to inquire about how to bill the Alliance directly should contact Alliance Provider Services at **1.510.747.4510** for more information.

To contact the VFC Program:

- Community and county clinics can call **1.510.267.3230**
- Private providers can visit the California Vaccine Programs – California Vaccines for Children (VFC) 130 website at eziz.org for more information

IMMUNIZATION EDUCATION

Federal law requires that Vaccine Information Sheets be handed out (before each dose) whenever certain vaccinations are given. These sheets are produced by the CDC, which explains to vaccine recipients, their parents, or their legal representatives both the benefits and the risks of a vaccine.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

All handouts can be downloaded from the Immunization Action Coalition website at www.immunize.org.

VACCINE STORAGE

Providers are required to have a freezer and a refrigerator for vaccine storage.

DOCUMENTATION

Medical record documentation of member immunization status is required. Immunization status and immunizations given should also be documented. Documentation of each member's need for ACIP recommended immunizations is required as part of all regular health visits, including but not limited to illness, care management, or follow-up appointments, initial health appointment (IHAs), pharmacy services, prenatal and postpartum care, pre-travel visits, sports, school, or work physicals, visits to a local health department, and well patient check ups

REPORTING

All health care providers who administer vaccines must submit patient vaccination records to local health departments, Division of Communicable Diseases Control and Prevention, using the Confidential Morbidity Report Card and appropriate immunization registries within the specified timelines in accordance with Health and Safety Code (H&S) 120440 and 16 CCR 174.4 (e) as applicable. All immunization records must be reported within 14 calendar days, in accordance with state and federal law.

Medi-Cal for Kids & Teens (Early Periodic Screening Diagnosis and Treatment (EPSDT) (Medi-Cal Only)

Medi-Cal for Kids and Teens (also known as EPSDT) services are a benefit for Medi-Cal members under **21 years of age** to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early, such as a defect, physical or mental illness, or other conditions. EPSDT services must be identified and referred in a timely manner.

METHODS OF SCREENING

- Well-child visits.
- Regular check-ups to look for any problems with the member's medical, dental, vision, hearing, mental health, and any substance use disorders. The Alliance covers screening services any time there is a need for them, even if it is not during a regular check-up.
- Preventive care can be shots. The PCP must make sure that all enrolled children get the needed shots at the time of any health care visit.

When a physical or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

These services covered by the Alliance include:

- Behavioral health treatment for autism spectrum disorders and other developmental disabilities
- Case management, targeted case management, and health education
- Doctor, nurse practitioner, and hospital care
- Home health services, which could be medical equipment, supplies, and appliances
- Physical, speech/language, and occupational therapies
- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance
- Shots
- Treatment for vision and hearing, which could be eyeglasses and hearing aids

OTHER EPSDT SERVICES

If the care is medically necessary and the Alliance is not responsible for paying for the care, then the PCP should refer the member to California Children's Services (CCS) to get the care they need.

These services include:

- Private duty nursing services
- Treatment and rehabilitative services for mental health and substance use disorders
- Treatment for dental issues, which could be orthodontics

REFERRALS FOR EPSDT SERVICES

PCPs have a responsibility for identifying the need for EPSDT services through routine primary care of Alliance members under **21 years of age**. Appropriate diagnostic and treatment services must be initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

Members/families must request EPSDT services through their PCP. An Alliance Prior Authorization (PA) Request Form must be submitted for EPSDT services. The Alliance will not pay for EPSDT services that have not received prior authorization. If EPSDT services are rendered under emergency conditions, standard procedures for emergency care must be followed.

If an out-of-plan provider (such as a mental health specialist, school nurse, or family planning provider) who is providing services to an Alliance member determines that EPSDT services are needed, that provider must contact the Alliance Health Care Services Division. The Alliance Health Care Services Division will notify and consult with the member's PCP.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

PROVIDER TRAINING REQUIREMENTS FOR EPSDT SERVICES

Alliance contracted pediatric and family medicine providers must complete the new Medi-Cal for Kids & Teens Provider Training developed by the California Department of Healthcare Services (DHCS). The self-paced training outlines the requirements for the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit for Medi-Cal members under age 21.

Starting January 1, 2024, providers must complete the training no less than once every two (2) years. This also includes any contracted primary care providers (PCPs) such as medical doctors (MD), Doctor of Osteopathic Medicine (DO), physician assistants (PA), and nurse practitioners (NP) levels that see members under the age of 21 years of age.

Alliance contracted providers can access the training by visiting the Alliance website at www.alamedaalliance.org/providers/provider-resources/training-and-technical-assistance-opportunities.

CASE MANAGEMENT & COORDINATION OF CARE

The PCP must maintain ongoing communication with the EPSDT services provider in order to ensure coordination of care. This communication shall be documented in the medical record. The PCP is still responsible for providing primary care services, diagnostic and treatment services, and appropriate referrals for specialty care.

Women, Infants & Children (WIC)

The WIC Program provides supplemental food vouchers and nutritional counseling to pregnant and postpartum women, infants, and children **five (5) years of age**. Eligibility is based on income. Members who have an active Medi-Cal eligibility may qualify for WIC.

Alliance providers of pediatric care should ensure the appropriate and timely referral of infants and children to the WIC Program. Alliance prenatal providers may refer pregnant women to WIC by having them call toll-free at **1.800.852.5770** or by visiting myfamily.wic.ca.gov.

Early Intervention Services

The Early Start Program is designed to provide comprehensive, coordinated, and family-focused early intervention services to children from **birth to age three (3)**, who have, or are at risk for, developmental disabilities. Providers are responsible for the appropriate and timely referral of children from **birth to age three (3)** to the Early Start Program, and for participating in the coordination of care provided to children enrolled in the program.

IDENTIFICATION

PCPs are responsible, through the assessment and examination process, for identifying Alliance members with the Early Start Program's eligible conditions. Identification of the following conditions in a child **0-36 months** of age requires a referral within **two (2) working days** to the program.

DEVELOPMENTAL DELAYS

A developmental delay may exist where there is a significant difference between the infant or toddler's current level of functioning and the expected level of development for his or her chronological age in one (1) or more of the following developmental areas:

- Adaptive
- Communication
- Physical and motor including vision, hearing, and health status
- Social or emotional

REFERRALS

Providers should refer directly to the appropriate agency for the Early Start Program as outlined below. Attempts should be made to obtain consent from the parents prior to making the referral. Providers must also release any requested information directly to the referral agency. Members may also self-refer to the Early Start Program.

For developmental delays or disabilities or high-risk infants, providers should refer to:

- Regional Center of the East Bay at **1.510.618.6100**
- Family Resource Network at **1.510.547.7322**
- Help Me Grow toll-free at **1.888.510.1211**

CASE MANAGEMENT AND ONGOING CARE

PCPs maintain responsibility for basic case management of a child enrolled in the Early Start Program and for referrals for specialty care as indicated. PCPs should participate, as appropriate, in the development and monitoring of the Individual Family Service Plan managed by the referral agency. PCPs must also make medical reports available, as requested, to the early intervention team in order to support their completion of the Individual Family Service Plan within the mandated **45-day** time limit after the referral is made.

Section 14: Perinatal Services

The Alliance defines perinatal services as care delivered to a pregnant woman to diagnose and manage the pregnancy and related conditions, the delivery, and the postpartum follow-up. The standards for the treatment of pregnant women in this section will help providers meet the goals we all share – healthy mothers and children. All providers who offer obstetrical (OB) services to members are required to follow the most current editions of the Standards for Obstetric Services, guidelines from the American College of Obstetricians and Gynecologists (ACOG), and other regulatory requirements or guidelines.

The Alliance recognizes that the Medi-Cal enrollment process may present a challenge to providers in the provision of quality prenatal care. Many women enter the plan well into their pregnancies. Regardless of when a pregnant woman enters the plan, it is imperative that providers see pregnant women as soon as possible.

PRENATAL PROVIDER ROLE

Prenatal providers should follow the same authorization protocols as PCPs.

The prenatal provider, during the course of the member's pregnancy, is considered the gatekeeper or manager of the member's care. As such, prenatal providers may refer members to specialty services, all such referrals and authorizations must be given prior to the provision of care. Retrospective authorization of services is not permitted.

Perinatal Services

PREGNANCY TESTING

Pregnancy testing is available to members through their PCP or from any obstetrician/gynecologist (OB/GYN), or family planning provider. No prior authorization is needed. A Medi-Cal member may receive a pregnancy test within or outside of the Alliance network. Alliance members enrolled in Alliance programs other than Medi-Cal must receive pregnancy test services in-network.

PRENATAL CARE APPOINTMENTS

Entry into prenatal care does not require a referral or prior authorization. Prenatal appointments should be scheduled within **two (2) weeks** of the member's request.

Members may go to any OB provider in the Alliance network unless they are assigned to CHCN. CHCN members must receive OB care from a CHCN provider, or a provider contracted with CHCN.

HIGH-RISK PRENATAL CARE

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

If a member's medical history or current condition indicates she may have a high-risk pregnancy, the member may be referred to the following types of Alliance practitioners:

- A Sweet Success affiliate for pregnancy and diabetes
- Genetic counselors
- Pediatricians and neonatologists for intensive newborn care and follow-up
- Perinatologists and obstetricians certified for high-risk care
- Tertiary ultrasonographers

To find the above providers, please refer to the Alliance Provider Directory.

MATERNAL MENTAL HEALTH

The Alliance requires providers to follow the American College of Obstetrics and Gynecology (ACOG), Bright Futures/American Academy of Pediatrics (AAP) guidelines for perinatal mental health screening, and other regulatory requirements.

Providers are encouraged to use an evidence-based screening tool to screen for depression. Screenings are required at least once during each pregnancy, at least once during the first six (6) weeks of the postpartum period, and when determined to be medically necessary and clinically appropriate.

The program guidelines below aim to support members at risk for perinatal depression during pregnancy and in the first year after birth. They include quality measures to encourage screening, diagnosis, treatment, and referral.

Maternal Depression Screening Guidelines can be found on the Alliance website at www.alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines.

DELIVERY

Members must deliver at an in-network hospital with which their prenatal provider is affiliated.

NOTIFICATION OF ADMISSION

The hospital is responsible for contacting the Alliance Health Care Services Department when the member is admitted for delivery within **one (1) working day** of admission.

POSTPARTUM CARE

The routine postpartum visit should generally be provided **21-56 days** after delivery, although this interval may be modified if warranted by the needs of the patient. The postpartum review should include interval history and physical examination, laboratory data as indicated, family planning counseling, nutritional health education, and psychosocial reassessments.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

The Alliance reimburses fee-for-service (FFS) for the postpartum visit using CPT code 59430, as long as the date of service is on or between **21-56 days** from the date of birth.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notice During Prenatal Care

During the course of prenatal care, prenatal providers must give Alliance members written notice of their benefits coverage under the Newborns' and Mothers' Health Protection Act of 1997 (NMHPA). NMHPA may not restrict benefits for a hospital stay in connection with childbirth to less than **48 hours** following a vaginal delivery or 96 hours following a delivery by cesarean section beginning at the time of the hospital admission.

If the attending provider, in consultation with the mother, determines that either the mother or the newborn child can be discharged before the **48-hour** (or **96-hour**) period, the Alliance does not have to continue covering the stay for the one ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to the mother or the newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. A health plan, hospital, insurance company, or HMO would not be an attending provider.

Maternity Lengths of Stay

A health plan cannot require discharge from a maternity stay sooner than **48 hours** (vaginal delivery) or **96 hours** (cesarean section) unless certain criteria are met. The Alliance does not limit maternity lengths of stay. A decision to discharge must be made by the treating physician in consultation with the mother. The prenatal provider must then advise the mother that she may receive a post-discharge follow-up visit within **48 hours** of discharge.

PERINATAL ASSESSMENT

Many providers may be affiliated with the Comprehensive Perinatal Services Program (CPSP). The forms and protocols connected with this program satisfy Medi-Cal Managed Care requirements for perinatal assessment and intervention.

If a provider is not affiliated with CPSP, it is necessary to do comparable perinatal assessments. This assessment should be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified should be followed up on by appropriate interventions, which must be documented in the medical record. The assessment must also be kept in the medical record. The Alliance provides prenatal assessment forms in the Alliance threshold languages. The Alliance recommends all providers use the Alameda CPSP postpartum assessment.

Please see the referenced sections of this manual for details on how to refer to these programs or services:

1. Dental Services
2. Family Planning
3. Genetic Screening and Counseling
4. Perinatal Health Education Classes and Handouts
5. STD Screening and Treatment
6. Women, Infants & Children (WIC)

PRENATAL CARE AND CONSULTATIONS BY PERINATOLOGISTS

Perinatologists may provide three (3) types of services to Alliance members:

1. Consultations
2. Perinatology OB care
3. Routine OB care

The authorization and claims process that perinatology practices must follow for each of these types of services is detailed below. Payment will be denied for any service that requires but has not received prior authorization from either the prenatal provider or the Alliance Health Care Services Department.

ROUTINE OB CARE (NOT PERINATOLOGY)

Routine OB care provided to Alliance members by a Perinatology practice, which is not Perinatology care, must be billed according to the standard OB billing procedures.

Routine OB care does not require an authorization number and will be paid at the applicable global rate.

ONGOING PERINATOLOGY CARE

If an Alliance member's total OB care must be managed by the perinatologist because of a high-risk medical condition, the following procedures apply:

1. The perinatologist must submit an Alliance Prior Authorization (PA) Request Form to the Alliance in order to obtain authorization for that pregnancy to be billed fee-for-service (FFS) by the perinatology practice. The medical condition necessitating perinatology management must be documented
2. The Alliance Health Care Services Division will issue an authorization number for all services related to that high-risk pregnancy
3. The CMS 1500 is submitted for all services rendered and payment is made on an FFS basis. Each CMS 1500 must have the original authorization number issued for that pregnancy documented in Box #23

4. The perinatologist is responsible for the administration of the required perinatal assessments. Forms for this assessment have been developed and translated by the Alliance. Per the Medi-Cal Managed Care direction, this assessment should be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified should be followed up on by appropriate interventions, which must be documented in the medical record. The assessment must also be kept in the medical record

Reimbursement and Documentation of OB Services (Medi-Cal and Group Care Only)

Use an HCFA 1500 (CMS 1500) form to bill for all prenatal, delivery, and postpartum services.

Submit claims within the following time frame:

- Initial prenatal visit - within **90 days** of the first prenatal visit.
- The balance of the prenatal care and the delivery – within **90 days** of the delivery postpartum office visit (must be provided between **21-56 days** after the delivery date) – within **90 days** of the date of service.

When submitting a claim for the initial prenatal visit:

- Use the appropriate ICD-10 codes to document a high-risk pregnancy. The diagnosis code submitted on the initial prenatal visit claim will determine whether that visit is paid at the normal or at-risk rate.

When submitting a final claim for antepartum and/or delivery care, services will be paid according to the following:

- Global payment when antepartum care and delivery services are provided.
- FFS when antepartum care only is provided; determined by the total number of visits.
- If only two (2) or three (3) antepartum visits are provided, bill individually for each of these visits. If a total of four (4)-six (6), or seven (7) or more visits are provided, bill the appropriate code for that number of visits (in addition to the initial visit).
- FFS when delivery only.

Postpartum office visits will only be reimbursed when the postpartum visit is between **21-56 days** after delivery.

SERVICES INCLUDED IN GLOBAL PAYMENTS FOR OB CARE

The following services are included in the risk-adjusted global OB payments:

- Prenatal visits
- Prenatal laboratory tests sent to Quest

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Hospital visits for delivery stays less than **72 hours**
- Health education, nutrition, and psychosocial counseling provided by office staff, unless authorized by Alliance
- Hospital visits, except antepartum greater than **72 hours**
- Delivery

SERVICES NOT INCLUDED IN GLOBAL PAYMENTS FOR OB CARE

The following services are not included in the global OB payments and may be billed fee-for-service:

1. Abortions
2. Amniocentesis
3. Chorionic villus sample
4. Family planning visit
5. Immunizations
6. Lab tests included in the PCP capitation scope of service
7. Non-stress tests
8. Postpartum care (only when provided **21-56 days** from delivery)
9. Pregnancy test
10. Prenatal genetic testing
11. Sonograms
12. Treatment of a sexually transmitted disease
13. Tubal ligations

Section 15: Community Supports (CS)

Community Supports (CS) services may be available for all Alliance members that qualify. CS are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for members to receive. These services are short-term services that may help members live more independently, but do not replace benefits they already get under Medi-Cal or other entities. Community Supports follows all Utilization Management regulations.

For authorization turnaround timeframes, please see the table below.

Request Type	Turnaround Time
Urgent	72 hours
Routine	5 business days
Retrospective/Post Service	30 calendar days

CS SERVICES OFFERED BY THE ALLIANCE

The Alliance is currently offering the following CS services:

- Asthma Remediation
- Caregiver Respite Services
- Community or Home Transition Services
- Environmental Accessibility Adaptations (Home Modifications)
- Homeless-related CS (includes Housing Transition Navigation, Housing Deposits, and Housing Tenancy & Sustaining Services)
- Medically Tailored Meals/Medically Supportive Food
- Assisted Living Facility (ALF) Transitions
- Personal Care and Homemaker Services
- Recuperative Care (Medical Respite)
- Transitional Rent (coming 01/01/2026)

There is no cost to the member for CS services.

Members can be referred to CS by their provider:

Alliance CS Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4545**

Email: **CSDept@alamedaalliance.org**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Section 16: Out-of-Plan Services

Alliance Medi-Cal members are entitled to many services that are not provided through the Alliance. Providers must ensure that members have access to these out-of-plan services and may also be referred to as carved-out services or other Medi-Cal programs and services. The Alliance requires providers to assess each member for the various types of services included in this section and refer members appropriately.

California Children Services (CCS)

California Children Services (CCS) Alliance Medi-Cal members **0-21 years of age** can receive care through CCS for specific eligible conditions as outlined in this section. CCS financial eligibility is automatic with Medi-Cal coverage. Providers treating a member with a CCS-eligible condition and/or an open CCS case should obtain authorization for services for that condition directly from CCS. The Alliance will also work directly with CCS to coordinate the payment of care; this involves referring eligible cases, obtaining authorization from CCS, and forwarding claims for payment if there is an open authorization. If the condition is not CCS-eligible or if CCS eligibility is uncertain, providers should follow the authorization procedures for the Medi-Cal Program members.

Please Note: The provider must be an authorized (also known as paneled) CCS provider to provide care and receive compensation for the treatment of a CCS patient for the eligible condition.

To obtain more information about the paneling process and to apply, please visit <https://cmsprovider.cahwnet.gov/PANEL/index.jsp>.

CONDITIONS ELIGIBLE FOR CCS

Please refer to the DHCS website for conditions eligible for CCS listing at www.dhcs.ca.gov/services/ccs/Pages/default.aspx.

ESTABLISHING A CCS CASE

Any provider, parent, social worker, or teacher may contact CCS to establish a case. Contacting CCS is not an authorization of service but does establish the earliest date for which eligibility may apply and begins the process of opening the case. A CCS referral, an Alliance authorization, or a PCP referral must be in place for any services to be covered.

The Alliance will pay for all medically necessary services during the interim referral period and if CCS denies the case. PCPs who identify a condition that may require CCS services should complete and submit an Alliance Prior Authorization (PA) Request Form for other services, such as DME or inpatient and outpatient services. Submission of the form ensures that providers will be paid by the Alliance for medically necessary services, if CCS determines the condition is not medically eligible for CCS.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

Indicate on the Alliance PA Request Form that a referral to CCS is requested. The Alliance will refer any case to CCS whose diagnosis might meet CCS eligibility criteria. Members can begin care with the specialist immediately.

Providers do not have to wait for CCS to determine eligibility because the services have been authorized by the Alliance or the PCP and will be paid by the Alliance in the interim period.

DIRECT REFERRAL TO CCS

If providers wish to contact CCS directly, the following information is required:

- Patient name
- Date of birth
- Medi-Cal member identification number
- Name, address, and telephone number of the parent/legal guardian
- Address and telephone number of the child, if different
- Medical condition
- Referring provider's name and phone number
- Medical notes, which must include a plan of treatment

The information may be faxed or mailed to CCS. Identify the specialist for referral if one has been selected. CCS will honor the request if the physician is CCS-paneled. Referrals should be made to specialists in the Alliance network who are also CCS paneled.

California Children Services (CCS)
1000 Broadway, Suite 5000
Oakland, CA 94607
Phone Number: **1.510.208.5970**
Fax: **1.510.267.3254**

Providers should also forward copies of medical reports that support the CCS-eligible condition or suspected condition. In addition to a history and physical, these might include laboratory test results, diagnostic imaging reports, and operative reports or pathology findings.

COORDINATION OF CARE

PCPs are required to coordinate services with CCS specialty providers. If the member is eligible for CCS services, CCS will provide medical case management for the specific CCS condition. In all cases, PCPs must continue to provide primary case management to the member. Children with CCS-eligible conditions should still see their PCP for routine care, urgent care of non-eligible conditions, and for preventive care, including immunizations.

CLAIMS

If the specialist has received CCS authorization for services, the specialty provider should submit claims for payment directly to the county CCS program. If CCS eligibility is pending or denied, specialty providers can send claims for care authorized by the Alliance or referred by an Alliance provider to the Alliance Claims Department. Upon CCS authorization, the Alliance will forward the claim to CCS.

Dental Screening – Medi-Cal

Dental screening is a component of a comprehensive health assessment for all members. PCPs should refer Medi-Cal members **0-20 years** of age to fee-for-service (FFS) Medi-Cal Dental Program providers. Members may also self-refer to dental services.

IDENTIFICATION, DOCUMENTATION, AND REFERRAL FOR CHILDREN

Dental screening for children is a required component of an oral exam. Mouth and teeth should be assessed, and referrals made as follows:

1. For children younger than **three (3) years old**, make a dental referral if any problems are suspected.
2. For children **3-20 years old**, ask the family/guardian if the child has seen a dentist in the past **12 months**. A referral should be made if the child has not seen a dentist or a problem is identified.

IDENTIFICATION, DOCUMENTATION, AND REFERRAL FOR ADULTS

Medi-Cal does not pay for dental care for adults **21 years of age** and older. PCPs should still assess whether adult patients have seen a dentist in the past **12 months**. If not, adult patients should be encouraged to find a dentist who provides low-cost dental care. For more information, please call the Medi-Cal Dental Program toll-free at **1.800.322.6384**.

TOPICAL FLUORIDE VARNISH

Topical fluoride varnish is a benefit for Medi-Cal children younger than **six (6) years of age**, up to three (3) times in a **12-month** period. From 6 years to 21 years at least 2 applications each year. In addition to dentists, physicians, nurses, and medical personnel are permitted to apply fluoride varnish when the attending physician delegates the procedures and establishes protocol.

CARVE-OUT DRUGS COVERED BY FEE-FOR-SERVICE MEDI-CAL

The California Department of Health Care Services (DHCS) covers certain drug classifications and are considered non-capitated to the Medi-Cal managed care (the Alliance) plan, in other words they are carved out of the Plans (the Alliance) responsibility.

For Medi-Cal members, the Alliance is not responsible to cover drugs under the below listed drug classifications in a professional, outpatient, or inpatient setting, and would need to be billed to Fee-For-Service (FFS) Medi-Cal.

- Antivirals (HIV/AIDS/Hepatitis B) Drugs
- Alcohol and Heroin Detoxification and Dependency Treatment Drugs
- Blood Factor: Clotting Factor Disorder Treatment Drugs
- Cell and Gene Therapies for Sickle Cell Disease
- Psychiatric/Antipsychotic Drugs

These drugs should be billed to Fee-For-Service (FFS) Medi-Cal.

The Alliance routinely reviews the above listed drug classifications to make changes to our claim and authorization system and processes to ensure we are in alignment with the DHCS requirements.

We encourage providers to review drugs in this classification provided to Alliance Medi-Cal members to ensure they are submitted directly to FFS Medi-Cal. May result in delays or denial of non-payment from the Alliance. For more information, please refer to the additional resources below.

Medi-Cal billing manual, MCP:

- Single Plan publication: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/11F02F0E-1773-4278-90B3-B934358F0D45/mcpsingle.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO
- DHCS All Plan Letter 16-004, Medi-Cal Managed Care Health Plans Carved-Out Drugs:
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-004.pdf

Tuberculosis (TB) Control Services

CLINICAL GUIDELINES

Providers should follow the guidelines of the American Thoracic Society in the provision of TB services. The Mantoux tuberculin test is the only screening test to be used.

Alliance providers must identify, refer, and coordinate services with the Alameda County Health Care Services Agency, Division of Communicable Disease Control and Prevention, or Directly Observed Therapy (DOT) or Directly Observed Preventive Therapy (DOPT) for tuberculosis. All suspected or confirmed TB cases should be reported to the TB Controller.

REPORTING

Per Title 17 of the California Code of Regulations, providers must promptly report all suspected or confirmed TB cases to the TB Controller within **one (1) day** of identification.

A completed Confidential Tuberculosis Report must be faxed to:

Tuberculosis Controller
Division of Communicable Disease Control and Prevention
Phone Number: **1.510.577.7000**
Fax: **1.510.577.7024**

REFERRAL CRITERIA

Some TB patients may require more medical management than typically provided by a PCP.

Patients meeting any of the following criteria require a referral DOT or DOPT when there is suspected or diagnosed TB:

- Adverse reaction to TB medications
- Any patient the physician or nurse case manager deems at risk for noncompliance
- Children and adolescents
- Demonstrated drug resistance to either Isoniazid or Rifampin
- History of drug or alcohol abuse
- History of previous TB treatment
- Homeless or shelter residents
- Immunocompromised, or at risk of being immunocompromised
- Individuals demonstrating non-compliance
- Living in a home with another case of DOT
- Major psychiatric, memory, or cognitive disorder
- Patients on intermittent therapy
- Patients whose treatment has failed, who have relapsed after completing a prior regimen, or who demonstrate slow sputum conversion or clinical improvement
- Poor or non-acceptance of TB diagnosis
- Smear and culture positive **three (3) months** into therapy
- Too ill for self-management

Document the referral to DOT/DOPT in the member's medical record.

HOSPITAL DISCHARGE

Providers must notify the TB Control Unit at **1.510.208.5940** at least **24 hours** prior to the anticipated hospital discharge of a member who is a TB suspect/case. Fax a completed TB Discharge Treatment Plan to **1.510.628.7898**.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Medi-Cal Rx – Outpatient Pharmacy Benefit (Medi-Cal Only)

Effective Saturday, January 1, 2022, the Medi-Cal pharmacy benefit is covered by the Department of Health Care Services (DHCS). The Alliance will no longer cover outpatient pharmacy. All providers will be required to use the Medi-Cal Rx Portal to submit authorizations for medications that require authorization and receive payment for these claims. The new program will be called “Medi-Cal Rx.”

Individual prescribers will each need to register to the Medi-Cal Rx portal to be a user by:

1. Visiting **www.medi-calrx.dhcs.ca.gov**
2. Clicking on “Provider Portal”
3. Then click on “Register”

Once registered, providers will receive a PIN in the mail to the address used when they signed up through the Medi-Cal Rx portal. It could take up to **three (3) months** to receive a PIN in the mail. Once received, the rest of the Medi-Cal Rx registration process may be completed online using the assigned PIN.

MEDI-CAL RX APPEALS

Providers will be able to submit appeals for prior authorization denials, delays, and modifications through the Medi-Cal RX portal once they have registered or by mail to:

Medi-Cal CSC, Provider Claims Appeals Unit
PO Box 610
Rancho Cordova, CA, 95741-0610

Member appeals will be handled through a State Fair Hearing by the California Department of Social Services. This process is different from the appeal process you may have used with the Alliance. In a State Hearing, a judge reviews the request and makes a decision.

The State Hearing Request Form is available at **www.dhcs.ca.gov/services/medi-cal/pages/medi-calfairhearing.aspx**. Instructions and additional options can be found on the DHCS website.

Section 17: Health Education

Health education services are important benefits that the Alliance offers to providers and members. This section outlines some of the available services.

Health Education Services

The Alliance offers health education services to Alliance members at no cost. Alliance-sponsored classes, materials, medical ID bracelets, and self-management programs help members achieve healthy lifestyles, prevent illness and injury, and manage health conditions. The Alliance partners with many local organization and providers to offer health education services. Programs and handouts are designed to meet the cultural, linguistic, and health literacy needs of our members. Providers can find a listing of health education offerings and community referrals in our Provider Health Education Resource Directory on the Alliance website at **www.alamedaalliance.org/providers/patient-health-wellness-education**.

Alliance Health Programs currently offers the following:

- Enrollment for eligible members into a CDC-approved Diabetes Prevention Program (DPP) or Medicare Diabetes Prevention Program (MDPP).
- Interpreter services and transportation for members who attend health education classes sponsored by the Alliance.
- Patient handouts on many health topics in English, Spanish, Chinese, Vietnamese, and Tagalog.
- Referrals to classes or groups on diabetes, hypertension, CPR/first aid, weight management, pregnancy/breastfeeding/childbirth, and parenting.
- Referrals for one-on-one support with diabetes, asthma (adults and children), hypertension and breastfeeding.

There are many ways to request health education services:

- Call Alliance Health Programs at **1.510.747.4577**
- Download materials and forms at **www.alamedaalliance.org/live-healthy**
- Members can mail the Member Wellness Programs and Materials Request Form
- Providers can fax the Provider Wellness Programs and Materials Request Form

Our programs often change to ensure we meet the needs of our members and providers. Please contact us to receive the most current information:

Alliance Health Programs
Phone number: **1.510.747.4577**
Email: **livehealthy@alamedaalliance.org**
www.alamedaalliance.org/providers/patient-health-wellness-education

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Section 18: Serving Our Diverse Population

Alameda County is culturally diverse, and residents speak a wide variety of languages. This section will help you provide Alliance members with culturally and linguistically appropriate services.

In accordance with the US Code of Federal Regulations, Title 42, CFR Section 440.262, we ask that all Alliance providers promote access and delivery of service in a culturally sensitive and culturally responsive manner to all patients, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. These methods must ensure that patients have access to covered services that are delivered in a manner that meets their unique needs.

The Alliance is committed to providing language assistance in the member's preferred language, including American Sign Language (ASL), and effective communication for individuals with disabilities. This section outlines how language preferences are identified and the requirements for providers with respect to language access and documentation.

TITLE VI COMPLIANCE

Alliance providers must comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d and 45 C.F.R. Part 80). Title VI prohibits recipients of federal funds, such as Medicare/Medi-Cal providers, from discriminating against persons based on race, color, or national origin.

In accordance with Title VI, all Alliance providers (PCPs, ancillary, specialty, and inpatient providers) must provide access to services in the member's language at all points of contact. At no time should a provider rely on translation or interpretation services from a member's family members or friends, unless the member insists, and the use of a non-qualified interpreter is documented.

When a member selects a provider who does not speak the member's language, the provider is still obligated to meet the member's language needs in compliance with Title VI by utilizing in-house bilingual and/or bi-cultural staff, using over-the-phone or video interpreter services, or scheduling in-person services for American Sign Language (ASL), complex, or highly sensitive appointments. These services are provided at no cost to the member.

Documenting Staff Language Proficiency

All Alliance providers must keep documentation of the language proficiency for all their clinical and non-clinical employees who are bilingual and communicate with a patient in a language other than English. Documentation should include demonstration of proficiency in both English and the other language(s) being assessed and fundamental knowledge of health care terminology and concepts relevant to health care delivery systems in English and other language(s) being assessed.

Signage for Interpreter Services

Providers should have multilingual signage available for non-English-speaking patients. This will help providers and office staff identify which languages Alliance members speak. The Alliance can provide providers with a sign for use in their office that states: “Point to your language! We will get you an interpreter” in multiple languages. For a laminated copy, please call the Alliance Provider Services Department at **1.510.747.4510**.

If a provider is unable to offer language access for the member through their office’s own resources, the Alliance will assist with interpreter services at no cost to the provider or member. Please refer to “Requesting Interpreter Services” in this section.

QUALIFIED MEDICAL INTERPRETER SERVICES

The Alliance provides interpreter services that include telephonic, video, or in-person interpretation when a provider cannot meet the language needs of an Alliance member. These interpreter services are used during discussions of medical and non-medical information.

Hospitals are required to provide interpreter services to patients in accordance with state and federal law.

When scheduling a medical appointment, please ask the member (or the parent/guardian of a minor) about their preferred spoken and written language. If a member’s language needs cannot be met by the provider, please offer to coordinate interpreter services. Please document the members’ preferred language and any refusal of qualified interpreter services in the medical chart.

Requesting Interpreter Services

The Alliance provides no-cost interpreter services including ASL for all Alliance-covered services, 24 hours a day, 7 days a week. Interpreter services include access to TTY and on-demand interpreter services in over 100 languages.

Please confirm your patient’s eligibility before requesting interpreter services.

TELEPHONIC INTERPRETER SERVICES

Common uses for telephonic interpreter services:

- Administrative communications with patients
- Allied health services such as physical, occupational, or respiratory therapy
- Freestanding radiology, mammography, and lab services
- Routine and follow-up clinic visits

To access telephonic interpreters, please follow the steps below:

1. Please call **1.510.809.3986**, available 24 hours a day and 7 days a week.
2. Enter your PIN:
 - a. Other Alliance providers – press **1004**
 - b. Alameda Health Systems – **1005**
 - c. Behavioral health care – press **1003**
 - d. Children First Medical Group (CFMG) – press **1002**
 - e. Community Health Center Network (CHCN) – press **1001**
3. Say or enter the language you need:
 - a. Spanish – press **1**
 - b. Cantonese – press **2**
 - c. Mandarin – press **3**
 - d. Vietnamese – press **4**
 - e. For all other languages – press **0**
4. Provide the nine (9)-digit Alliance member ID number.

For communication with a patient who is deaf, hearing, or speech impaired, please call the California Relay Service (CRS) at **711**.

TELEHEALTH AND VIDEO INTERPRETER SERVICES

When you are ready to connect with a telephonic interpreter during a telehealth visit, please follow steps 1-4 above. Provide the telehealth phone number and login information to the interpreter. The interpreter will then call in to join your telehealth visit. For more information about video interpreters and telehealth visits using online platforms, please email [**interpreters@alamedaalliance.org**](mailto:interpreters@alamedaalliance.org).

IN-PERSON INTERPRETER SERVICES

Members can receive in-person interpreter services for the following:

- Sign language for the deaf and hard of hearing.
- Complex courses of therapy or procedures, including life-threatening diagnoses (e.g., cancer, pre-surgery instructions, and evaluation or reevaluation for physical or occupational therapy, chemotherapy, transplants, etc.).
- Highly sensitive issues (e.g., sexual assault/abuse, end-of-life, and initial evaluation for behavioral health, etc.).
- Other conditions by exception. Please include your reason in the request.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at [**www.alamedaalliance.org**](http://www.alamedaalliance.org).

If the appointment requires an in-person interpreter, please follow these steps to request:

1. You must request in-person interpreter services at least **five (5) business days** in advance. For ASL, **five (5) days** is recommended, but not required.
2. You can complete the online Interpreter Services Request Form on the Alliance Provider Portal or download the fillable form on the Alliance Website:
 - Online form:
 - Visit the Alliance website at www.alamedaalliance.org.
 - Click on the 'Provider Portal' link in the upper right-hand corner, then log in.
 - Look up your patient's eligibility, then click on the link at the top of the eligibility page to access the online form.
 - Fillable form:
 - Visit the Alliance website at www.alamedaalliance.org/language-access.
 - Download the Interpreter Services Request Form.
 - Complete and fax the form to 1.855.891.9167.

If you need to revise a request, please cancel the original request and submit a new one. The Alliance will notify providers by fax or phone if for any reason we cannot schedule interpreter services.

If needed, please cancel interpreter services at least **48 hours** prior to the appointment by calling the Alliance Provider Services Department at **1.510.747.4510**.

TRANSLATION OR ALTERNATIVE FORMAT OF ALLIANCE DOCUMENTS

Members can also request written member materials in a language or alternative format. All vital Alliance member materials are offered in our threshold languages: English, Spanish, Chinese, Vietnamese, and Farsi. Members can call the Alliance Member Services Department to request materials in their preferred language, or materials in audio, Braille, large print, or other alternative formats.

Professional medical interpreter services, written translation, and alternate formats of plan member literature are available to Alliance members at no cost. Auxiliary aids are also available to Alliance members' authorized representatives, or someone involved in the member's healthcare.

Members may request language assistance, translations, alternative formats, and auxiliary aids by calling:

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

MATCHING MEMBER AND PRIMARY CARE PROVIDER LANGUAGE

Members may select their PCP by language using the Provider Directory. The Provider Directory identifies the language capabilities available for each provider office. Alliance members are encouraged to choose their own PCP. However, if a member does not choose a PCP within 30 days of becoming an Alliance member, one will be chosen for the member through auto-assignment. If auto-assignment is necessary, the Alliance makes every effort possible to match the member's preferred language with the provider office's language capabilities.

Cultural and Linguistic Provider Training and Development

DIVERSITY, EQUITY, AND INCLUSION (DEI) TRAINING PROGRAM

Alliance providers and clinic staff are required to complete DEI training as a part of the new provider orientation within 90 days of hire and during recredentialing and contract renewals and regularly thereafter to remain updated on best practices and changing member demographics and needs.

The training includes:

- Diversity, Equity, Inclusion, and Belonging
- Cultural Competency and /Sensitivity.
- Health Equity Fundamentals
- Diversity among the Alliance's member population.
- Provider and member resources to include language assistance services and translated materials.
- Best practices for providing health care services to members with limited English proficiency, diverse cultural and ethnic backgrounds, seniors and persons with disabilities (SPDs), and diverse gender, sexual orientation, or gender identities.
- How structural and institutional racism and health inequities impact members, staff and network providers.

The Alliance's DEI Training is updated annually and available online at **www.alamedaalliance.org/providers/provider-resources/training-and-technical-assistance-opportunities**. Providers can also request a copy by calling the Alliance Provider Services Department at **1.510.747.4510**.

Providers and office staff who need help locating culturally and linguistically appropriate health education materials and programs can call Alliance Health Programs at **1.510.747.4577**.

Monitoring Alliance Cultural and Linguistic Services Program

Alameda Alliance for Health is committed to ensuring that all members receive cultural and linguistic services (CLAS) that align with state and federal regulations, including National CLAS Standards. To learn more about the National CLAS Standards, visit <https://thinkculturalhealth.hhs.gov/clas>.

The Alliance's Cultural and Linguistic Services (CLS) Program monitors language access and cultural and linguistic care through the following activities:

- Tracking utilization of interpreter services
- Surveying member satisfaction on access and quality of interpreter services
- Document translation and readability review to ensure that member materials are available in Alliance threshold languages and are written at a 6th-grade reading level and follow plain language best practices
- Ensuring the Alliance provider network has the capacity to meet members' cultural and linguistic needs.
- County level data review to inform of language trends and needs.
- Quality monitoring and grievance data review to identify trends and address language access concerns through provider education.
- Facility site review of provision and documentation of language services
- DEI and cultural sensitivity training participation

These monitoring activities support the CLS Program's goal to ensure that all members receive equitable access to high quality health care services that are culturally and linguistically appropriate.

Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training

The Alliance has implemented an evidence-based cultural competency training for the purpose of providing informed trans-inclusive health care in accordance with the Department of Healthcare Services (DHCS) All Plan Letter (APL) 24-017, Department of Managed Health Care (DMHC) 24-018 and SB 923.

The Alliance requires all of its staff, Subcontractors, and Downstream Subcontractors who are in direct contact with enrollees in the delivery of care or enrollee services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI). The evidence-based cultural competency training includes:

- Information about the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of TGI communities.

- Information about communicating more effectively across gender identities, including TGI-inclusive terminology, using people's correct names and pronouns, even when they are not reflected in records or legal documents; avoiding language, whether verbal or nonverbal, that demeans, ridicules, or condemns TGI individuals; and avoiding making assumptions about gender identity by using gender-neutral language and avoiding language that presumes all individuals are heterosexual, cisgender or gender conforming, or non intersex.
- Discussion on health inequities within the TGI community, including family and community acceptance.
- Perspectives of diverse, local constituency groups and TGI-serving organizations, including, but not limited to, the California Transgender Advisory Council.
- Recognition of the difference between personal values and professional responsibilities with regard to serving TGI people.
- Facilitation by TGI-serving organizations that meets the criteria of §150900(f)(2).

TGI Provider Directory Updates:

The Alliance's provider directory will include information identifying which of the plan's in-network (contracted and credentialed) providers have voluntarily affirmed they offer gender-affirming services and agree to identify them as such in our provider directory by making a survey available to providers.

Gender affirming services include but not limited to, the services listed in Section 1367.28: Gender-affirming services, including, but not limited to, feminizing mastectomy, male chest reconstruction, mastectomy, gender-confirming facial surgery, hysterectomy, oophorectomy, penectomy, orchiectomy, feminizing genitaloplasty, metoidioplasty, phalloplasty, scrotoplasty, voice masculinization or feminization, hormone therapy related to gender dysphoria or intersex conditions, gender-affirming gynecological care, or voice therapy related to gender dysphoria or intersex conditions.

To access and complete the TGI survey, please visit **<https://aahportal-forms.alamedaalliance.org/tgisurvey>**

FACILITY SITE REVIEWS (FSR)

During PCP facility site reviews (FSR), Alliance staff will evaluate:

- Whether providers are recording the member's preferred language in medical records or on a computerized system.
- The procedures followed when serving a member whose preferred language is not English.
- Whether persons providing language interpreter services, including American Sign Language, are trained in medical interpretation.
- Whether site personnel used as interpreters have been assessed for their

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

medical interpretation performance skills/capabilities, and whether a written policy is in place.

- The provider's system for scheduling members who require interpretation services.
- The availability of patient literature and signage in languages other than English.

REVIEW OF QUALITY INDICATORS

The Alliance examines culture and language as elements in its quality studies. These studies allow the Alliance to identify patterns of use that may indicate unmet cultural and linguistic needs.

Results are used to help the Alliance and its providers develop services that meet members' cultural and linguistic needs.

Section 19: Transportation Services

This section contains information on the transportation benefits covered by the Alliance.

Transportation Benefits

The Alliance provides the following transportation benefits to Medi-Cal members for all medically necessary services covered by the Alliance:

- Emergency medical transportation (EMT)
- Non-emergency medical transportation (NEMT)
- Non-medical transportation (NMT)

The Alliance provides the lowest-cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation vendor.

The following guidelines will be used when reviewing requests for transportation services:

- **Emergency medical transportation (EMT)** is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization.

The following guidelines apply to EMT:

- Emergency medical transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.
- Ground emergency medical transportation is covered when ordinary public or private medical transportation is medically contraindicated, and transportation is needed to obtain care.
- Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.
- Medical transportation, which represents a continuation of an original emergency transportation event does not require prior authorization.
- **Non-emergency medical transportation (NEMT)** is covered for all medically necessary Medi-Cal services covered by the Alliance. Members may schedule a ride for services by calling 1.866.791.4158 at least three (3) business days (Monday - Friday) before your appointment. Providers may schedule a ride on behalf of a member by calling **1.866.529.2128** at least three (3) business days (Monday - Friday) before your appointment. For urgent appointments, call as soon as possible. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services.

The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with the Department of Health Care Services (DHCS).

Requests for NEMT transportation services must meet the following requirements:

- To determine the appropriate level of service, the treating physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender (PA or NP) must complete and sign the Alliance Physician Certification Statement (PCS) Form approved by the Department of Health Care Services (DHCS).
 - The PCS Form collects data regarding the member's functional limitations, prescribed dates of service, and prescribed mode of transportation. The provider must also attest that medical necessity was used to determine the type of requested transportation. The provider must document the member's functional limitations justification on the PCS Form to provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicle.
 - The PCS form must be completed **before** NEMT services can be provided to the member. The PCS form includes the certification statement (prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested). The signed PCS form with the required fields will be considered completed.
 - Based on medical necessity, a provider may prescribe NEMT for up to **12 months** for members.

The completed PCS Form must be submitted to:

Alliance Case and Disease Management Department

Phone: **1.510.747.4512**

Email: **deptcmdm@alamedaalliance.org**

Fax: **1.510.747.4130**

- Once the completed PCS Form is received by the Alliance, it may not be modified. The Alliance and its transportation vendor coordinate with the prescribing provider to ensure the PCS Form submitted captures the lowest-cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

- The Alliance captures data from the PCS Form for reporting and submitting the data to the DHCS.

NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with the written consent of a parent or guardian or when applicable state or federal law does not require parental consent for the minor's service.

NEMT is provided in the following modalities and situations:

- NEMT ambulance services are provided for:
 - Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
 - Transfers from an acute care facility to another acute care facility. Members transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate licensed care facility. These NEMT services do not require the PCS form.
 - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
 - Transport for members with chronic conditions who require oxygen when monitoring is required.
 - Advanced Life Support services are provided when the member requires a paramedic during transport.
 - Critical Care Transportation/Specialty Care Transportation services are provided when the member's condition requires cardiac monitoring.
 - Life Support (LS) services are provided when the member's condition requires oxygen that is not self-administered or regulated.
- Litter / Gurney van services are provided when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets both of the following:
 - Requires that the member be transported in a prone or supine position because the member is incapable of sitting for the period of time needed to transport.
 - Requires specialized safety equipment over and above that is normally available in passenger cars, taxicabs, or other forms of public conveyance.
- Wheelchair van services are provided when the member's medical and physical condition does not meet the need for litter van services but meets any of the following:
 - Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.

- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
- Requires specialized safety equipment over and above that is normally available in passenger cars, taxicabs, or other forms of public conveyance.
- NEMT by air is provided only when transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician or mid-level provider.

For Medi-Cal services not covered by the Alliance, including specialty mental health substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance will make its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

- **Non-medical transportation (NMT)** is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation vendor. Members may schedule a ride for services by calling 1.866.791.4158 at least three (3) business days (Monday-Friday) before your appointment. Providers may schedule a ride on behalf of a member by calling 1.866.529.2128 at least three (3) business days (Monday-Friday) before your appointment. For urgent appointments, call as soon as possible. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

The Alliance does not require prior authorization for NMT services, unless over **50 miles** in one (1) direction.

NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with the written consent of a parent or guardian or when applicable state or federal law does not require parental consent for the minor's service.

NMT coverage includes transportation costs for the member and one (1) attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation. This must be requested at the time of the initial NMT request.

NMT is provided using the lowest-cost modality appropriate for the member's condition.

NMT modalities include the following:

- Public transportation/mass transit
- Paratransit
- Taxicab/curb-to-curb passenger vehicle
- Door-to-door passenger vehicle
- Any other form of private conveyance (private vehicle), including mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged.

Members seeking NMT must attest to the Alliance's transportation vendor in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member does not have a valid driver's license, no working vehicle available in the household, is unable to travel or wait for medical or dental services alone, or has a physical, cognitive, mental, or developmental limitation.

In order to receive gas mileage reimbursement for the use of a private vehicle (driven by someone other than member), members must first inform transportation vendor of intent to use private vehicle for upcoming NMT.

After the NMT occurs, the following documentation must be submitted to the Alliance's transportation vendor in compliance with all California driving requirements, including:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance

NMT services for Medi-Cal carved-out services will be provided upon the member or provider's request to the Alliance. NMT can continue to be provided through Medi-Cal FFS agencies, such as CCS if requested directly to the agency.

Transportation Liaison

The Alliance Transportation liaison is available to members and providers to ensure eligible transportation requests are scheduled.

You can reach the transportation liaison at **1.510.373.5654**.

Section 20: Formulary and Pharmacy Services

This section covers how to obtain pharmacy services for Group Care and Alameda Alliance Wellness members. Please refer to section 15: Out-of-Plan Services for information on the pharmacy benefit for Medi-Cal members.

The Alliance subcontracts with a Pharmacy Benefit Manager (PBM) for select pharmacy services through PerformRX LLC (PerformRX).

The role of PerformRX includes:

- Conducting online Drug Utilization Review (DUR) programs at the point of sale
- Developing and leading the drug class reviews in the Pharmacy & Therapeutics (P&T) committee meetings
- Managing the pharmacy network
- Monitoring and reporting drug utilization patterns
- Processing initial prior authorization and exception requests
- Processing pharmacy claims

Providers and pharmacies are encouraged to contact PerformRX for questions related to pharmacy prior authorizations and claim transactions. The most current contact information, operating hours, and operating manual related to PerformRX are located online at **www.alamedaalliance.org**.

Formulary

The Alliance maintains a formulary (Preferred Drug List) for Group Care members for the outpatient prescription benefit (also known as a retail pharmacy benefit). The formulary lists drugs available to members without the need for a prior authorization (PA) request.

The Alameda Alliance Wellness Drug List covers brand name, generic, and biologic products (which may include biosimilars.) Alliance offers a one-tier formulary for its D-SNP members. Providers can refer to the D-SNP Drug List for further explanation and a list of specific drugs and UM requirements. The Drug List is updated each month and the most current version is posted <Insert Website>.

Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Alliance D-SNP Drug List. For information on how to submit a coverage determination (prior authorization or formulary exception request), please refer to the section below called “Pharmacy Prior Authorizations and Exceptions.”

The Alliance P&T Committee is responsible for the development of the formulary using sound clinical evidence. Therapeutic classes in the formulary are reviewed at least annually by the P&T Committee. The P&T Committee consists of the Alliance Chief Medical Officer (CMO) or designee, Alliance Director of Pharmacy, licensed practicing pharmacists, and licensed practicing physicians from the community with expertise in elderly and disabled care. The group meets at least quarterly.

Updates to the formulary are communicated online to both members and providers. Providers may request changes to the formulary. Requests for changes are reviewed during the P&T meeting in the following quarter.

The Alliance P&T Committee uses the following criteria in the evaluation of drug selection for its formulary:

- Comparable cost and outcomes of the total cost of drug and medical care
- Comparison of relevant drug benefits to current formulary drugs of similar use, with a goal of minimizing duplication
- Drug effectiveness
- Drug efficacy
- Drug safety profile

The Alliance provides coverage for at least one medication approved by the FDA in each of the following categories without prior authorization, step therapy, or utilization review:

- Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.
- Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.
- A long-acting buprenorphine product.
- A long-acting injectable naltrexone product.

FORMULARY CATEGORIES

There are five (5) drug dispensing categories on the Alliance formulary, including restrictions and preferences:

1. Formulary Drugs

Drugs on the formulary are preferred and may or may not require prior authorization for claim adjudication.

When covered, the drugs may also have one (1) or more of the following restrictions:

- Generic Substitution – The generic equivalent has to be dispensed when available.
- Biosimilar substitution required for bioidentical biosimilars

- Quantity Limits – A limit on the quantity and/or duration of therapy.
- Step Therapy – Requires one (1) or more of a prerequisite first step drug to be tried before progressing to a second step drug.
- Age Restriction – Restriction to a specific age when medically appropriate for the drug.

Providers can refer to the comprehensive formulary for further explanation and a list of specific drugs that are subject to generic substitution and step therapy or have quantity limits or age/gender restrictions.

2. Therapeutic Interchange

Therapeutic interchanges promote rational pharmaceutical therapy when evidence suggests that clinical outcomes are comparable when substituting a drug that is therapeutically equivalent but chemically different from the prescribed drug. The substituted drug may be of a different drug class but has comparable effectiveness.

Therapeutic interchange protocols are never automatic and require authorization from the prescribing provider

3. Drugs Requiring Prior Authorization

Non-formulary drugs subject to prior authorization require approval from the Alliance or the PerformRX Authorization Department for the Group Care line of business. The prior authorization review process serves as a quality measure to ensure the drug is safe and cost-effective. To review requests for the outpatient pharmacy benefit, the Alliance and PerformRX uses drug treatment guidelines (criteria), reviewed and approved by the P&T Committee.

If a drug is not listed as covered on the comprehensive formulary, it can be assumed that it requires prior authorization or exception.

4. Drugs Requiring Exception

Non-formulary drugs can also be requested and processed as an exception. An exception is similar to a prior authorization except the Alliance does not have drug review guidelines (criteria) to guide the clinical reviewer, or the requested drug exceeds the scope of coverage (see Non-Formulary Drugs below). Rather, approval will be based on evidence of medical necessity on a case-by-case basis.

The exception review process serves as a quality measure to ensure the drug is safe, cost-effective, and medically necessary. The PerformRX Prior Authorization Department for the Group Care line of business will forward all exception requests to the Alliance to be reviewed by a licensed pharmacist or physician. Providers can request an exception authorization by submitting a Prescription Drug Prior Authorization (PA) Request Form to PerformRX per the exception protocols.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Please contact PerformRX for inquiries on any of the above formulary categories or to submit a verbal or written prior authorization or exception request. The most current contact information is located online at www.alamedaalliance.org.

5. Emergency Supply

In compliance with state rules, the Alliance will cover a **three (3)-day** supply of medication for Alliance members in emergency situations. This policy applies to medication that normally would require a Prescription Drug PA Request or exception request.

Emergency situations include:

- A recent discharge from an emergency room (ER)
- A recent discharge from the hospital
- Any event that involves an imminent and serious threat, including (but not limited to) severe pain, potential loss of life, limb, or major bodily function

Contracted Alliance pharmacies can help Alliance members obtain an emergency supply. Alliance members can find a list of pharmacies that work with us in the Alliance Provider Directory or online Pharmacy Search.

After the **three (3)-day** supply is over, providers will need to submit a Prescription Drug PA Request Form. The Alliance will review the request and will inform the doctor of the decision within **one (1) business day**.

HOW TO ACCESS THE FORMULARY

Providers can access the Alliance formularies online at www.alamedaalliance.org.

Pharmacy Prior Authorizations and Exceptions

In some instances, a provider may want to prescribe a drug for a member that is not listed on the formulary or does not meet a step therapy restriction, quantity limit, or duration of therapy limits (as listed on the formulary). Providers can submit a prior authorization or exception request to obtain coverage for these drugs.

HOW TO REQUEST A PRIOR AUTHORIZATION OR EXCEPTION

If a drug is not listed as covered on the comprehensive formulary, it can be assumed that it requires prior authorization or exception.

Prescribers can be proactive with obtaining prior authorization or exception approvals to ensure continuity of care. Prescribers do not have to wait until the claim is rejected at the pharmacy to initiate a request. Once the request is received and approved, an authorization will be entered into the pharmacy claims system. The patient can fill the prescription at any network pharmacy without further involvement by the provider or the pharmacist.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

Providers should submit a prior authorization or exception request using the Prescription Drug PA Request Form. It is important to document the appropriate clinical information that supports the medical necessity of the requested drug, quantity, refill frequency, and/or duration of therapy. A determination decision will be made within regulatory time frames per the member's line of business. The Prescription Drug PA Request Form can be found on the Alliance website at **www.alamedaalliance.org**.

Prior authorization requests for Group Care can be submitted by fax to PerformRX at **1.855.811.9329** (24 hours a day, 7 days a week) or by calling toll-free at **1.855.508.1713** (Monday – Friday, 8:30 am – 5:30 pm PT).

Prior authorization requests for [D-SNP/Alameda Wellness] can be submitted by fax (24 hours a day, 7 days a week) to PerformRX at **1.855.5081714** for Standard requests and **1.855.806.6237** for Urgent requests or by calling toll-free at **1.833.793.3767** (24 hours a day, 7 days a week).

To file a prior authorization request or formulary exception request providers can:

- Submit an ePA via your Electronic Health Record (EHR) platform
- Call PerformRx Prior Authorization line at <XXX>
- Fill out the online form available at <XXXXXX>
- Print and submit form for Request for Medicare Prescription Drug Coverage Determination available at <XXXXXX>

PRIOR AUTHORIZATION AND EXCEPTION REVIEW PROCESS

All prior authorization and exception requests are initially reviewed by PerformRX for the Group Care line of business. Requests that cannot be approved by PerformRX are forwarded to the Alliance clinical pharmacy staff for review.

The Alliance reviews the request against the following resources:

- Drug request guidelines (approved by P&T Committee)
- Evidence of Coverage (EOC)
- Evidenced-based treatment guidelines
- External specialist review based on medical necessity
- Medical director review based on medical necessity
- Prior use of formulary alternative

PRIOR AUTHORIZATION AND EXCEPTION DENIALS

If a request for prior authorization or exception is denied, the member and requesting provider will be notified by mail and have the right to appeal per the Alliance guidelines as described in Section 22: Grievance and Appeals.

PRIOR AUTHORIZATION TURN AROUND TIMES:

In general, Alliance will make a decision about prior authorization or coverage determination requests within the timeframes in the table below. Providers can request that a request be expedited if the member's health could be seriously harmed by waiting the full timeframe for a decision. If the request is for a formulary exception, the timeframe to make a decision will start upon receipt of receiving the prescriber's supporting statement.

Request Type	Medi-Cal	Group Care	Wellness D-SNP
Urgent Medical Drug	72 hours	72 hours	24 hours
Urgent Prescription Drug	Submit to Medi-Cal Rx	24 hours	24 hours
Routine Medical Drug	5 business days	5 business days	72 hours
Routine Prescription Drug	Submit to Medi-Cal Rx	24 hours	72 hours

EMERGENCY SUPPLY FOR DRUGS REQUIRING PRIOR AUTHORIZATION

Dispensing pharmacists can dispense up to a **three (3)-day** supply of non-formulary drug(s) using the emergency supply override while waiting to obtain prior authorization for Group Care members. Dispensing pharmacists should only utilize this override for use of alleviation of severe pain and/or treatment of unforeseen medical conditions, which, if not treated immediately, would lead to disability or death. Pharmacies can enter a universal code in the prior authorization field for the override.

For the most current override code, please contact PerformRX or consult the operating manual available online. The use of this code will be monitored.

A Prescription Drug PA Request Form must be submitted to PerformRX by the following business day for approval of the balance of the prescription.

Pharmacy Network

The Alliance pharmacy network includes most retail pharmacies in addition to a small selection of specialty pharmacies. The pharmacy network serves Group Care members.

LOCATING A NETWORK PHARMACY

To find a nearby Alliance network pharmacy, please visit **www.alamedaalliance.org**.

Injectables

SELF-ADMINISTERED

Self-administered injectables are dispensed by specialty pharmacies through the pharmacy benefit. The injectables are managed through the usual formulary management process. The Alliance contracts with select specialty pharmacies to provide most of the self-administered injectables and as such, claims will be denied at retail pharmacies unless there is a prior authorization. Some self-administered injectables, like insulin, are listed in the formulary and are handled by retail pharmacies. For the most current specialty pharmacies' contact information and the specialty pharmacy restricted drug list, please visit our website at **www.alamedaalliance.org**.

PROVIDER-ADMINISTERED DRUGS (PHYSICIAN ADMINISTERED DRUGS (PAD)

Provider-administered injectables can be processed as a medical benefit or as a pharmacy benefit through Alliance specialty pharmacies. Injectables procured directly by the provider should be billed directly to the Alliance as a medical claim. Injectables procured through specialty pharmacies are processed directly through the PBM; providers do not need to submit a separate claim. Provider-administered drugs (PAD) billed through the medical benefit may be subject to prior authorization. More information about submitting prior authorization requests may be found Section 6 Utilization Management .

Providers are encouraged to use the specialty pharmacies to order the available physician-administered injectables (refer to the specialty pharmacy restricted drug list). The specialty pharmacies can deliver directly to providers' offices. For more information on how to order from specialty pharmacies please visit our website at **www.alamedaalliance.org**.

Medicare Covered Medical Prescription Drugs (Medicare Part B Drugs)

Prescription drugs that are covered under Original Medicare are also covered for Alliance D-SNP members. Examples of drugs covered under Part B include:

- Drugs that usually are not self-administered by the member and are injected while receiving physician services.
- Drugs used with durable medical equipment (such as nebulizers) for use in the home.
- Clotting factors self-administered by a member that has hemophilia.
- Immunosuppressive drugs if the member had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if the member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and the member cannot self-administer the drug.
- Antigens.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Certain oral anti-cancer drugs and anti-nausea drugs.
- Insulin when administered via an insulin pump.
- Erythropoietin by self-injection if the member has end-stage renal disease, receives home/outpatient dialysis, and needs this drug to treat anemia.

Opioid Overutilization Monitoring Program (Drug Management Program, DMP)

CMS mandates that Part D sponsors must employ effective concurrent and retrospective drug utilization review (DUR) programs to address overutilization of medications – specifically to address opioid overutilization among its Part D members. CMS recognizes “overutilization” as filling of multiple prescriptions written by different prescribers at different pharmacies for the same or therapeutically equivalent drugs in excess of all medically accepted norms of dosing. Members with a history of opioid-related overdose may also be included in this program. For more information about the Alliance opioid overutilization monitoring program, refer to the CMS website at www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d.

Medication Therapy Management Program (MTMP)

The Alliance Medication Therapy Management Program (MTMP) is a no-cost program aimed at improving medication use and therapeutic outcomes. Alliance partners with Outcomes Operating, Inc. to administer the MTMP.

Certain members who have chronic diseases, take multiple medications, and have high cost for medications are enrolled in the program. Members also qualify if identified as an at-risk beneficiary (ARB) under the plan’s Drug Management Program for potential misuse of opioid medications. The Outcomes CMR is an interactive, person-to-person consultation with an MTM provider. The provider reviews the member’s medications, including prescription, non-prescription, samples, and herbals/supplements. At the conclusion of the CMR, an individualized, written summary of the interactive consultation is provided to the member, caregiver or other authorized representative (if applicable) and any drug therapy problems identified are resolved with the beneficiary and the prescriber, as appropriate. Targeted medication reviews (TMR) are also performed to help identify and resolve medication related problems. Our program complements the care patients receive from their physicians and does not interfere with the doctor-patient relationship. Additional information is available at <insert link to MTM webpage>.

Real-Time Prescription Benefit

The Real Time Benefit program by PerformRx allows providers to instantly access up-to-date prescription coverage and pricing information at the point of care, ensuring patients receive cost-effective and appropriate medication. Prescribers can see which drugs require prior authorization and evaluate therapeutic alternatives for patients. The Real-Time Prescription Benefit program can be integrated within your existing electronic prescribing workflow. For additional information please contact PerformRx at <XXXXXX>

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

Section 21: Clinical Laboratory Services

Alliance clinical laboratory services are contracted through Quest Diagnostics, which includes multiple testing sites throughout Alameda County. This section covers how to obtain clinical laboratory services for Alliance members.

Outpatient Laboratory Services

Most outpatient laboratory services must be provided through Quest Diagnostics.

Providers should send members or specimens to Quest Diagnostics for all laboratory testing except:

- Genetic, chromosomal, and alpha-fetoprotein prenatal testing
- HIV testing
- Members who are assigned to the Alameda Health System (AHS) Network*
- Renal tests performed at a dialysis center
- Tests that are included in the PCP capitation contract
- Tests that are provided through alternative sites described on the following pages

*Members with an AHS PCP assignment will use AHS outpatient laboratory facilities.

QUEST DIAGNOSTICS LAB SERVICES

Quest Diagnostics lab services and programs include:

- Two (2) four (4)-hour STAT testing services
- Client services available 24 hours a day, 7 days a week
- Courier service
- Custom ICD-10 Requisition Program
- Quest Express – Same-day testing service
- Supplies

QUEST DIAGNOSTIC LAB SERVICES

For courier service, STAT pickup, or will call, please call toll-free at **1.866.697.8378**.

QUEST DIAGNOSTICS CLIENT/PATIENT LAB SERVICES

Quest Diagnostics representatives are available Monday – Friday, 8 am – 5 pm, toll-free at **1.866.697.8378**.

Laboratory Procedures in the PCP Office

ASSIGNED MEMBERS

PCPs may perform certain, specific laboratory tests in their offices. These services need

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

to be documented and submitted to the Alliance. All other tests must be sent to Quest Diagnostics.

NON-ASSIGNED MEMBERS

PCPs who provide laboratory services that are normally capitated to a member who is not assigned to them should submit an FFS claim when:

- Diagnosing or treating a sexually transmitted disease
- Providing family planning services
- Providing minors with consent services
- The services are for a member not assigned to any PCP
- The test has received prior authorization

Part 3. Care Management

Section 22: Care Management

Measuring and Improving Plan Performance (HEDIS®)

Health Effectiveness Data Information Set (HEDIS®) measures are developed by a national group of health care experts, issued annually, and used as a standard across the country. Using HEDIS® measures, the Alliance can compare its performance against other managed care plans. HEDIS® study methodology and results are also validated and audited by an external agency.

HEDIS® studies use data submitted by providers on their claims/encounter forms and may be supplemented with data retrieved from providers' medical records. The Alliance makes every effort to request records or schedule HEDIS® data retrieval for all studies at the same time and only once each year.

Measuring and Improving Plan Performance (CAHPS and HOS)

The Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey and HOS (Health Outcomes Survey) are consumer satisfaction surveys that health plans including the Alliance are required by the Centers for Medicare and Medicaid Services to administer annually. It is required that the surveys are administered by an approved CMS vendor, with results carrying a direct impact on the CMS Medicare Part C & D Star Ratings. By thoroughly understanding the survey questions, providers and staff can better comprehend how regulating entities evaluate member experiences.

Questions in the CAHPS survey cover:

- Annual Flu Vaccine
 - Have you had your flu shot?
- Care Coordination
 - In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
 - In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
 - In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
 - In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
 - In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
- Getting Appointments and Care Quickly
 - In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
 - In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic?
 - Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
- Getting Needed Care
 - In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
 - In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
- Getting Needed Prescription Drugs
 - • In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- Rating of Health Care Quality
 - Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the beset health care possible, what number would you use to rate all your health care in the last 6 months

Questions in the HOS survey cover the following categories are available by request at **hosonline.org**:

- Improving Bladder Control
- Improving/ Maintaining Mental Health
- Improving/Maintaining Physical Health
- Monitoring Physical Activity
- Reducing Risk of Falling

The Alliance is invested in the success of providers, experience of the members, and improvement of health outcomes. To learn how you might enhance members' experience and their journey to meet their wellness goals, please email **providerservices@alamedaalliance.org**.

QUALITY IMPROVEMENT ACTIVITIES

In addition to HEDIS® measures, the Alliance has several monitoring responsibilities for its members. The Quality Improvement Health Equity (QIHE) Program examines data from internal studies in such areas as access (e.g., waiting times for appointments, adequacy of provider network), coordination and continuity of care, utilization, and members' rights. Providers play an important role in our QIHE Program and are required to cooperate with the Alliance quality improvement activities to improve the quality of care and services and member experience. Cooperation includes the collection and evaluation of data and participation in the organization's QIHE programs. Activities related to the QIHE Program, including the program description, work plan, and evaluation, are posted on the Alliance website at www.alamedaalliance.org/provider/quality. Further, the QIHE Committee, which is a standing committee of the Board of Governors, has meeting materials and policies and procedures posted for review (<https://alamedaalliance.org/about/standing-committees/>). The results of HEDIS® and internal studies for the plan's members are the basis of planned quality improvement activities. Mandated by the Federal Balanced Budget Act for Medicaid and Medicare health plans, quality improvement activities are aimed at producing statistically significant and sustained improvement in an important aspect of health care delivery or clinical outcome.

An External Quality Review Organization (EQRO) contracted with the Department of Health Care Services validates the Alliance's quality improvement activities. This external review process may also involve requests for member medical records from providers and/or site visits. Providers are required to cooperate with the Alliance quality improvement activities to improve the quality of care and services and member experience. Cooperation includes the collection and evaluation of data and participation in the organization's QIHE programs.

Failure to comply with the Quality Improvement Health and Utilization Management Programs, including but not limited to authorization procedures, site visits, recertification, corrective action plans, and grievance procedures may result in actions taken by the Alliance and/or termination.

Alliance Measures of Provider Performance

Giving providers feedback about their performance in relation to their peers has proven to be a powerful tool to move behavior toward the best practice.

Alliance providers allow the plan to use provider performance data in quality improvement activities and to conduct the Alliance QIHE Program.

The Alliance QIHE Program includes systems to recognize providers based on:

- Partnership behaviors that assist the plan in the measurement and management of health.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Clinical practices that are linked to improved health outcomes for members.

The data collected from the claims and encounter data are used to measure a provider's clinical practice. The diagnoses and procedure codes documented on these forms are crucial to accurate profiling. Missing, inaccurate, or non-specific codes significantly impact systems such as the reporting of annual HEDIS® measures.

Accurate coding of diagnoses and procedures affects the quality profile.

PROVIDER QUALITY REPORT

The Alliance compiles a provider quality report for each PCP undergoing re-credentialing.

The report summarizes a range of provider statistics and activities available from the following areas:

- Member complaints
- Member satisfaction surveys
- Quality reviews
- Site review score

Care Management Programs

Alliance Care Management Programs coordinate with providers and community partners to improve health outcomes and the integration of care for all our members across medical and behavioral health and social services. Care Management Programs address the patient's health care needs across the continuum of care from well-being to end of life, through the identification, assessment, development, and execution of targeted, evidence-based, individualized care plans.

PROGRAM GOALS

- Improve health outcomes for the Alliance patient population
- Identify and document measurable member-specific health goals and plan of care
- Facilitate coordination of care and services to meet member health needs
- Enhance the patient-to-provider relationship
- Reduce unnecessary medical utilization
- Avoid readmissions
- Reduce avoidable emergency department visits
- Manage chronic conditions

INTERVENTIONS

Interventions include the following:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Coordinate with the providers of care about progress toward or lack thereof, the plan of care.
- Assess member needs through Health Risk Assessments (HRAs)
- Develop individualized care plans that address member health and social needs.
- Review and analyze utilization data for opportunities for improved care management and coordination.
- Work in partnership with community agencies and health practitioners who provide case/care management and services to our members.
- Assist members in obtaining measurable health outcome goals through educating and facilitating access to services and community resources.
- Select targeted members for specific Care Management Programs through predictive modeling methodologies.
- Empower and educate members with resources and information to self-manage their health conditions.
- Deliver member-centric coordination of care across the continuum.

PROGRAMS

- Care Planning Coordination: HRAs & Care Plans
- Basic Population Health Management (PHM)/Care Coordination
- Complex Case Management (CCM)
- Enhanced Care Management (ECM)
- Disease Management
- Transitional Care Services

Basic Population Health Management

The PCP retains primary responsibility for coordinating the member's overall health care and has the responsibility and authority to direct and coordinate the member's services. The Alliance supports the PCP in care coordination by providing the Basic Population Health Management (PHM) program to ensure that needed programs and services are made available to each member at the right time and in the right setting.

INTERVENTIONS

Interventions include, but are not limited to:

- Access to primary care
- Care coordination
- Case manager services for children under EPSDT
- Chronic disease programs
- Information sharing
- Navigation and referrals across health and social services
- Programs focused on improving maternal health outcomes
- Services provided by community health workers (CHWs)
- Wellness and prevention programs

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Care Coordination

The Care Coordination Program helps members identify their needs and develop a plan for meeting those needs. Members' needs are identified by HRAs and other member-centric information provided to the Alliance.

INTERVENTIONS

Interventions include, but are not limited to:

- HRAs: Assessment of the member's current health and functional status
- Care plans: Setting individualized goals and interventions.
- Self-management tools
- Mailing materials to members based on need.
- Member education
- Providing mailed and verbal coaching appropriate for the member
- Referrals to other Alliance programs when appropriate
- Coordinated care both within the Alliance and with community partners.

Complex Case Management (CCM)

The Complex Case Management (CCM) Program aims to intensively manage and coordinate care for members who have multiple chronic conditions, require extensive use of resources, and need help navigating the system to facilitate the appropriate delivery of care and services. CCM referrals may originate from any source including, but not limited to, self-referral, caregivers, PCPs or specialists, discharge planners at medical facilities, health information line referrals for Group Care members, and internal department referrals, including but not limited to, such as the Alliance UM Department, and the Alliance Member Services Department.

CRITERIA

CCM criteria include:

- Typically severe degree and complexity of the member's illness.
- Typically intensive level of management necessary.
- Typically extensive amount of resources required for the member to regain optimal health or improved functionality.

The Alliance's goals and intervention schedule for completion shall guide the care manager in managing the case. Additionally, the member shall be provided with the name and number of the CM to contact as needed.

The CM will perform the following:

- Evaluate cultural and linguistic needs, preferences, or limitations.
- Evaluate visual and hearing needs, preferences, or limitations.
- Address the availability of caregiver resources and their involvement with the member.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Address available benefits and any needs for community and financial resources.
- Provide the member with available programs, resources, and program requirements based upon their and their caregiver's preferences and desired level of involvement in their plan of care.
- Make and follow up on referrals to resources. Follow-up on all referrals will be scheduled at the time of the referral and can be combined as part of the next monthly contact, if not considered urgent.
- Contact the member monthly, at a minimum, or more frequently based on the needs of the member and the referrals made. Each contact includes an assessment of the member's progress toward the goals, an evaluation of the barriers to the goals, and adjusting the care plan and its goals, as needed.
- Continually update and evaluate the Care Plan based on the member's need and using information from ongoing screenings and assessments.

Community Health Worker (CHW) Services

Beginning, Friday, July 1, 2022, community health worker (CHW) services became a Medi-Cal covered benefit.

The California Department of Health Care Services (DHCS) defines CHW services as preventive health services to prevent disease, disability, and other health conditions or their progression; prolong life, and promote physical and mental health. CHWs may include individuals known by several job titles, such as promoters, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

Contracted licensed providers, hospitals, outpatient clinics, local health jurisdiction (LHJ), or community-based organizations may submit claims for CHW services as long as the supervising provider meets the credentialing requirements. This includes submitting a completed Supervising Provider Attestation for Community Health Workers Form. Please refer to Section 20: Credentialing Process.

For more information on the benefit and/or Medi-Cal billing requirements, refer to the DHCS ALL PLAN LETTER (APL) 22-016 (and any subsequent related APL).

Enhanced Care Management (ECM)

The Alliance covers Enhanced Care Management (ECM) services for Medi-Cal members with highly complex needs. ECM is a benefit that provides extra services to help members get the care they need to stay healthy. ECM helps coordinate primary care, acute care, behavioral health care, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to available community resources.

If a member qualifies, they may be contacted about ECM services. Members and providers can also call the Alliance to find out if a Medi-Cal member qualifies and how they can receive ECM services.

COVERED ECM SERVICES

Members who qualify for ECM will have their own care team, including a care coordinator to coordinate with members, doctors, specialists, pharmacists, case managers, social services providers, and others to make sure everyone works together. There is no cost to the member for ECM services.

ECM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

Members can be referred by their provider by calling:

Alliance Case Management Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4512**

Toll-Free: **1.877.251.9612**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

California Integrated Care Management (CICM)

The Alliance covers California Integrated Care Management (CICM) services for D-SNP members with highly complex needs. CICM is a benefit that provides extra services to help members get the care they need to stay healthy. CICM helps coordinate primary care, acute care, behavioral health care, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to available community resources.

If a member qualifies, they may be contacted about CICM services. Members and providers can also call the Alliance to find out if a member qualifies and how they can receive CICM services.

COVERED CICM SERVICES

Members who qualify for CICM will have their own care team, including a care coordinator to coordinate with members, doctors, specialists, pharmacists, case managers, social services providers, and others to make sure everyone works together.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

There is no cost to the member for CICM services.

CICM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

Members can be referred by their provider by calling:

Alliance Case Management Department

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Phone Number: **1.510.747.4512**

Toll-Free: **1.877.251.9612**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

Disease Management

The Alliance has four (4) disease management programs based on patient population needs and prevalence. These programs are offered to Alliance members with a diagnosis of asthma, diabetes, high blood pressure, or perinatal depression. These programs aim to address gaps in care, prevent complications related to chronic disease, promote health equity, and improve the health and well-being of members. The programs provide education, chronic care management, patient activation, and coordination of care.

All program interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified by claims, pharmacy, and lab data, as well as direct referrals from physicians or community partners.

Happy Lungs – Serves members who are 18 years or younger and identified with low-risk asthma based on clinical, pharmacy, and utilization data or direct referral. The members (and their caregivers) will receive an educational letter entitled “Happy Lungs” and an invitation to engage in pediatric asthma services.

Living Your Best Life with Asthma – Serves members who are 19 years or older with asthma based on clinical, pharmacy, and utilization data or direct referral. The members will receive an educational letter entitled “Living Your Best Life with Asthma” and an invitation to engage with the Alliance for additional resources.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Living Your Best Life with Diabetes – Serves members living with diabetes who are 19 years of age or older and identified based on clinical, pharmacy, and utilization data or direct referral. The members will receive an educational letter and an invitation to access diabetes management programs. Members identified with diabetes at a higher risk of worsening outcomes will also receive an outreach call.

Living Your Best Life with a Healthy Heart – Serves members 19 years or older with high blood pressure based on clinical, pharmacy, and utilization data or direct referral. These members will receive an educational letter and an invitation to engage with the Alliance for additional resources. Members identified with high blood pressure at a higher risk will also receive an outreach call.

BirthWise Wellbeing – Serves members between the ages of 18-50 who are pregnant or have given birth within the past year. These members will receive an educational flyer on perinatal depression and the Alliance Baby Steps educational materials for a healthy pregnancy. Members will be informed of how they can engage with the Alliance for additional resources. Members identified as higher risk for depression may also receive an outreach phone call.

Providers can refer members by completing and sending the Alliance Case and Disease Management (CMDM) – Program Referral Form. To access the form, please visit the Alliance website at www.alamedaalliance.org/providers/provider-forms.

Alliance members may also self-refer.

Please advise Alliance members to call:

Alliance Case Management Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4512**

Toll-Free: **1.877.251.9612**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

Diabetes Prevention Program (DPP)

The Diabetes Prevention Program (DPP) is a Medi-Cal benefit that helps eligible members adopt healthy habits, lose weight, and significantly decrease their risk of developing type 2 diabetes. It is currently not available for Group Care members.

ELIGIBILITY

- Patient must be **18 years of age** or older
- Overweight; and
- At risk for type 2 diabetes

PROGRAM DETAILS

- Members are assigned a lifestyle health coach that helps them set goals and stay on track.
- The first 6 months of the program includes 16 weekly sessions, followed by monthly sessions for the remainder of the year.
- The second year includes monthly sessions if the member achieves attendance and weight-loss goals.
- Members may receive up to \$100 in gift cards as an incentive for participation.

The DPP curriculum is approved by the Centers for Disease Control and Prevention (CDC). The program is available online only, in both English and Spanish.

Providers can refer members to the DPP by downloading and completing the Provider Wellness Form. This form can be found on www.alamedaalliance.org/providers/patient-health-wellness-education.

Alliance members may also self-refer.

Please advise Alliance members to call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

Alliance members with Medi-Cal may also take a risk quiz and enroll. Please refer them to the Alliance website at www.alamedaalliance.org/live-healthy/dpp.

Medicare Diabetes Prevention Program (MDPP)

The Medicare Diabetes Prevention Program (MDPP) is a Medicare benefit covered once in a member's lifetime for Alameda Alliance Wellness members. It helps eligible members adopt healthy habits, lose weight, and significantly decrease their risk of developing type 2 diabetes.

ELIGIBILITY

In order to participate, all of these conditions must apply:

- Within 12 months before attending the first core session, have either a:
- Hemoglobin A1c test result between 5.7% and 6.4%;
- Fasting plasma glucose of 110-125mg/dL; or a
- 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test).
- Have a body mass index (BMI) of 25 or more (BMI of 23 or more if the member is Asian).

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

- Have never been diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease.
- Have never participated in the MDPP.

PROGRAM DETAILS

- Members are assigned a lifestyle health coach that helps them set goals and stay on track.
- The first 6 months of the program includes 16 weekly sessions, followed by monthly sessions for the remainder of the year.
- The second year includes monthly sessions if the member achieves attendance and weight-loss goals.

The MDPP curriculum is approved by the Centers for Disease Control and Prevention (CDC). The program is available online via distance learning only.

Providers can refer members to the MDPP by downloading and completing the Provider Wellness Form. This form can be found on www.alamedaalliance.org/providers/patient-health-wellness-education.

Alliance members may also self-refer.

Transitional Care Services

Care transitions are defined as a member transferring from one (1) setting or level of care to another, including but not limited to discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings.

Under Population Health Management (PHM) and in line with CalAIM, the Alliance is accountable for providing strengthened Transitional Care Services (TCS) to all members, across all settings and delivery systems. Members are supported from discharge planning until they have been successfully connected to all needed services and supports. This is accomplished by ensuring that a single point of contact can assist members throughout their transition and ensure all required services are complete.

TCS HIGHLIGHTS

TCS highlights include:

- Connecting the patients to their Alliance PCPs, including facilitating discharge follow-up appointments
- Coordination of care services
- Facilitating referrals to social service organizations
- Facilitating referrals to necessary at-home services
- Medication reconciliation

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at www.alamedaalliance.org.

- Providing education and symptom management
- SUD and treatment referral

You can refer members to Alliance programs through the following:

Case and Disease Management

Phone Number: **1.877.251.9612**

Fax: **1.510.747.4130**

Referral Form: www.alamedaalliance.org/members/medi-cal/cmdm

Infertility Services

STANDARD FERTILITY PRESERVATION SERVICES

Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345, and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.557. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).

For Medi-Cal members, fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.

Reconstructive Surgery

Reconstructive surgery that is medically necessary is available to beneficiaries.

Reconstructive surgery is “surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function. (B) to create a normal appearance, to the extent possible” (Health and Safety Code § 1367.63m (c) (1) (A) (B)), or (C) to treat gender dysphoria.

Cosmetic surgery, defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance, is not a covered benefit.

Reporting Provider-Preventable Conditions (PPCs)

BACKGROUND

Federal law requires that all providers report provider-preventable conditions (PPCs) that occurred during the treatment of Medi-Cal patients. Providers must report all PPCs that are associated with claims for Medi-Cal payment or with courses of treatment given to a Medi-Cal patient for which payment would otherwise be available.

Providers do not need to report PPCs that existed prior to the provider initiating treatment for the beneficiary.

The Federal Affordable Care Act section 2702 and Title 42 of the Code of Federal Regulations, sections 447, 434, and 438 also require that Medi-Cal and Medi-Cal Managed Care plans no longer reimburse providers for PPCs that occur during the treatment of Medi-Cal patients. The Alliance will investigate all reports of PPCs, including those it discovers through any means, to determine if payment adjustment is necessary.

REPORTING REQUIREMENTS

For Alliance Medi-Cal members, providers should use the Department of Healthcare Services (DHCS) new secure online reporting portal to report PPCs to DHCS. Please see the [instructions](#) about using the portal, which includes the [link to the online portal](https://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx) (https://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx). Providers are required to send a copy of all PPCs submitted to the online portal to the Alliance.

Please submit a copy of all PPCs submitted to DHCS to:

Alliance Compliance Department

Fax: **1.510.373.5999**

Email: **compliance@alamedaalliance.org**

Please Note: Reporting PPCs for a Medi-Cal beneficiary does not preclude the reporting of adverse events and health-care-associated infections (HAI) to the California Department of Public Health (DPH) pursuant to the Health and Safety Code.

Section 23: Grievance and Appeals

The Alliance maintains a grievance and appeals process under which members may submit their grievance or appeal to the Alliance in accordance with state and federal regulations. The Alliance does not delegate the resolution of grievances and appeals.

Providers are to comply with the grievance and appeals process in accordance with their contract. Failure to comply with our grievance and appeals process may lead to corrective action plans or a possible hold on member assignment.

DEFINITIONS

Grievance – A written or oral expression of dissatisfaction with regard to the Alliance and/or provider, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by a member or the member's representative.

PLEASE NOTE: An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include but are not limited to, questions pertaining to eligibility, benefits, or other managed care plan processes. Where the Alliance is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Adverse Benefit Determination – Defined to mean any of the following actions taken by a managed care plan (MCP):

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure to act within the required time frames for standard resolution of grievances and appeals.
- For a resident of a rural area with only one (1) managed care plan, the denial of the beneficiary's request to obtain services outside the network.
- The denial of a beneficiary's request to dispute financial liability.

Notice of Action (NOA) – Also known as a Notice of Adverse Benefit Determination.

Appeal – Defined as a review by the Alliance of an Adverse Benefit Determination:

- **Prior Authorization Appeal** – A request to change a prior authorization adverse determination for care or service that the Alliance must approve, in whole or in part, in advance of the member obtaining care or services.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- **Retro Authorization Appeal** – A request to change a prior authorization adverse determination for care or services that have already been received by the member.

MEMBER GRIEVANCE PROCESS

A member may file a grievance:

- Medi-Cal Members – At any time following any incident or action that is the subject of their dissatisfaction.
- Group Care Members – Within **180 calendar days** following any incident or action that is the subject of their dissatisfaction.

The Alliance does not discourage the filing of grievances. A member who files a grievance may not be discriminated against, and cannot be disenrolled from the Alliance, the provider group, the provider's office, or the facility in retaliation for filing a grievance.

Provider Assistance for Filing Member Grievances

The Alliance is responsible for processing and resolving all grievances.

When a provider has become aware that a member is dissatisfied with the delivery of care that has been provided, please provide the following information to the member:

- The member can state that they would like to file a grievance with the Alliance by calling:

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

- For D-SNP, the member can state that they would like to file a grievance with the Alliance by calling:

Alameda Alliance Wellness Customer Services

Monday – Sunday (seven (7) days a week), 8 am – 8 pm

Phone Number: **1.510.747.4508**

Toll-Free: **1.888.88A.DSNP (1.888.882.3767)**

If you cannot hear or speak well, use TTY or call **1.800.735.2929**

- Contracted provider offices or facilities are required to make member grievance forms and assistance readily available in accordance with the California Code of Regulations, Title 28 §1300.68 (b)(7).

- Providers can access the Alliance Grievance Forms by contacting:

Alliance Provider Services Department

Phone Number: **1.510.747.4510**

Email: **providerservices@alamedaalliance.org**

www.alamedaalliance.org/providers/provider-resources/grievances-appeals

MEMBER AUTHORIZATION APPEAL PROCESS

Members or their authorized representative (AR) may request an appeal of an adverse benefit determination. A provider may submit an appeal on behalf of a member for prior authorization and retro authorizations.

When submitting an appeal on behalf of a member, please provide the Alliance Grievance and Appeals Department with a copy of the authorization, denial notification, and all pertinent supporting documentation within:

- **60 days** from the date of denial for Medi-Cal members
- **180 days** from the date of denial for Group Care members

Please mail or fax all information to:

Attn: Grievances and Appeals Department
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
Fax: **1.855.891.7258**

NON-CONTRACTED PROVIDER APPEALS

In accordance with CMS regulations, providers who are not contracted with a Medicare Advantage organization may file a standard appeal for a claim that has been denied, in whole or in part, but only if they submit a completed Waiver of Liability Statement (PDF). If you complete a Waiver of Liability Statement, you waive the right to collect payment from the member, with the exception of any applicable cost sharing, regardless of the determination made on the appeal.

If you appeal and we uphold the denial, in whole or in part, you will have additional appeal rights available to you including, but not limited to, reconsideration by a CMS contracted independent review entity.

RESOLUTION TIME FRAMES

In order to provide excellent service to our members, the Alliance maintains processes by which the member can obtain thorough investigation and timely resolution of their grievances with the following process:

Expedited Grievances

- Investigation and resolution within **72 hours for Medi-Cal and Group Care**.
- Investigation and resolution within **24 hours for D-SNP**.
- Classification of expedited review will be considered for grievances involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Standard Grievances

- Acknowledgement of receipt received in writing or by telephone within **five (5) calendar days**.
- Resolution within **30 calendar days** from receipt of the complaint.

Expedited Appeals*

- Resolution and written notice within **72 hours**.

Standard Appeals

- Acknowledged in writing within **5 calendar days**; and
- Resolved within **30 calendar days** from receipt of the complaint.

The Alliance does not permit extensions for integrated reconsiderations (appeals) of Medicare and Medicaid services. The Plan will ensure that needed relevant information is obtained to make a decision. For appeals, members have the right to continue receiving benefits pending the resolution of the appeal. Providers may be requested to continue approval of benefits/services pending the final resolution. The Alliance Grievances and Appeals Department will coordinate these requests with the Alliance Utilization Management (UM) Department or the delegate's UM Department.

RESOLUTION DETERMINATIONS

Grievances

- Resolved – The beneficiary's submitted grievance has reached a final conclusion.

Appeals

- Uphold – The investigation found the initial determination was correct.
- Overturn – The appeal investigation found the initial determination was not correct and therefore the determination is made to modify or approve the request in favor of the member. The Alliance or its delegate must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the Alliance reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. The Alliance or its delegate shall authorize or provide services no later than **72 hours** from the date it reverses the determination.

DELEGATE OR PROVIDER RESPONSIBILITIES

The Alliance is committed to ensuring thorough research and investigation in addition to compiling all applicable information pertinent to the complaint. As part of the Alliance's investigation, the provider will be required to respond in writing to the complaint and provide medical records if applicable. Written responses are to be received within **10 calendar days** for standard and **24 hours** for expedited cases or if otherwise specified in the request.

MEMBERS' RIGHTS – ADDITIONAL ACTIVITIES

Member Grievances

The member may also contact the Department of Managed Health Care (DMHC) if they have a grievance about an emergency, a grievance that has not been appropriately resolved by the Alliance, or a grievance that has not been resolved for more than **30 calendar days** for a standard complaint, and **72 hours** if expedited criteria were met.

The department also has a toll-free telephone number (**1.888.466.2219**) and a TDD line (**1.877.688.9891**) for the hearing and speech impaired. **Independent Medical Review (IMR)**

The member has the right to contact DMHC and request an Independent Medical Review (IMR). Members may request an IMR if they have not initiated a State Fair Hearing (Medi-Cal only) and if the member has already completed the Alliance's grievance process. They may contact the DMHC Health Maintenance Organization (HMO) Help Center for further information toll-free at **1.888.466.2219** or people with hearing and speaking impairments (TDD) at **1.877.688.9891**.

The DMHC HMO Help Center is open 24/7 at no charge to the member. For complaint forms and instructions, please visit the DMHC website at **www.dmhc.ca.gov**.

Fair Hearing

Medi-Cal members have the right to file a State Fair Hearing with the California Department of Social Services, State Hearings Division. They may contact the State Hearings Division for further information toll-free at **1.800.743.8525** or people with hearing and speaking impairments (TDD) at **1.800.952.8349**. Medi-Cal beneficiaries may also request a State Fair Hearing through the Alameda County Social Services Agency. State Fair Hearings must be requested within **120 calendar days** from the date of the "Notice of Appeal Resolution." If you and the member want to continue treatment, you must ask for a State Fair Hearing within **10 days** from receiving an appeal response letter from the Alliance, or before the date your services will stop.

Ombudsman Assistance

Medi-Cal members can also request assistance with enrollment and other problems by contacting:

Medi-Cal Managed Care Division Office of the Ombudsman
Monday – Friday, 8 am – 5 pm, excluding holidays
Toll-Free: **1.888.452.8609**
Email: **MMCDOmbudsmanOffice@dhcs.ca.gov**

For D-SNP

Part C:

If we deny (uphold) any part of enrollee's first appeal, their appeal automatically goes on to Appeal Level 2 where an independent review organization (IRE) will review enrollee's case.

Please Note: When a plan makes a fully favorable determination on a level 1 appeal less than 24 hours after the end of the adjudication timeframe, the plan should consider effectuating and notifying the enrollee of the favorable appeal decision (within the 24-hour period the appeal must be forwarded to the IRE) in lieu of forwarding the appeal to the IRE.

Forwarding Case Files to IRE Timeframes for Adverse and Untimely Decisions

Part C:

- Expedited- 24 hours of the decision.
- Standard Items and Services- 30 calendar days of receipt of request (or no later than expiration of extension).
- Standard Part B Drug- 7 calendar days of receipt of the request (no extension permitted).
- Standard Payment- 60 calendar days of receipt of request

Part D:

- Expedited- 24 hours of receipt of IRE's request for case files.
- Standard- 48 hours of receipt of IRE's request for case files.
- Untimely- 24 hours of the expiration of the adjudication timeframe.

If we say **No** to the member's Level 1 Part D Appeal (including dismissals), the member can accept our decision or make another appeal.

If a member decides to make another appeal, the member can use the Level 2 Appeal process. The **Independent Review Organization (IRO)** reviews our decision when we said **No** to member's first appeal. This organization decides if we should change our decision.

The formal name for the "Independent Review Organization" (IRO) is the "Independent Review Entity", sometimes called the "IRE".

IRE- Independent Review Entity (Level 2)

Deadlines for a fast appeal at Level 2

- If a member's health requires it, they can ask the IRO for a fast appeal.
- If they agree to a fast appeal for drug coverage, they must give the member an answer **within 72 hours** after getting the appeal request.
- If they say **Yes** to part or all of the member's request, we must provide the approved drug coverage **within 24 hours** or benefit coverage within 72 after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If a member has a standard appeal at Level 2, the IRO must give the member an answer:

- **Within 7 calendar days** after they get the member's appeal for a drug they didn't get and within 30 days for benefit coverage appeals (Part C).
- **Within 14 calendar days** after getting the member's appeal for repayment for a drug they bought and within 60 days for Part C payment appeals.

If the IRO says **Yes** to part or all of a member's request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision and provide service (Part C) within 14 calendar days.
- We must pay the member back for a drug they bought within 14 calendar days after we get the IRO's decision and pay for services (Part C) within 30 calendar days.
 - If the IRO says **No** to the member's appeal, it means they agree with our decision not to approve the member's request. This is called "upholding the decision" or "turning down the member's appeal."

If the IRO says **No** to a member's level 2 Appeal, members have the right to a Level 3 Appeal if the dollar value meets a minimum dollar value. If the dollar value the member asks for is less than the required minimum, the member can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends the member a letter that tells them the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of the member's request meets the requirement, the member can choose if they want to take their appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to a member's Level 2 Appeal and they meet the requirement to continue the appeals process, they can:
 - Decide if they want to make a Level 3 Appeal.
 - Refer to the letter the IRO sent to the member after their Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge (ALJ) or attorney adjudicator handles Level 3 Appeals.

If a member made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of their appeals were turned down, they may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item the member appealed does not meet a certain minimum dollar amount, they cannot appeal any further. If the dollar value is high enough, they can continue the appeals process. The letter the member gets from the IRO for their Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

ALJ - Administrative Law Judge (Level 3)

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says Yes to the member's appeal, the Alliance has the right to appeal a Level 3 decision that is favorable to the member.

- If we decide to appeal the decision, we send the member a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide not to appeal the decision, we must authorize or provide the member with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
 - If the ALJ or attorney adjudicator says No to the member's appeal, the appeals process may not be over.
- If the member decides to accept this decision that turns down their appeal, the appeals process is over.
- If the member decides not to accept this decision that turns down their appeal, they can continue to the next level of the review process. The notice the member gets will tell them what to do for a Level 4 Appeal.

MAC – Medicare Appeals Council (Level 4)

The Medicare Appeals Council (Council) reviews the member appeal and gives them an answer. The Council is part of the federal government.

If the Council says Yes to the member's Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to the member, the Alliance has the right to appeal to Level 5.

- If we decide to appeal the decision, we will inform the member in writing.
- If we decide not to appeal the decision, we must authorize or provide the member with the service within 60 calendar days after getting the Council's decision.

If the Council says No or denies our review request, the appeals process may not be over.

- If the member decides to accept this decision that turns down their appeal, the appeals process is over.
- If the member decides not to accept this decision that turns down their appeal, they may be able to continue to the next level of the review process. The notice they get will tell them if they can go on to a Level 5 Appeal and what to do.

Federal Court (Level 5)

- A Federal District Court judge will review the member appeal and all of the information and decide Yes or No. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section 24: Credentialing

All health care providers who contract with the Alliance must have credentials verified through the credentialing process. This section covers the credentialing and re-credentialing requirements providers are expected to meet.

Credentialing Process

The Alliance utilizes a credentialing process in order to ensure the participation of quality network providers. The Alliance follows National Committee on Quality Assurance (NCQA) guidelines in conjunction with special credentialing guidelines required by state regulation and policy.

DEPARTMENT OF HEALTH CARE SERVICES (DHCS) APL 22-013 SUPERSEDES APL 19-004

The Alliance follows the regulatory guidance specified in All Plan Letter (APL) 22-013, Provider Credentialing/Re-credentialing and Screening/Enrollment. The APL specifies that managed care plans are required to maintain contracts with their Network Providers (Network Provider Agreement) and perform credentialing and re-credentialing activities on an ongoing basis. The APL also requires the Alliance to perform pre- and post-enrollment site visits to medium- and high-risk providers to verify the information on the application (i.e., comprehensive outpatient rehabilitation facilities, hospice, and home health organizations, independent diagnostic laboratories, independent diagnostic testing facilities, durable medical equipment (DME) suppliers, and prosthetic and orthotic suppliers for initial and re-credentialing applicants).

CONFIDENTIALITY

The information obtained during the credentialing process, whether directly from the provider or from another source, will be treated as confidential information.

THE APPLICATION

Applicants must submit a signed application and supporting documentation to the Alliance. The Alliance then has **120 days** from the signature date on the attestation form to work with the applicant and Credentialing Committee (CC) to complete the credentialing process.

As part of the application process, providers will be asked to attest to statements regarding:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of disciplinary actions taken against the license

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- History of loss of license
- History of convictions
- History of loss or limitation of privileges or disciplinary activity at a facility
- History of professional liability judgments and/or claims that resulted in settlements or judgments paid by or on behalf of the applicant, or pending lawsuits
- Current malpractice insurance coverage

COMMUNITY HEALTH WORKERS (CHW) CREDENTIALING

Contracted providers may submit claims for CHW services as long as the supervising provider has submitted a completed Supervising Provider Attestation for Community Health Workers Form to the Alliance Housing and Community Services Department. The Supervising Provider must be a contracted licensed Provider, hospital, outpatient clinic, local health jurisdiction (LHJ), or a community-based organization (CBO).

ADDITIONAL CREDENTIALING STEPS

Facility Site Review

All PCP sites are reviewed by an Alliance Provider Relations representative and Quality Improvement nurse specialists prior to approval as an Alliance provider. For more information, please see Section 24: Facility Site Review (FSR).

Recommendation by the Credentialing Committee (CC)

The CC is a standing Alliance committee responsible for credentialing/re-credentialing Alliance network providers. The Peer Review Committee (PRC) is responsible for reviewing providers that are identified with quality of care issues.

The CC recommends the approval or denial of an applicant as follows:

- If the recommendation is for **APPROVAL**, the applicant receives written notification of the decision, and the number of credentialed and re-credentialed practitioners are reported monthly to the Board of Governors in the credentialing summary.
- If the recommendation is for **DENIAL**, the applicant receives written notification of the decision and supporting reasons. If the denial is due to the quality of medical care, the appeal process is included.

Practitioner Rights

Practitioners have the right to review the information submitted to support their credentialing application, correct erroneous information, receive the status of their credentialing or re-credentialing application, upon request, and receive notification of these rights. Practitioners are notified of these rights in the application cover letter.

Practitioners are allowed access to their credentialing documentation obtained by the Alliance Peer Review and Credentialing Department to evaluate their credentialing application, attestation, or curriculum vitae (CV) with the exception of National Practitioner Data Bank Reports, references, recommendations, or other peer-review protected information.

Practitioners are notified when credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples of the type of information that would cause the Alliance to alert the practitioner, if there are substantial variations from the practitioner's information, include actions on a license, malpractice claims history, and/or board certification decisions.

The Alliance Peer Review and Credentialing Department staff will contact the practitioner via written request (email or certified mail) of the discrepancy and the practitioner will be asked to submit corrections/explanations within **15 business days** by mail or fax to the Alliance Peer Review and Credentialing Department staff contact.

Right to receive status: Practitioners may contact the Alliance Peer Review and Credentialing Department at any time regarding the status of their application for appointment or reappointment. All such requests will be responded to within **four (4) business days** and the practitioner will be notified of progress in the credentialing process.

Credentialing Criteria and Basic Qualifications

The following credentialing criteria are reviewed at initial credentialing and re-credentialing.

LICENSE

All providers must maintain a current license, which is applicable to the provider's scope of practice in the state of California. If providers have or had out-of-state licenses, the status of these licenses shall also be verified for the same qualifications. All initial providers must have an unrestricted license. All provider Medical Board actions are reviewed by the CC.

HOSPITAL ADMITTING PRIVILEGES

All providers must maintain current hospital admitting privileges with unrestricted clinical privileges at a hospital in the Alliance network. The Alliance may waive this requirement if the provider has admitting arrangements in writing through another provider in the Alliance network.

DEA CERTIFICATION

All providers must maintain a current Drug Enforcement Administration (DEA) certification, if applicable to the provider's scope of practice. The Alliance may waive this requirement if the provider's DEA certification is pending, and the provider presents documented evidence that another participating provider in the same office will write all prescriptions that require a DEA.

SPECIALTY BOARD CERTIFICATION

Specialists applying to the network must be board-certified in the specialty and subspecialty effective Tuesday, July 1, 2003, unless the provider was contracted with the Alliance prior to Tuesday, July 1, 2003. Specialists who have recently completed postgraduate training may be credentialed and will be expected to complete their board certification within the time frame set forth by the American Board of Specialties. If a Specialist is not board-certified in the specialty or subspecialty the practitioner will be reviewed by the CC and considered for network participation based on network needs.

NPDB AND HIPDB

The National Practitioner Data Bank (NPDB) checks medical malpractice claims and the license status for any state in which the physician has practiced. The Healthcare Integrity Protection Data Bank (HIPDB) collects information regarding licensure and certification actions, exclusion from federal and state health care programs, criminal convictions, and civil judgments related to health care.

PROFESSIONAL LIABILITY CLAIMS HISTORY

Information related to malpractice suits and settlements will be collected and reviewed.

CLEAR FROM SANCTIONS

The Alliance does not contract with providers who are excluded or sanctioned from participation in Medicare/Medicaid programs.

PROFESSIONAL LIABILITY INSURANCE

All participating providers must maintain professional liability insurance with limits of liability of at least \$1,000,000 per occurrence and \$3,000,000 aggregate at all times.

WORK HISTORY

All providers will be reviewed for work history at initial credentialing as obtained through their submitted application or CV.

CREDENTIALING AND ALLIANCE EFFECTIVE DATES

All providers will be entered into our system as a contracted provider once they have been approved through the credentialing process. The effective date is the first of the month following the month that the provider was credentialed.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Re-Credentialing

Participating providers are re-credentialed in accordance with Alliance policy. Currently, re-credentialing occurs at least every **three (3) years** or more often as directed by the CC. The process is similar to the initial credentialing process as outlined earlier in this section.

The following performance areas will be reviewed for all providers, as applicable:

- Member complaints/grievances
- Results of quality reviews
- Facility site review results

DENIED RE-CREDENTIALING

If the CC determines that a provider does not meet re-credentialing criteria, the provider's participation in the Alliance network will be terminated pursuant to the terms of the provider service agreement. From that time onward, the provider may not submit claims to the Alliance for health services provided to Alliance members.

PROVIDERS WHO OPT-OUT OF MEDICARE

The Alliance complies with the provider contracting requirements as set forth by the Centers for Medicare and Medicaid Services (CMS). The Alliance monitors its provider network to ensure no providers are contracted with or paid when they are ineligible to receive payment by Medicare.

Individual providers who appear on the Medicare Opt-Out list will be not be added to the Alliance Wellness Plan as a network provider. If a provider was previously added to the Alliance Wellness Plan and then the Alliance becomes aware that the provider is now appearing on the opt-out list, the provider will immediately be removed. It is the responsibility of the provider group (contract holder) to be aware of providers within their practice that have opted out of Medicare. Providers who Opt-Out of Medicare cannot see Alliance Wellness Plan members but can still see Medi-Cal only members.

The Alliance reviews the Medicare Opt-Out File Monthly and changes to remove any provider found on the list will be made as soon as it is identified.

There are no appeal rights for a provider on the Opt-Out file to the Alliance for reinstatement. The provider must direct any follow up questions Medicare Opt-Out Website.

It should come as no surprise to the provider to be on the Medicare Opt-Out file as opting out is a provider decision. Opting out of the Medicare program is for 2 years. Only providers within their first 90 days of Opt-Out status can request to change their status with CMS.



Should the provider no longer be included on the Medicare Opt-Out file, the provider may reapply for a contract with the Alliance. The provider must contact the Alliance Credentialing and Contracting Departments to begin the Credentialing process to be added as a provider.

Opt-out providers will not be paid for services rendered to D-SNP members while they are in Opt-Out status. Previous claims paid during an Opt-Out period may be recovered or recouped.

Section 25: Facility Site Review (FSR)

All Alliance PCPs will receive periodic facility site reviews (FSRs). This section covers what to expect during a site review.

FSR Overview

DHCS mandates initial and periodic FSR and Medical Record Review (MRR) audits for PCP provider sites, and the Alliance complies with this DHCS mandate. The Alliance additionally conducts Physical Accessibility Review Surveys (PARS) for all PCP sites, specialist sites, ancillary services sites, and Community-Based Adult Services (CBAS) provider sites which provide care to a high volume of seniors and persons with disabilities (SPD).

The purpose of FSRs is to ensure that all contracted primary care provider sites:

- Provide appropriate primary health care services to members.
- Carry out processes that support continuity and coordination of care.
- Maintain patient safety standards and practices.
- Operate in compliance with all applicable local, state, and federal laws and regulations.

FSRs are conducted during the initial provider credentialing process. Additionally, site reviews will be conducted as part of the ongoing provider re-credentialing process. This process ensures that each provider continues to meet the Alliance's site review standards. The Alliance Quality Improvement (QI) Department is responsible for conducting site reviews.

FSR Preparation

The Alliance will help providers prepare for the review in several ways. Prior to a review, providers will receive a copy of the FSR and MRR tools and standards. To access the FSR Tool, MRR Tool, and other resources, please visit the Alliance website at **www.alamedaalliance.org/providers/provider-resources**.

Providers should review the tools and standards carefully to ensure a successful review. FSR nurses offer provider and office staff training prior to initial facility site reviews and/or upon the provider's request.

The Alliance has developed the Facility Site Review (FSR) and Medical Record Review (MRR) Preparation Checklist to assist you in meeting the standards of the site review. For help preparing your practice for the FSR, please call the Alliance Provider Services Department at **1.510.747.4510**.

PROBLEMS IDENTIFIED THROUGH FSRs AND MRRs

If a facility is found to be out of compliance with Alliance and/or state requirements, the provider is notified through the Corrective Action Plan (CAP). For FSRs, a CAP is required for a total score of less than 90%, or for a total score of 90% or above if there are deficiencies in Critical Elements (CE), Pharmaceutical Services, or Infection Control.

For MRRs, a CAP is required for any score below 90%, or any section score below 80% regardless of the total score. A total score of 79% or below for FSRs and/or MRRs will result in a hold on new member assignments as well as follow-up reviews.

Per APL 22-017, the Alliance must not assign new members to providers who do not correct site review deficiencies within established CAP timelines. The Alliance must verify that the PCP site has corrected the deficiencies and that the CAP is closed.

CAP Timeline:

- CE CAP must be submitted within **10 business days** of review.
- FSR/MRR CAP is submitted within **30 calendar days** from the CAP Report. All CAPs must be closed within **90 calendar days** from the date of the FSR and/or MRR report.

The Alliance must remove any provider from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and the Alliance must expeditiously reassign that provider's members to other providers.

Participation in the Alliance network may be suspended until the facility meets compliance standards. If a provider's non-compliance issues present a clear and immediate danger to patients, the provider's members will be reassigned to another provider in the Alliance network. If problems are documented, providers are allowed time for correction. Failure to provide a timely response will result in a resurvey within **12 months** and/or reporting the provider's site review status to the Alliance's CC. They may suspend a provider from plan participation or recommend termination due to non-compliance to the Alliance CC.

DHCS-CONDUCTED FSR

DHCS conducts FSRs independently of the Alliance on a small sample of providers in the Alliance network. DHCS does this to monitor the Alliance's compliance with the DHCS contract and to determine how well provider sites are able to implement and meet the standards. DHCS-conducted FSRs may be conducted without prior notice. DHCS will notify Alliance of critical findings within **10 business days** following the date of the FSR and/or MRR and will provide a written report summarizing all DHCS review findings within **30 calendar days** following the review. Within **30 calendar days** from the date of Alliance receipt of the DHCS-conducted FSR report, the Alliance must provide a CAP to DHCS responding to all cited deficiencies documented in the report.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Should a DHCS inspector find a primary care site in substantial noncompliance, the Alliance may suspend that site from plan participation until the facility can meet compliance standards. If the provider's noncompliance issues present a clear and immediate danger to Alliance members, they will be reassigned to another provider in the Alliance network.

FSR Tool

The Alliance utilizes a Facility Site Review (FSR) Tool mandated by DHCS. The FSR Tool contains applicable state requirements. A copy of the full FSR Tool can be found on the Alliance website at www.alamedaalliance.org/providers/provider-resources.

The FSR Tool mandates review in the broad areas listed below:

- Access/Safety
- Personnel
- Office Management
- Clinical Services
- Preventive Service
- Infection Control

CRITICAL ELEMENTS

Within the FSR, there are 14 critical survey elements related to the potential for adverse effects on patient health or safety. These critical elements have a weighted score of two (2) points. All other survey elements are weighted at one (1) point.

Critical elements include:

- Exit doors and aisles are unobstructed and egress accessible
- Airway management equipment (i.e., oxygen delivery system, nasal cannula or mask, bulb syringe, and Ambu bag) appropriate to practice and populations served are present on-site
- The on-site availability of emergency medicine based on patient population served for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia (i.e., Epinephrine 1 mg/ml [injectable], and Benadryl 25 mg [oral] or Benadryl 50 mg/ml [injectable], Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication [solution for nebulizer or metered dose inhaler], and glucose); appropriate sizes of engineered sharps injury protection (ESIP) needles/syringes, and alcohol wipes
- Only qualified/trained personnel can retrieve, prepare, or administer medications
- Office practice procedures provide timely physician review and follow-up of referrals, consultation reports, and diagnostic test results
- Only lawfully authorized persons dispense drugs to patients
- Drugs and vaccines are prepared and drawn only prior to administration

- Personal protective equipment (PPE) for Standard Precautions is readily available for staff use
- Blood, other potentially infectious materials, and regulated wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing storage, transport, or shipping
- Needle stick safety precautions are practiced on-site
- Staff demonstrates/verbalizes necessary steps/processes to ensure sterility and/or high-level disinfection of equipment
- Appropriate PPE, exposure control plan, Material Safety Data Sheets (MSDS), and clean-up instructions in the event of a cold chemical sterilant spill are available on-site
- Spore testing of autoclave/steam sterilizer is completed (at least monthly) with documented results
- Staff adheres to site-specific protocol and/or manufacturer/product label for management of positive mechanical, chemical, and/or biological indicators of the sterilization process

CRITICAL ELEMENT DEFICIENCIES

All critical element deficiencies found during a full-scope site survey, focused survey, or monitoring visit must be corrected by the provider within **10 business days** of the survey date and verified as corrected by the plan within **30 calendar days** of the survey date.

HELPING PROVIDERS MEET STANDARDS

Sites that are non-compliant with the Alliance and/or state requirements are given a **30-day** period to correct identified deficiencies.

MRR Tool

The Alliance utilizes an MRR tool mandated by DHCS. The MRR Tool is separate from the FSR Tool.

The MRR Tool and MRR Standards can be found on the Alliance website at **www.alamedaalliance.org/providers/provider-resources**. The MRR Tool contains applicable state requirements. The MRR Tool mandates review in the broad areas listed below.

Please see the full MRR Tool for a detailed explanation of the six (6) criteria listed below:

- Format
- Documentation
- Coordination/Continuity of Care
- Pediatric Preventive Health Care

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- Adult Preventive Health Care
- Obstetric/Comprehensive Perinatal Services Program (OB/CPSP) Preventive Criteria

Alliance providers are required to have a medical record for each member. During an MRR, a minimum of 10 member records are audited per contracted provider. Reviewers may request additional records.

Help and Resources

The Alliance wants to help all our providers meet the standards. The Alliance Provider Services Department staff and FSR nurses offer guidance and training or refer providers to resources that can help providers meet the established standards. To request assistance, please call the Alliance Provider Services Department at **1.510.747.4510**.

Provider Initial Review and Fair Hearing Process

Physicians, ancillary professionals, and other providers shall be entitled to an Initial Review or Fair Hearing and Appeals proceeding when dissatisfied with certain adverse credentialing and/or participation decisions made by the Alliance, including those based on a medical quality concern.

The Initial Review and Fair Hearing process is divided into two (2) phases:

- Phase I – Initial Review: An Initial Review before the Peer Review Committee (PRC) to try to amicably resolve the matter; and
- Phase II – Formal Hearing: For Providers who are dissatisfied with the PRC Initial Review decision and eligible for a Phase II hearing, a formal hearing in front of an impartial Judicial Review Committee (JRC)

PROCEDURES FOR INITIAL REVIEW

The Alliance offers providers an Initial Review when the provider is dissatisfied with an adverse credentialing and/or participation decision made by the PRC. Decisions may include recommendations, such as practice restrictions, denial of the application, or participation in the Alliance network. The provider will be notified in writing of the PRC decision.

The provider may request an Initial Review within **30 days** of receipt of the notice of action or proposed action by PRC. A request for Initial Review must be in writing and must state the basis for the challenge, whether the provider would like to present evidence or oral testimony to the PRC, or both, whether the provider needs special accommodations and any preferred time or dates for the Initial Review within the next **60 days**.

The following procedures are followed for Initial Reviews:

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

- All credentialing and peer review issues shall be brought before the PRC for review and recommendation.
- Notice will be given to the provider stating the date of the initial review meeting and the provider shall have an opportunity to present their position.
- The decision of the PRC shall be binding and final if the decision was for any reason other than medical quality of care concern.
- If a decision of the PRC is based in whole or in part on medical quality of care concerns, the provider shall have the right to appeal the PRC decision to an impartial JRC through the Fair Hearing process.

FAIR HEARING PROCESS

Providers may request a Fair Hearing if they are dissatisfied with the PRC Initial Review decision and are eligible for a Phase II hearing, a formal hearing in front of an impartial JRC.

GROUND'S FOR A FAIR HEARING

One (1) or more of the following actions, or proposed actions, against a provider by the PRC after the Initial Review shall be grounds for a formal hearing before the JRC:

- Upholding the Alliance's reduction or failure to renew credentialing and/or participation based on medical quality concerns
- Upholding the Alliance's suspension or imposition of restrictions on credentialing and/or participation for a cumulative total of **30 calendar days** or more in any **12-month** period based on medical quality concerns
- Upholding the Alliance's denial or termination of credentialing and/or participation based on medical quality concern

Requesting an Appeal

If the PRC recommends an adverse decision based on medical quality concerns of an initial application or re-credentialing that results in a mandatory reportable action, the practitioner will be notified in writing of this decision. The practitioner has the right to request a hearing before the JRC within **30 days** of receipt of the PRC notification. A provider who wishes, and is eligible, to file an appeal for an adverse credentialing or participation decision, the practitioner must deliver a written notice requesting a fair hearing before the JRC to the Alliance Chief Medical Officer within the time period specified.

The following procedures are followed for a Judicial Review process:

- Fair Hearings shall be brought before the JRC for review and recommendation
- Notice will be given to the provider stating the date of the JRC and the provider shall have an opportunity to present their position
- The decision of the JRC will be sent to the PRC and the practitioner
- The JRC will issue a written decision which shall include findings of fact and a conclusion within **30 calendar days** after the final adjournment of the hearing

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

Requirements for Mid-Level Clinicians

REQUIREMENTS FOR MID-LEVEL CLINICIANS

PCPs who employ or contract with mid-level clinicians in their practices are responsible for making sure that the clinicians meet the standards set forth by the clinician's licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. They must meet certain qualifications and standards in order to be credentialed by the Alliance. This helps ensure quality care for members.

DEFINITIONS OF MID-LEVEL CLINICIANS

Mid-level clinicians are non-physician medical practitioners, including:

- Certified Nurse-Midwives
- Nurse Practitioners
- Physician Assistants

DEFINITIONS OF BEHAVIORAL HEALTH CARE INTERNS AND ASSISTANTS

All non-licensed behavioral health providers must be supervised by a licensed behavioral health provider who is contracted with the Alliance and who also follows all California Licensing Board requirements for registration and supervision of non-licensed providers.

These providers include:

- Registered Psychological Associates (PA)
- Registered Associate Social Workers (ASW)
- Registered Associate Marriage and Family Therapist (AMFT) interns

CREDENTIALING

Any mid-level clinician, ASW, AMFT intern, or PA who provides care to Alliance members must be credentialed by the Alliance.

LICENSING REQUIREMENTS

To provide services to Alliance members, mid-level clinicians must have a valid, current license or registration issued by the state of California. Nurse-midwives must be certified by the ACNM Certification Council, Inc. Physician assistants must be licensed in accordance with the requirements of the Physician Assistant Examiners Committee.

INSURANCE

The supervising physician or licensed behavioral health care provider must submit proof that their liability insurance covers the mid-level or non-licensed PA, ASW, or AMFT clinician, or that the clinician has individual coverage.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

CPR AND ACLS CERTIFICATION

Mid-level clinicians must maintain CPR certification. They also are encouraged to obtain ACLS certification.

PHYSICIAN/CLINICIAN AGREEMENT

Each physician/mid-level clinician team must sign an agreement stating that the clinician will follow the practice protocols developed by the supervising physician. The agreements, also known as a Delegated Services Agreement and a Supervising Physician's Responsibility document, must be submitted at the time of credentialing and re-credentialing.

PROTOCOLS

Protocols must be reviewed and approved by the supervising physician annually. These protocols and any updates must be submitted to the Alliance at the time of credentialing and site reviews.

Organizational Providers

The Alliance is responsible for verification of the accreditation status, license, certification, and standing with regulatory bodies of all directly contracted organizational providers. This includes but is not limited to acute care hospitals, freestanding surgical centers, home health agencies, and skilled nursing homes that provide care to Alliance members at the time of contracting and a minimum every **three (3) years** thereafter.

Hospitals, facilities, and organizational providers must meet the following requirements to contract with the Alliance by submitting all licensing and specialty qualification documents to the Alliance for verification as part of the Alliance credentialing and re-credentialing process and demonstrate the ability to meet Alliance requirements as outlined in the Alliance Quality Improvement Health Equity Program Description, Assessment of Organizational Provider Policy, and contract provisions.

REQUIREMENTS

- Accreditation or certification reviewed and approved by an accrediting body. If not accredited, the organization must submit a copy of the CMS or state site survey.
- Clear of any sanctions, negative findings, or deficiencies.
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable.
- Completed Alliance application including attestations.
- Current malpractice/general professional liability insurance.
- Eligibility to participate in state and federal programs.
- Valid and current Medicare/Medicaid certification.
- Valid, current, and unrestricted health care/state and business licenses.

Part 4. Member Rights and Compliance

Section 26: Member Rights and Responsibilities

As a member of our health plan, each Alliance member is entitled to certain rights.

Alliance Member Rights

1. To be treated with respect and dignity, giving due consideration to their right to privacy and the need to maintain the confidentiality of their medical information.
2. To receive services without discrimination, consistent with federal and state civil rights laws, including Section 1557 of the Affordable Care Act.
3. To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
4. To receive fully translated written member information in their preferred language, including all grievance and appeals notices.
5. To make recommendations about the Alliance's member rights and responsibilities policy.
6. To be able to choose a primary care provider within the Alliance network.
7. To have timely access to network providers and to receive services without discrimination, consistent with federal and state civil rights laws, including Section 1557 of the Affordable Care Act.
8. To participate in decision-making with providers regarding their own health care, regardless of cost or benefit coverage, including the right to refuse treatment.
9. To voice grievances or appeals, either verbally or in writing, about the organization or the care they received.
10. To know the medical reason for the Alliance's decision to deny, delay, terminate, or change a request for medical care.
11. To get care coordination.
12. To ask for an appeal of decisions to deny, defer, or limit services or benefits.
13. To get no-cost interpreting services for their language.
14. To get legal help at their local legal aid office or other groups at no cost.
15. To formulate advance directives.
16. To ask for a State Hearing if a service or benefit is denied and they have already filed an appeal with the Alliance and are still not happy with the decision, or if they did not get a decision on their appeal after **30 days**, including information on the circumstances under which an expedited hearing is possible.

17. To disenroll from the Alliance and change to another health plan in the county upon request.
18. To access minor consent services.
19. To get no-cost written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
20. To request Confidential Communications. A member may choose an alternate address, phone, fax, or email to receive mailings from the Alliance.
21. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
22. To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand, regardless of cost or coverage.
23. To have access to and get a copy of their medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
24. Freedom to exercise these rights without adversely affecting how they are treated by the Alliance, their providers, or the State.
25. To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside the Alliance's network pursuant to the federal law.
26. To access the Advice Nurse Line, anytime, 24 hours a day, 7 days a week. Medi-Cal members can call toll-free at **1.888.433.1876**. Group Care members can call toll-free at **1.855.383.7873**.
27. To access their medical records. They have the right to share the records of any telehealth services provided with their primary care doctor. These records will be shared with their primary care doctor unless they object.

Alliance Member Responsibilities

The Alliance is responsible for providing members with access to medically necessary covered services in a timely manner. Alliance members have certain responsibilities as well.

1. To treat all the Alliance staff and health care staff with respect and courtesy.
2. To give their doctors and the Alliance correct information (to the extent possible) needed to provide care.
3. To work with their doctor.
4. To learn about their health and help to set goals for their health.
5. To follow care plans and instructions for care that they have agreed to with their doctors.
6. To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
7. To always present their Alliance Member ID Card to receive services.

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**. Visit us online at **www.alamedaalliance.org**.

8. To ask questions about any medical condition, and make sure they understand their doctor's reasons and instructions.
9. To help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
10. To make and keep medical appointments and inform their doctor at least **24 hours** in advance when they need to cancel an appointment.
11. To use the emergency room only in case of an emergency or as directed by their doctor.

What Can You and Your Office Do to Protect Member Privacy?

- Keep PHI actively in mind and in your policies among your staff.
- Provide training for yourself and staff about privacy.
- Always verify the identity of the person requesting PHI before disclosing any information, including by phone or in person
- Develop a process to respond to privacy issues that arise (including notifying the Alliance of any breach).
- Limit transporting PHI out of your office.
- Use secure email when communicating about members with someone outside your office.
- Store and lock up records and documents containing PHI.
- Secure your office computers from unauthorized access.
- Shred physical documents that contain PHI when no longer needed.
- Keep appointment and registration sheets away from public view.
- Do not text PHI.
- Only access, use, or disclose the minimum necessary PHI needed to do your job.
- Do not leave PHI on voicemail unless the patient has given explicit consent.
- When speaking about, or to patients, in public areas use hushed tones so as not to be overheard by others

For more information about PHI and HIPAA compliance, please visit **www.hhs.gov**. If you have questions about how to improve the security and storage of member PHI or would like a copy of the privacy practices, please call the Alliance Provider Services Department at **1.510.747.4510**.

How to Protect the Protected Health Information (PHI) of Your Patients

As you are well aware, protecting the privacy of patients and their Protected Health Information (PHI) is a responsibility that we all share. The Alliance is committed to protecting every member's PHI, and we want to ensure that you do too!

The Health Information Portability and Accountability Act (HIPAA) clearly outlines how providers can use and disclose PHI. Additional federal and California state laws have been enacted governing the release of information, mandating that information be protected, creating new breach notification rules, and setting civil and criminal penalties and fines for the inappropriate release of PHI.

Written patient permission is required for most uses and disclosures of PHI. The exceptions generally are that PHI may be used and disclosed for the purpose of treatment, payment, and health care operations (and a few other specific exceptions).

Section 27: Fraud, Waste, and Abuse (FWA) and Protected Health Information (PHI)

Overview of Fraud, Waste, and Abuse (FWA)

The Alliance has developed an Anti-Fraud Program to comply with federal and state regulations in preventing and detecting fraud in federal, state, or county-funded programs offered by the Alliance. Health care fraud includes but is not limited to, the making of intentionally false statements, misrepresentations, or deliberate omissions of material facts from any record, bill, claim, or any other form for the purpose of obtaining payment, services, or any type of compensation for health care services for which members are not entitled.

The objective of the Alliance's Anti-Fraud Program is to identify and reduce costs caused by fraudulent activities and to protect members, health care providers, and others in the delivery of health care services.

The Alliance Compliance Officer and Compliance Committee oversees its Anti-Fraud Program and manages suspected fraud and abuse reporting. The Alliance reports its fraud/abuse prevention activities and suspected fraud/abuse to regulatory and law enforcement agencies as required by law.

FWA Definitions

- **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.
- **Waste:** The overutilization or inappropriate utilization of services and misuse of resources.
- **Abuse:** Activities that are inconsistent with sound fiscal, business, or medical practices, and result in the following: unnecessary cost to health care programs or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary costs to health care programs.

Examples of FWA

In general, fraud costs the state and federal taxpayers up to \$260 billion annually.

Below are examples of fraudulent activity you may encounter as a health care provider in public programs.

MEMBER/BENEFICIARY/RECIPIENT

- Impersonation: Someone using the personal information of another person to obtain Medi-Cal or Medicare benefits for which he or she would otherwise not qualify or be entitled to receive.

PROVIDER

- Payment for referrals: When an individual or provider recruits and pays individuals money or offers gifts in exchange for referrals in the Medicare or Medi-Cal programs.
- Balance billing: A provider charging a Medicare or Medi-Cal beneficiary for the difference between the allowed reimbursement rate and the customary charge for the service.

PROVIDER BILLING AND CODING ISSUES

- Billing for services not rendered
- Billing for services at a frequency that indicates the provider is an outlier as compared with their peers
- Billing for non-covered services using an incorrect CPT, HCPCS, and/or diagnosis code in order to have services covered
- Billing for services that are actually performed by another provider
- Up-coding for services more severe or expensive than what is diagnosed or performed
- Unbundling services that should be billed together
- Billing for more units than rendered
- Services performed by an unlicensed provider yet billed under a licensed provider's name or information
- Altering records to receive covered services

How to Report Potential FWA

The Alliance requires its providers, members, contractors, and subcontractors to report suspected fraudulent activity to the Alliance or the appropriate regulatory and law enforcement agencies within ten working days of discovery of fraud, waste, or abuse.

Under no circumstances will the reporting of any such information or possible impropriety serve as a basis for retaliatory action to be taken against any individual making the report. No Alliance employee, provider, contractor, or member who reports suspected fraudulent activity will be retaliated against or otherwise disciplined by the Alliance or an Alliance employee for making a report in good faith.

When reporting FWA, please provide as much of the following information as possible:

- Name, address, license, or insurance ID of the suspect (if known).

- Description and details of the incident: who, what, where, when, date, and time of the incident(s).
- Any documentation you may have related to the incident(s).
- Your name and telephone number (if you would like to be contacted).

Any person may report a compliance or FWA matter through the following means:

Alliance Compliance Department
Toll-Free Hotline: **1.844.587.0810**
Email: **compliance@alamedaalliance.org**

Medi-Cal Fraud and Abuse
Toll-Free Hotline: **1.800.822.6222**
Email: **fraud@dhcs.ca.gov**

Medicare or Medi-Cal Fraud, Office of Inspector General
Toll-Free: **1.800.447.8477**

The Alliance Compliance Line is available and can receive tips 24 hours a day, 7 days a week. The Hotline is operated by a third-party vendor to maintain confidentiality for the reporter.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law that requires the Alliance and its network providers to protect and maintain the security and confidentiality of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights.

PHI is any individually identifiable health information, including demographic information. PHI includes but is not limited to the member's name, address, phone number, medical information, social security number, ID card number, date of birth, and other types of personal information.

This section of the Provider Manual seeks to guide providers on the following: 1) implementation of safeguards to protect Alliance member PHI; 2) ensure appropriate uses and disclosures of PHI; 3) ensure members are able to timely access their own PHI; and 4) how to identify and report privacy incidents and breaches to the Alliance.

Safeguarding PHI

As covered entities under the HIPAA Privacy Rule, the Alliance, and its providers must comply with HIPAA requirements.

Below are a few reminders on how to protect and secure PHI.

PHI IN PAPER FORM

- Documents containing PHI should not be visible or accessible to visitors or others who are unauthorized to have access to PHI.
- When faxing documents containing PHI, verify the recipient, the recipient's fax number, and the documents being sent.
- Ensure that outgoing faxes include a fax cover sheet that contains a confidentiality statement.
- When mailing PHI, verify the recipient, the recipient's mailing address, and the documents being sent.
- Ensure that envelopes and packages are properly sealed and secured, and if using a clear window envelope, ensure that information is not visible through the window of the envelope prior to mailing out.
- When transporting PHI, ensure that the information is protected by using binders, folders, or protective covers.
- PHI must not be left unattended in vehicles.
- PHI must not be left unattended in baggage at any time during travel.
- PHI should be locked away during non-business hours.
- PHI must be properly disposed of by shredding. Never recycle or dispose of documents containing PHI in the trash bin.

PHI IN ELECTRONIC FORM

- When transmitting PHI via email ensure that the email is encrypted. This prevents anyone other than the intended receiver from obtaining access to the PHI.
- Do not include PHI such as an individual's name or beneficiary ID number (CIN) in the subject line of the email.
- Confirm the recipient, recipient's email address, and documents or information being sent, prior to sending the email.
- Ensure all portable data storage devices (CDs, DVDs, USB drives, portable hard drives, laptops, etc.) are encrypted.

PHI IN ORAL FORM

- Do not discuss PHI in public areas such as the patient waiting room.
- Do not discuss PHI with unauthorized people.
- Always verify the identification of an individual prior to discussing PHI with the individual.
- Ensure to speak quietly when discussing PHI.

Uses and Disclosures of Member PHI

The HIPAA Privacy Rule allows member PHI to be used and disclosed without the member's written consent for the following reasons (not a complete list):

- Treatment
- Payment
- Health care operations

And under certain circumstances, PHI can be disclosed without written consent for the following reasons:

- Court and administrative proceedings
- Health oversight activities
- Public health activities
- Law enforcement purposes

Providers must obtain specific written consent through a HIPAA Compliant Authorization Form for all other uses and disclosures of PHI not for treatment, payment, or health care operations or otherwise permitted or required by the HIPAA Privacy Rule. The Alliance and its providers are required to maintain and distribute a Notice of Privacy Practices (NPP), which describes how PHI may be used or disclosed, and explains member rights and provider responsibilities under HIPAA.

Member Access to PHI

The HIPAA Privacy Rule requires the Alliance and its providers to provide members, upon request, with access to their PHI. Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever a member requests access to their PHI. Providers must also provide the member with timely access to their PHI in the form and format requested by the member. **Members also have the right to request an amendment of their PHI, request restrictions on certain uses or disclosures, and to request an accounting of disclosures of their PHI, as outlined in 45 CFR §§164.526–528.**

Reporting of Privacy Incidents and Breaches to the Alliance

The HIPAA Privacy Rule requires covered entities to provide notification to enrollees following a breach of PHI. Providers must immediately and upon discovery report both privacy incidents and breaches involving Alliance members. A privacy incident is defined as an event or situation where an individual or organization has suspicion or reason to believe that PHI may have been compromised.

Privacy incidents include but are not limited to the following:

- PHI sent to the wrong individual or organization.
- PHI sent unencrypted.
- Loss or theft of documents containing PHI.

- Loss or theft of unencrypted devices (laptop, hard drives, USB drives).

A breach is defined as unauthorized access, use, or disclosure of PHI that violates either federal or state laws, or PHI that is reasonably believed to have been acquired by an unauthorized person. Timely reporting of incidents and breaches involving the PHI of our members is crucial in the response, investigation, and mitigation of incidents and breaches.

To report suspected or known privacy incidents and breaches you may contact the Alliance through any of the following means:

Alliance Compliance Department

Toll-Free Hotline: **1.844.587.0810**

Email: **deptComplianceprivacy@alamedaalliance.org**

Violations of HIPAA policies and procedures may result in disciplinary action, up to and including termination of a provider's contract or employment, in accordance with Alliance policies and applicable law.