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Part One: Alliance Services

Section 1: Introduction

Welcome to the Alliance

Alameda Alliance for Health (Alliance) welcomes you to our health plan. We are pleased that you are one of our network providers. This manual provides information you will need as an Alliance provider.

ABOUT THE ALLIANCE

The Alliance is a not-for-profit health plan that utilizes managed care principles. In the Alliance, physicians are the primary managers of our members’ health care needs. This promotes continuity of care, coordination of services, and better health outcomes, while reducing duplication of services, and unnecessary hospital emergency room visits.

Our success depends on the effective coordination and continuity of care for Alliance members.

ALLIANCE PRODUCTS

The information contained in this manual applies to all of the Alliance’s products. Exceptions are specifically noted.

The Alliance is licensed by the California Department of Managed Health Care (DMHC) under the Knox-Keene Act for health plans. The product lines available to the residents of Alameda County are:

- **Medi-Cal Managed Care** - The Alliance contracts with the State Department of Health Care Services (DHCS) to serve as the local health plan for Medi-Cal beneficiaries in this county. Not all Medi-Cal beneficiaries are eligible for Medi-Cal Managed Care. This was the Alliance’s first program and continues to have the vast majority of Alliance members.

- **Healthy Families Program** - The Alliance contracted with the Managed Risk Medical Insurance Board (MRMIB) for the Healthy Families Program. Effective January 1, 2013, most Healthy Families members were transitioned to Medi-Cal Managed Care.

- **Alliance Group Care** - The Alliance provides an employer-sponsored group product. Currently, In-Home Supportive Services (IHSS) workers in Alameda County are covered under this product.

- **Alliance CompleteCare** - Alliance CompleteCare is a Medicare Advantage Special Needs Plan (HMO SNP) for people of all ages who live in Alameda County and have Medicare and Medi-Cal (or are eligible for Medi-Cal). This program is licensed by the Centers for Medicare and Medicaid Services (CMS). Additional information about this program can be found in the Alliance CompleteCare Provider Manual.

The Provider Manual

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.

The Provider Manual is designed to help you understand your responsibilities. In this manual, you will find important information in order to serve your Alliance members. In addition to the Provider
Manual, you will receive periodic Provider Bulletins, letters, and memos with additional information to keep you updated on Alliance policies and procedures.

WHAT’S INSIDE
This manual is divided into the following parts and sections:

Part One: Alliance Services
Sections 1 - 4 include general information about Provider Services, Member Services, resources for providers and members, and marketing guidelines.

Part Two: Providing Services
Sections 5 - 16 include specific instructions on obtaining authorizations, making referrals, and submitting claims. This section also provides information about prenatal care, children’s services, health education, and required services. The formulary, other information about pharmacy services, and clinical laboratory services are also included in these sections.

Part Three: Monitoring Services
Sections 17 - 21 include information about the ways in which the Alliance monitors services you provide, including provider credentialing, quality management, site reviews, and Clinical Practice Guidelines. These sections also include information about the way the Alliance responds to member and provider complaints, and sets forth the Alliance’s quality improvement standards.

Part Four: Additional Sections
Section 22 includes information on how to access the provider connection area on the Alliance Web site located at www.alamedaalliance.com. This allows providers and/or their staff to: verify member eligibility, check authorization status, request an authorization, check claim status, and check the Provider Directory.
Section 23 covers reporting of infectious diseases.
Section 24 describes guidelines for providers to use for preventing and reporting fraud, waste and abuse.
Section 25 provides the list of Members Rights and Responsibilities.
Section 26 includes Care Management programs.

BOXES
Boxes highlight important pieces of information, such as a phone number and when to use it. For example:

![Phone icon]

Alliance Provider Services
510-747-4510

Getting Involved
We encourage providers to be active Alliance partners. Provider involvement helps us improve services for our members and providers.
WAYS TO PARTICIPATE

Board of Governors Meetings: The Alliance Board of Governors is comprised of providers, consumers, and community representatives. Meetings are open to the public and are held on the fourth Friday of the month, 12:30 p.m. to 2:30 p.m. (except November and December).

Health Care Quality Committee (HCQC): HCQC meets quarterly. Alliance Providers are encouraged to participate in the HCQC and its peer subcommittees. HCQC and other subcommittee members are paid a stipend. Please call Provider Services at 510-747-4510 for more information.

Peer Review & Credentialing Committee (PRCC): PRCC meets monthly to review new provider applications, re-credentialing information and peer review issues on contracted providers.

Alliance Provider Manual: The Alliance communicates with providers through this manual and periodic updates. Provider suggestions have been incorporated in this manual, but feedback is still needed to keep the manual as up-to-date and helpful as possible. Call Provider Services at 510-747-4510 with your ideas and comments.

Alliance Provider Bulletin: The Alliance distributes a quarterly bulletin to all of our providers and other special bulletins throughout the year. If you don’t receive the bulletin, or if you have ideas for articles, please contact Provider Services at 510-747-4510.

Provider Training Sessions: The Alliance conducts training sessions throughout the year for providers and their staffs. If you or your staff is interested, please contact Provider Services at 510-747-4510.

Section 2: Alliance Resources

Provider Services Department

The Provider Services department is your primary link to the Alliance. Many of your questions can be answered with a quick phone call to a Provider Services Representative.

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

- Office Address Changes
- Contract Issues
- Provider Credentialing & Recredentialing
- Peer Review
- Site Reviews
- Provider Recruitment
- Provider Bulletins
- Authorization Request Forms
- Trainings
- Grievances/Complaints and Resolution
- Disciplinary Actions
- Alliance Promotional Materials
- Internet Access
- Provider Accounts

Alliance Provider Services: 510-747-4510
**Member Services Department**

In addition to a dedicated Provider Services department, providers may call the Member Services department. The Member Service department serves both Alliance members and providers. You may call Member Services or refer members to this department. Member Services assists members in seeking health care services and in resolving problems and grievances. Member Services also offers information to help members use medical services more effectively. For members enrolled in Alliance CompleteCare, these types of services are offered through the Care Advisor Unit at 1-877-585-7526.

The Member Services department sends members the Combined Evidence of Coverage (EOC) and Disclosure Form which describes the plan benefits for each product line. Call Member Services at 510-747-4567 to obtain a copy for your office.

The Member Services department performs the following functions:

- Assigns members to PCPs
- Helps providers verify a member’s eligibility
- Makes referrals to community resources
- Assists members with scheduling appointments
- Handles member grievances
- Promotes member retention
- Schedules interpreters for medical appointments
- Provides application assistance to potential eligible applicants
- Member reassignment requests
- Reporting member status & address changes
- Interpreter services
- Grievances

For after-hours eligibility questions use the Alliance Eligibility Line at 510-747-4505 or Alameda Alliance for Health Online Provider Connection.
**Other Key Alliance Departments**

Providers may sometimes have a question that may be better addressed by another Alliance department. Other departments you can call for help include:

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>REASON FOR CALL</th>
<th>PHONE NUMBER</th>
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<tbody>
<tr>
<td>Alliance Eligibility Line</td>
<td>Member eligibility &amp; PCP assignment</td>
<td>510-747-4505</td>
</tr>
<tr>
<td>Utilization Management &amp; Authorizations</td>
<td>Referral and Authorization Requests for elective inpatient and other specific services</td>
<td>510-747-4540 1-877-747-4507 Fax</td>
</tr>
<tr>
<td>Claims</td>
<td>Claim payment status &amp; corrections Claim inquiry forms Assistance with pending claims Notification of third party liability claims</td>
<td>510-747-4530</td>
</tr>
<tr>
<td>Health Programs</td>
<td>Health Education classes and disease management resources.</td>
<td>510-747-4577</td>
</tr>
<tr>
<td>Case &amp; Disease Management (CMDM)</td>
<td>Supporting management of patient’s health Navigation support to members through health care system Collaborative partner for appropriate care coordination</td>
<td>877-251-9612</td>
</tr>
<tr>
<td>Compliance</td>
<td>Compliance Hotline to report suspected fraud, waste, abuse or unethical conduct</td>
<td>510-747-4576</td>
</tr>
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</table>

**Alliance Subcontractors**

The Alliance subcontracts with some organizations to provide a menu of services to Alliance members. In some cases, these are delegated medical groups or individual practice associations who, through their contracted providers, provide healthcare services to members who have selected these groups’ PCPs. These delegated groups also handle certain administrative functions necessary to support their contracted providers. In other cases, these vendors are contracted to provide a specific set of services for your members. In either case, these subcontractors may have their own policies and procedures that must be followed to allow members to access services and for claims to be processed. When you have questions about their services, you should contact them directly. The chart below outlines who these subcontractors are and how they can be contacted.
<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>SUBCONTRACTOR</th>
<th>ALLIANCE PRODUCTS</th>
<th>ALLIANCE PRODUCTS</th>
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<td>AMR</td>
<td>1-800-913-9126</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-888-887-6112 Fax</td>
<td></td>
</tr>
<tr>
<td>Children First Medical Group</td>
<td>Children First Medical Group</td>
<td>510-428-3489</td>
<td>Medi-Cal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>510-450-5868 Fax</td>
<td></td>
</tr>
<tr>
<td>Community Health Center Network</td>
<td>Community Health Center Network</td>
<td>510-297-0200</td>
<td>All</td>
</tr>
<tr>
<td>Non-Medical Transportation Services</td>
<td>Call Alameda Alliance Member Services</td>
<td>510-747-4567</td>
<td>All</td>
</tr>
<tr>
<td>Kaiser/Alliance Member Referral and Authorization</td>
<td>Kaiser Foundation Health Plan, Inc.</td>
<td>1-800-447-3777</td>
<td>Medi-Cal</td>
</tr>
<tr>
<td>Mental Health Care Services</td>
<td>OptumHealth (formerly PacifiCare Behavioral Health)</td>
<td>1-888-789-7110</td>
<td>Alliance Group Care</td>
</tr>
<tr>
<td>Mental Health Care Services</td>
<td>Alameda County Behavioral Health</td>
<td>1-800-491-9099</td>
<td>Medi-Cal</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>MedImpact</td>
<td>1-800-788-2949</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-858-790-7100 Fax</td>
<td></td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td>Diplomat</td>
<td>1-877-319-6337</td>
<td>All</td>
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### Clinical Laboratory Outpatient Services

| Vision Services                | March Vision Care (MVC) | 1-888-493-4070 | Medi-Cal |
| Vision Services                | Selection made upon enrollment by member | N/A | Alliance Group Care |
| Dental Services                | Denti-Cal                | 1-800-322-6384 | Medi-Cal ages 20 and below |
| Dental Services                | Delta Dental             | 1-888-335-8227 | Alliance Group Care |

### Section 3: Eligibility and PCP Choice

#### Identifying Alliance Members

Each Alliance member is issued an Alliance identification card with a 9-digit subscriber identification number followed by a 2-digit person code. The 2-digit person code identifies a specific individual in a family because members in the same family will sometimes have the same 9-digit subscriber identification number. Providers can also use the member’s Client Index Number (CIN) if they are in Medi-Cal, to identify members. Products are identified by the abbreviation described in the table. A sample card for the following product lines is included in the back of this section:

<table>
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<th>PRODUCT</th>
<th>GROUP (ID CARD ABBREVIATION)</th>
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<td>Medi-Cal</td>
<td>MCAL</td>
</tr>
<tr>
<td>Alliance Group Care</td>
<td>IHSS</td>
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**NOTE:** Alliance CompleteCare members receive a purple and white Alliance CompleteCare ID card.

#### How to Verify Member Eligibility

All providers must verify eligibility at the time of service. There are several ways to verify member eligibility:

- If Medi-Cal, swipe the patient’s Beneficiary Identification Card (BIC) card using the Point of Service device (POS) and look for “PHP: Alameda Alliance for Health;” or
- If Medi-Cal, call the State’s Automated Eligibility Verification System (AEVS), 1-800-456-2387; or
- For all Alliance products, call the Alliance Eligibility Line, 510-747-4505, which also verifies PCP assignment; or
- Call the Member Services department, 8 a.m. to 5 p.m., weekdays at 510-747-4567.
• On-Line Provider Connection Website (See Section 22: Provider Connection Website Instructions for information on accessing the website)

• For Alliance CompleteCare members only, call the Alliance Care Advisor Unit, 8 a.m. to 8 p.m., seven days a week, at 1-877-585-7526.

PRIMARY CARE PROVIDERS
Primary Care Providers (PCPs) should verify member eligibility by using one of the options noted above on the date services are rendered.

SPECIALTY CARE PROVIDERS
Specialty Care Providers (SCPs) should also verify eligibility on the date services are rendered. A referral or authorization does not guarantee that the member is eligible at time of service.

Alliance Eligibility Line
510-747-4505

Selecting PCPs
The Alliance encourages member choice and member participation in health care services. Every new Alliance member has the opportunity to select her or his own Primary Care Provider (PCP) from the plan provider network.

Members who wish to continue an established relationship with a network PCP can choose that PCP without disruption of care. If members do not select a PCP when they first enroll in the Alliance, the Member Services department attempts to contact these members to help them choose a PCP.

If Member Services is unable to contact a new member within the first month, the member is automatically assigned to a PCP the first of the following month. (Please see Automatic Assignment of PCP below.)

Whether chosen or assigned, the designated PCP is entered into the Alliance’s information system. The selection is confirmed in a mailing sent to the member with their new ID card reflecting the PCP’s name and phone number. The member may change his or her PCP simply by calling the Member Services department.

AUTOMATIC ASSIGNMENT OF PCP
When a member does not select a PCP, automatic assignment is designed to facilitate good matches between members and PCPs. Factors such as member age, language, and geographic location, as well as PCP capacity and PCP specialty, are considered in making automatic assignments.

Automatic assignments are made as follows:

• Automatic PCP assignment will occur no later than thirty (30) days after the member’s effective enrollment date.
• Within ten (10) days of the automatic assignment, the Member Services department will notify the member with a letter and new ID card. The letter instructs the member to contact the Member Services department to discuss change options if he or she is not satisfied with the assignment.

• At any time, the member may avoid an automatic PCP assignment simply by calling the Member Services department and selecting a PCP. If automatic assignment already has occurred, the member’s selection will be treated as a change request rather than an initial assignment.

AUTOMATIC ASSIGNMENT CRITERIA
PCP auto-assignment is based on the following criteria:

• Provider Capacity: Members are assigned to providers who have not yet reached 90% of their maximum capacity. Any provider at 90% or higher capacity is not automatically assigned additional members; the last 10% is reserved for members who request that provider.

• Age & Family Grouping: All children within a family group under age 18 are assigned to the same PCP. All individuals within a family group age 18 or older will be assigned to the same PCP.

• ZIP Code of Member: Members are assigned to a PCP within their three-mile zip code “zone.”

• Language: If the Alliance knows the member’s language preference, then best efforts are made to assign a PCP who provides services in that language.

CLINIC AND MEDICAL GROUP ASSIGNMENTS
Members who choose or are auto-assigned to a clinic or medical group must also select an individual clinic or medical group physician.

Changing PCPs
In keeping with the Alliance’s philosophy of empowering members to choose their own PCP, members may request a change in PCP at any time. If the request is received by the 15th of the month, the PCP change will be effective the first of the following month. If the change request is received on or after the 15th of the month, the PCP change will be effective the first of the month following the next month. Exceptions to these timeframes will be considered on a case-by-case basis. Members must call the Member Services department to request the change.

If one of your members requests a change of PCP, instruct the member to contact the Member Services department at 510-747-4567.

When a member changes PCP more than once, the Member Services department advises him or her that having the same PCP over time can enhance the quality and continuity of their health care. If a member requests three or more PCP changes within a year, the Member Services department will determine the need for any additional member outreach.

After the Member Services department completes the PCP change, the member will receive a confirmation letter, effective date, and new Alliance card reflecting the PCP change.

Member Services ensures that members are notified of a PCP’s termination as soon as possible.
Members will be informed of how to access care during the period when they are not assigned to a contracted PCP and how to choose a new PCP.

**Discharging Members**

The physician/patient relationship is a personal one. In addition to honoring member requests for a change in PCP, the Alliance allows PCPs to request discharge of members. The Alliance will work with the member to choose another PCP who can best meet her or his needs.

**HOW TO DISCHARGE A MEMBER**

1. Determine the reason for the proposed discharge. Under the Medical Services Agreement, PCPs may only request discharge of a member if medical services can no longer be successfully provided for reasons other than medical conditions. Requests to discharge a member due to medical conditions, frequent visits, or high cost of care will be denied.

2. PCPs must contact the Provider Services department in writing to request a discharge. Include complete documentation regarding the nature of the problem and reason for the requested discharge. The Provider Services department will review the request and notify the PCP of the decision.

3. If the discharge request is granted, the Member Services department will notify the member regarding the change in status, and will work with the member to find a new PCP.

4. The original assigned PCP must maintain responsibility for the member’s care until reassignment is completed. This responsibility includes giving the patient 30 days’ notice of the discharge. The member discharge notice must state the following:
   - That the PCP will be available for emergencies and prescriptions for the 30 days or until a new PCP assignment is effective;
   - That the member should contact the Alliance Member Services department for assistance with selecting a new PCP; and
   - That the PCP will make the member’s medical records available to the member’s new PCP upon request.

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

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

**SPECIALTY CARE PROVIDER DISCHARGE REQUESTS**

Specialty Care Providers (SCPs) may request a member discharge if they can show that medical services can no longer be successfully provided for reasons other than medical conditions. In these cases, the SCP should follow the steps outlined in the “How to Discharge a Member” section above.

**Disenrolling Members from the Alliance**

A member in one of the Alliance’s plans may be disenrolled if a member permits someone else to use their card, fails to establish any satisfactory doctor-patient relationship, acts in a disruptive manner while receiving care, provides false information to the Alliance, or repeatedly fails to comply with terms linked to other health coverage. Details about this possibility, as well as these and potential reasons for disenrollment are communicated to members in the Evidence of Coverage booklet for
Disenrolling Medi-Cal Members from the Alliance

A member in the Medi-Cal program may be disenrolled from the Alliance for the following reasons:

**Voluntary Disenrollment:** Members may contact the Alliance Member Services department or the California Department of Health Care Services (DHCS) Health Care Options to initiate the disenrollment process without cause at any time.

**Disenrollment Initiated by DHCS:** This may occur if a member moves out of the eligibility area, loses Medi-Cal eligibility, or requires Medi-Cal services that are not provided by the Alliance (carve-outs).

**Disenrollment for Violation of State Regulations:** This will occur if enrollment is based on a mistake on the part of the Alliance or DHCS, or if the contract between DHCS and the Alliance is terminated.

**Medical Exemption:** Medi-Cal Managed Care members may be exempted from Medi-Cal Managed Care if they have certain medical conditions being treated by a physician who is not a member of a Medi-Cal Managed Care health plan. The request must be submitted to DHCS Health Care Options by the member and provider.

The Alliance will work with providers to ensure quality and continuity of care during the disenrollment process.

**Provider Coordination of Care**

Providers should continue to care for a patient until disenrollment becomes effective. Providers should contact the Member Services department with any questions regarding the status of a patient’s disenrollment.

Please see Section 11 – Out-of-Plan Services for more details on coordination and continuity of care for members who are disenrolled for Long-Term Care.

Upon request, Alliance providers must make the following information available to any new providers rendering care to the disenrolling member. This medical information should be passed along to the new provider in a manner that will ensure confidentiality of medical information and in accordance with all applicable State and federal laws:

- Patient’s history and latest physical status
- Patient’s response to past and present treatment plans
- Length of time you will be responsible for patient before transfer
- Your availability to answer questions after the effective transfer date
- Advance directives
- Information on patient allergies
- Pertinent lab, radiology and imaging reports
- Present treatment plan, including medications, therapies, and considered surgeries
- Discharge summary

You must follow members who change to Medi-Cal fee-for-service until the member’s effective disenrollment date from the Alliance.
Section 4: Provider Marketing

The Department of Health Care Services (DHCS) has established guidelines for appropriate marketing activities for the Medi-Cal program. Providers should familiarize themselves with these guidelines to avoid sanctions, fines, or suspension of membership.

Note: Alliance CompleteCare (HMO SNP) is a coordinated care plan with a Medicare contract and a contract with the California Medicaid program. Alliance CompleteCare has marketing guidelines established by the Centers for Medicare & Medicaid Services (CMS). For information about CMS guidelines, or approval of any materials you are planning to distribute to Medicare beneficiaries, contact the Alliance’s Communications & Marketing department at 510-747-6267.

Alliance Marketing Materials

PROMOTIONAL MATERIALS

If you are interested in obtaining brochures or promotional materials on the Alliance’s product lines, please contact the Provider Services department at 510-747-4510.

Approved Medi-Cal Marketing Methods

As a health care provider, you may:

- Tell your Medi-Cal patients the name of the health plan or plans with which you are affiliated.
- Actively encourage your Medi-Cal patients to seek out and receive information and enrollment material that will help them select a Medi-Cal health care plan for themselves and their family.
- Provide patients with the phone number of the outreach and enrollment or member services departments of the plan(s) with which you are affiliated.
- Provide patients with the toll-free phone number of the DHCS Health Care Options (HCO) enrollment contractor (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 and activities, presentations, and problem resolution functions.

Prohibited Medi-Cal Marketing Methods

As a health care provider you may NOT:

- Coerce, threaten, or intimidate patients into making a particular selection.
Tell patients they could lose their Medi-Cal health benefits if they do not choose a particular health plan.

Make any reference to competing plans, e.g., comparing plans in a positive or negative manner.

Copy sample enrollment forms with your name filled in and distribute them to patients, use photocopied blank forms, or use plan-printed enrollment forms.

Make false or misleading claims, inquiries, or representations that:
  - Office staff are employees or representatives of the State or County.
  - A plan is recommended or endorsed by any State or County agency or any other organization.
  - The State or County recommends that a Medi-Cal beneficiary enroll with a specific health plan.

Offer or give any form of compensation, reward, or loan to a prospective enrollee to induce or procure Medi-Cal beneficiary enrollment in a specific health plan.

Use any list of Medi-Cal beneficiaries obtained originally from confidential State, County, or health plan data sources or from the data sources of other contractors for enrollment purposes.

Engage in marketing practices which discriminate against prospective members based on marital status, religion, age, sex, national origin, language, sexual orientation, ancestry, pre-existing psychiatric problem, or medical condition (such as pregnancy, disability, acquired immune deficiency syndrome (AIDS), etc., other than those specifically excluded from coverage under the health plan contract).

Sign an enrollment application for the member.

Provide marketing presentations by a health plan or provider’s staff at primary care sites.

Engage in any Medi-Cal marketing activity on State or County premises or any other location not authorized in the health plan’s marketing plan.

Distribute unauthorized or unapproved material to Medi-Cal beneficiaries.

For information about the Alliance’s marketing plan, DHCS guidelines, or approval of any materials you are planning to distribute to Medi-Cal beneficiaries, contact the Alliance’s Communications & Marketing department at 510-747-6267.

Engaging in prohibited practices may result in sanctions or fines imposed by the Department of Health Care Services (DHCS).

Contact the Alliance’s Communications & Marketing department at 510-747-6267 to have materials approved.