Alameda Alliance For Health

2017 2nd Quarter Provider Packet

Provider Name: _________________________________Date of Visit: _____________

PCP___ Specialist___ CBAS___ Home Health___ SNF___ Ancillary___ Other___

- Pay for Performance Program (P4P) - Program Guide-Directly Contracted Primary Care Physicians
- P4P Point Value and Goals – At A Glance
- Clinic Quality Goal and Points Earned Sample Scenarios-P4P
- Provider Webinar 2016 Membership Needs Assessment Results
- Cultural Sensitivity Training 2017
- Formulary Updates
- Interpreter Services Quick Reference Guide
- Provider Dispute Resolution Request Form
- Provider Dispute Policy and Procedure
- Patient Health Education
- Ownership Form

Provider /Office Staff Signature: ____

Health Plan Representative Signature: ____

Comments: ____

____

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Pay for Performance Program (P4P) – Directly Contracted Primary Care Physicians (PCPs)

Program Guide – 2017

Created by:
Healthcare Analytics
Date: 3-15-17

Background

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- The program goal is to pay providers for improvements in quality, outcomes, and performance.
- Incentives are based on meeting specific performance thresholds in various measure categories.

Criteria

The following applies to the 2017 P4P program:

Provider Criteria:

- Provider must be a directly contracted PCP with Alameda Alliance for Health (Alliance) .
- PCPs must be active as of the end of the measurement period through the payment date.

Grouping Level:

- Measures and payments will be calculated at the medical group/solo practitioner level ("PCP Group").

Eligible Population:

- Alliance membership for Medi-Cal and IHSS assigned to a "PCP Group".

Payment Pool/Dates: 2017 P4P

Pool Dollars:
The total payment pool consists of the Alliance's Board-approved budgeted amount.

- This amount is subject to adjustment depending on the Alliance's financial performance

Measurement Period: 1/1/2017 - 12/31/2017

Payment Date: November 2018

Payment Methodology

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Distribution Method:
The potential dollars for a PCP Group will be based on their percentage of member months compared to the total member month population for directly contracted PCPs.

Minimum Payout:
PCP Groups with calculated payouts less than $1,000 will receive a minimum $1,000 payout.

Payment: Sample Calculation

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Payment Pool = $100,000:

Group/ Solo	Member Months	Avg Monthly Membership	% of Total MMS	Potential P4P$	Points Earned	Total Earned	PMPM Earned	Actual Payment
Group1	7,000	583	44.44%	$ 44,444	50	$22,222	$3.17	$22,222
Group2	3,500	292	22.22%	$ 22,222	100	$22,222	$6.35	$22,222
Group3	3,500	292	22.22%	$ 22,222	10	$2,222	$0.63	$2,222
Solo1	1,000	83	6.35%	$ 6,349	90	$5,714	$5.71	$5,714
Solo2	350	29	2.22%	$ 2,222	90	$2,000	$5.71	$2,000
Group4	400	33	2.54%	$ 2,540	20	$508	$1.27	$1,000
Total	**15,750**		**100.00%**	**$ 100,000**		**$54,889**	**$3.49**	**$55,381**

Member Months = the sum of monthly enrollment counts for the 12 month measurement period. Ex. A PCP Group has 1,000 members each month for every month in 2015. The member months for the group would be 12,000.

Points Earned = the total number of points earned out of the 100 possible points in the measurement set.

Measures

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The measurement categories are:

- Clinical Quality (selected HEDIS measures)
- Appropriate Resource Use
- Access and Operations

PCP Groups are categorized as Family, Internal Medicine or Pediatric and are responsible for different Clinical Quality measures.

Measures: Clinical Quality

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#	Measures	2017 Points Family	2017 Points Internal	2017 Points Pediatric
1	Cervical Cancer Screening	7	9	N/A
2	Diabetes Management (18-75 years) – HbA1c Testing	7	9	N/A
3	Prenatal and Postpartum Care - Timeliness of Care (Prenatal)	7	9	N/A
4	Well Child Visits (3-6 years)	6	N/A	15
5	Childhood Immunization – Combo 3	6	N/A	15
6	Monitoring for Patients on Persistent Medications (>18 years) - ACE or ARB	5	8	N/A
7	Monitoring for Patients on Persistent Medications (>18 years) - Diuretics	5	8	N/A
8	Diabetes Management (18-75 years) – Retinal eye exam	4	5	N/A
9	Diabetes Management (18-75 years) - HbA1c Control (<8.0%)	4	5	N/A
10	Asthma Medication Ratio (Total Rate)	3	3	6
11	Screening for Clinical Depression and Follow Up Plan	3	3	2
12	Breast Cancer Screening	1	1	N/A
13	Immunizations for Adolescents - Combo 2 (Meningococcal, TDAP, HPV completed prior to 13th b-day)	2	N/A	8

Measures: Clinical Quality

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#	Measures	2017 Points Family	2017 Points Internal	2017 Points Pediatric
14	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, BMI percentile	N/A	N/A	2
15	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; Counseling for Nutrition for children and adolescents	N/A	N/A	6
16	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, Physical Activity for Children/Adolescents	N/A	N/A	6
Clinical Quality Total Points:		**60**	**60**	**60**

Points:

- **Per HEDIS measure:** Full points if the HEDIS rate per measure per PCP Group meets the following:
  - 1) If prior year rate is below the Minimum Performance Level (MPL), then the current year rate must be at or above the MPL **OR**
  - 2) If prior year rate is above MPL, then the current year rate must be at or above 5% above prior year.
  - Note: If current year rate is at or above the High Performance Level (HPL), then full points are awarded.

Measures: Appropriate Resource Use

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#	Measures	2017 Points Family	2017 Points Internal	2017 Points Pediatric
17	Initial Health Assessments (IHA)	10	10	10
18	Pharmacy Utilization - % of Generic Usage	6	6	6
Appropriate Resource Use Total Points		**16**	**16**	**16**

Points:

- **Initial Health Assessments (IHA)**: Points distributed based on 1 point for every 10% increment of the percent compliant.
  - Ex. Less than 1% = 0 points, 1-9.9% = 1 point, 10-19.9% = 2 points
- **Pharmacy Utilization:** Full points if the % of generic utilization is at or above 87%

Measures: Access and Operations

#	Measures	2017 Points Family	2017 Points Internal	2017 Points Pediatric
19	Primary Care Physician (PCP) Office Visits Per Member Per Year	8	8	8
20	Providers Open to new Alliance Members	8	8	8
21	Claims Timeliness	8	8	8
Access and Operations Total Points:		**24**	**24**	**24**

Points:

- **Primary Care Physician (PCP) Office Visits**: Full points if the number of PCP Office Visits per Member per Year is at or above 2.0 visits.
- **Providers Open:** 2 points awarded for every quarter the PCP Group is accepting new Alliance members.
- **Claims Timeliness:** Full points if percentage of claims received within 50 calendar days from the date of service is >= 65%.

Measure Descriptions: Clinical Quality

- **Cervical Cancer Screening**
  - Measures the percentage of women 21-64 years of age who were screened for cervical cancer by:
    - Women age 21-64 who had cervical cytology performed every 3 years.
    - Women age 30-64 who had cervical cytology with human papillomavirus (HPV) co-testing performed every 5 years.

- **Diabetes Management (18-75 years)**
  - Measures the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had the following:
    - **HbA1c Testing:** Hemoglobin A1c (HbA1c) test in the measurement year.
    - **Retinal eye exam:** Retinal or dilated eye exam in the measurement year or a negative retinal or dilated eye exam in prior year.
    - **HbA1c Control (<8.0%):** The most recent Hemoglobin A1c (HbA1c) value in the measurement year is below 8.0%

Measure Descriptions: Clinical Quality

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- **Prenatal and Postpartum Care - Timeliness of Care (Prenatal)**
  - Measures the percentage of deliveries that received a prenatal care visit as a member of AAH in the first trimester *or* within 42 days of enrollment in AAH.
- **Monitoring for Patients on Persistent Medications (>18 years)**
  - Measures the percentage of members 18 years of age and older who received:
    - **ACE or ARB:**
      - At least 180 treatment days of angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)
      - **AND** at least one medication monitoring event (creatinine and potassium values) in the measurement year.
    - **Diuretics:**
      - At least 180 treatment days diuretics (DIU)
      - **AND** at least one medication monitoring event (creatinine and potassium values) in the measurement year.

Measure Descriptions: Clinical Quality

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- **Well Child Visits (3-6 years)**
  - Measures the percentage members 3–6 years of age as of December 2017, who received one or more well child visits with a PCP during the measurement year.

- **Childhood Immunization – Combo 3**
  - Measures the combined percentage of children who received the following Immunizations by their 2nd birthday:
    - 4 DTaP
    - 3 IPV
    - 3 HepB
    - 3 HiB
    - 1 VZV (chicken pox)
    - 1 MMR
    - 4 PCV (pneumococcal conjugate)

Measure Descriptions: Clinical Quality

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- **Asthma Medication Ratio (Total Rate)**
  - Measures the percentage of members 5-64 years of age with persistent asthma who had a ratio of controller medications to total asthma medications of 0.5 or greater in the measurement year.
- **Screening for Clinical Depression and Follow Up Plan**
  - Measures the percentage members 12 years of age and older screened for clinical depression at the time of their visit. If the screen is positive, a follow up plan is documented.
- **Breast Cancer Screening**
  - Measures the percentage women 52-74 years of age who had one or more mammograms between two years prior to the measurement year and the end of the measurement year.

Measure Descriptions: Clinical Quality

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- **Immunizations for Adolescents - Combo 2**
  - Measures the percentage of adolescents who received the following Immunizations by their 13th birthday:
    - 1 meningococcal conjugate
    - 1 Tdap
    - 3 HPV (*HPV series is required for both males and females)*

- **Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents**
  - Measures the percentage of children and adolescents 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:
    - Body Mass Index (BMI) percentile
    - Counseling for nutrition
    - Counseling for physical activity

Measure Descriptions: Appropriate Resource Use

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- **Initial Health Assessment (IHA):**
  - Measures the percentage of new members who have received an IHA within a specified number days of becoming an Alliance member.
    - All members: within 120 calendar days of initial enrollment
    - A completed IHA includes the SHA (Staying Healthy Assessment).
- **Pharmacy Utilization - % of Generic Usage:**
  - Measures the percentage of generic prescriptions fill compared to total fills (brand + generic) for members assigned to that PCP Group.

Measure Descriptions: Access and Operations

- **Primary Care Physician (PCP) Office Visits Per Member Per Year:**
  - Measures the average number of assigned members' visits to the PCP Group per member per year.
- **Providers Open to new Alliance Members:**
  - Measures if the PCP Group is accepting new Alliance members. Status will be determined on a quarterly basis. If PCP Group is accepting new members anytime during the quarter then credit is given for that quarter.
- **Claims Timeliness:**
  - Measures the percentage of claims received from the PCP Group within 50 calendar days from the date of service.

AAH Pay For Performance (P4P) Program for Directly Contracted PCPs
Measures, Point Values and Goals - At A Glance
Measurement Calendar Year: 2017

			2017 Points			
	#	**Measures**	**Family**	**Internal**	**Pediatric**	**2017 Goal**
Clinical Quality	1	Cervical Cancer Screening	7	9	N/A	At PCP Group level: If prior year is below the MPL, goal = MPL. If prior year is above MPL, goal = 5% above prior year. If at or above the HPL, then measure is met.
	2	Diabetes Management (18-75 years) – HbA1c Testing	7	9	N/A	
	3	Prenatal and Postpartum Care - Timeliness of Care (Prenatal)	7	9	N/A	
	4	Well Child Visits (3-6 years)	6	N/A	15	
	5	Childhood Immunization – Combo 3	6	N/A	15	
	6	Monitoring for Patients on Persistent Medications (>18 years) - ACE or ARB	5	8	N/A	
	7	Monitoring for Patients on Persistent Medications (>18 years) -Diuretics	5	8	N/A	
	8	Diabetes Management (18-75 years) – Retinal eye exam	4	5	N/A	
	9	Diabetes Management (18-75 years) - HbA1c Control (<8.0%)	4	5	N/A	
	10	Asthma Medication Ratio (Total Rate)	3	3	6	
	11	Screening for Clinical Depression and Follow Up Plan	3	3	2	
	12	Breast Cancer Screening	1	1	N/A	
	13	Immunizations for Adolescents - Combo 2 (Meningococcal, TDAP, HPV completed prior to 13th b-day)	2	N/A	8	
	14	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, BMI percentile	N/A	N/A	2	
	15	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; Counseling for Nutrition for children and adolescents	N/A	N/A	6	
	16	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, Physical Activity for Children/Adolescents	N/A	N/A	6	
	Clinical Quality Total Points:		**60**	**60**	**60**	
Appropriate Resource Use	17	Initial Health Assessments (IHA)	10	10	10	IHA Range
	18	Pharmacy Utilization - % of Generic Usage	6	6	6	At or above 87%
	Appropriate Resource Use Total Points		**16**	**16**	**16**	
Access and Operations	19	Primary Care Physician (PCP) Office Visits Per Member Per Year	8	8	8	> = 2.0 visits
	20	Providers Open to new Alliance Members	8	8	8	2 points for each quarter open
	21	Claims Timeliness	8	8	8	65% received within 50 calendar days of the date of service
	Access and Operations Total Points:		**24**	**24**	**24**	
TOTAL			**100**	**100**	**100**	

IHA Range	**Points**
Less than 1.0	0
1-9.9	1
10-19.9	2
20-29.9	3
30-39.9	4
40-49.9	5
50-59.9	6
60-69.9	7
70-79.9	8
80-89.9	9
90-100	10

AAH Pay For Performance (P4P) Program 2017
Clinical Quality Goal and Points Earned Sample Scenarios

Points Earned for Clinical Quality (ie. HEDIS) measures:

Per HEDIS measure: Full points if the HEDIS rate per measure per PCP Group meets the following:

1) If prior year rate is below the Minimum Performance Level (MPL), then the current year rate must be at or above the MPL *(see Scenario A)* **OR**
2) If prior year rate is above MPL, then the current year rate must be at or above 5% above prior year. *(see Scenario B)*

Note: If current year rate is at or above the High Performance Level (HPL), then full points are awarded. *(see Scenario C)*

Sample Scenarios for Measure X:

Point Value	Current Year MPL	Current Year HPL
10	50.00%	80.00%

Scenario A: Prior Year Rate is BELOW Current Year MPL

	Prior Year Rate	Current Year Goal	Current Year Rate	Current Year Points Earned
PCP Group A	40.00%	50.00%	50.00%	10
PCP Group B	40.00%	50.00%	45.00%	0

Scenario B: Prior Year Rate is ABOVE Current Year MPL

	Prior Year Rate	Current Year Goal	Current Year Rate	Current Year Points Earned
PCP Group C	51.00%	56.00%	56.00%	10
PCP Group D	51.00%	56.00%	52.00%	0

Scenario C: Current Year Rate is AT OR ABOVE Current Year HPL

	Prior Year Rate	Current Year Goal	Current Year Rate	Current Year Points Earned
PCP Group E	70.00%	75.00%	80.50%	10
PCP Group F	40.00%	45.00%	85.00%	10

Scenario D: Prior Year Rate is ABOVE Current Year HPL

	Prior Year Rate	Current Year Goal	Current Year Rate	Current Year Points Earned
PCP Group G	82.00%	80.00%	81.00%	10
PCP Group H	82.00%	80.00%	70.00%	0

Provider Webinar

Alameda Alliance for Health
2016 Membership Needs Assessment Results

2016 Needs Assessment Results

As a managed care plan, Alameda Alliance for Health has conducted a Group Needs Assessment of our membership to evaluate health status, needs and preferences based on language, ethnicity, age and disability.

Our webinar for providers will review the 2016 results, our next steps, opportunities as a health plan and your role as a provider.

Our webinar will cover:

- Needs assessment methodology
- Member demographics
- Health status and risks
- Health education needs
- Cultural, linguistic and communication needs
- Alliance' plans to address identified needs
- Next Steps & QA

Join our live webinar!

April 26, 2017, 12:00-1:00 pm

or

May 25, 2017, 12:00-1:00 pm

To register email:
jstill@alamedaalliance.org

Who should attend?

Healthcare providers, front office staff, office managers, and quality improvement staff

Unable to attend?

View the presentation on our website.
Find it at this link after 4/26:
alamedaalliance.org/providers/provider-training

Questions?

(510) 373-5680
jstill@alamedaalliance.org

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Cultural Sensitivity Training 2017

Updated Alliance Cultural Sensitivity Training Now Available

Ongoing Cultural Sensitivity training is an important way to ensure you meet the diverse needs of your patients. To assist you in your training efforts, we have created a training that is updated yearly and available for use by our provider network. To download the training, go to:

www.alamedaalliance.org/providers/provider-training

The Alliance's Cultural Sensitivity training is approximately one hour and includes:

- State and federal laws and regulations regarding cultural and linguistic services
- Current Alliance membership demographics
- Why culture is important to health care
- Practical tips for cultural sensitive practice
- Best communication practices for sub-groups including:
  - Refugee and immigrant members
  - Limited-English speaking members
  - LGBTQ members
  - Senior and Persons with Disabilities
- Accessible communications: interpreters, translation, and alternate format
- ***New!*** Case studies, section on religion and healthcare, enhanced information on working with LGBTQ members and more Alameda County data

Find more cultural resources on the Alliance website at the link above or contact Provider Relations at 510-747-4510.

ALAMEDA Alliance FOR HEALTH

ALAMEDA ALLIANCE FORMULARY UPDATES

Dear Provider,

The Alameda Alliance for Health (the Alliance) Formulary is managed by the Pharmacy & Therapeutics Committee, which meets quarterly. Changes made at the meetings go into effect on the 15th day of the following month.

Changes may include:

- Additions and deletions to the formulary
- Changes to formulary status (e.g., quantity limits, step therapy, age limits)
- Changes to the prior authorization review criteria

In order to make the most updated Alliance formulary available to providers, we have provided easy to access formulary lookup tools and summaries of the individual changes. All changes to the formulary will be published by the same date of the formulary changes, which is the 15th day of the following month after the P&T meeting. You have the following resources available to help you with these changes at your fingertips:

FULL LIST OF CHANGES PER P&T MEETING:

- www.alamedaalliance.org/providers/pharmacy-drug-benefits/formulary

FULL FORMULARY LOOKUP INCLUDING MOST RECENT UPDATES:

- https://www.alamedaalliance.org/members/pharmacy-and-drug-benefits
- https://online.epocrates.com/ (*see note below*)

Additionally, Alameda Alliance provides the following online resources available to you

Resource	Location
Pharmacy Exception Process	www.alamedaalliance.org/providers/pharmacy-drug-benefits/pharmacy-exception-process
Alameda Alliance Formulary Limits and Restrictions	www.alamedaalliance.org/members/pharmacy-and-drug-benefits/description-of-formulary-limits
Three-Day Emergency Supply of Medication	www.alamedaalliance.org/members/pharmacy-and-drug-benefits/emergency-medication-supply
Pharmacy Safety Resources	www.alamedaalliance.org/members/pharmacy-and-drug-benefits/safety-resources

Alameda Alliance is dedicated to providing all members the best health care available in the most effective and efficient manner. We believe that changes made to the pharmacy drug benefit will not affect the quality of your care. Thank you for your continued support of Alameda Alliance for Health!

**Epocrates formulary lookup tool requires creation of an account and login, which is free. Download the Epocrates app for both Android and Apple devices. For questions on how to add the Alameda Alliance formulary to your profile, please contact the pharmacy department.*

Alameda Alliance for Health
1240 S. Loop Road
Alameda, CA 94502

AAH Provider Services
Phone: 510-747-4510

Alameda Alliance for Health

INTERPRETER SERVICES QUICK REFERENCE GUIDE

ALAMEDA Alliance FOR HEALTH
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Alameda Alliance for Health provides no-cost interpreter services for all Alliance Covered Services. Interpreters are available 24 hours a day, 7 days a week. Your patient must be an Alliance member to receive interpreter services. Please confirm patient's eligibility before requesting services.

Using professional interpreter services is good medicine.

- Alameda Alliance strongly encourages the use of professional interpreters.
- Using a professional interpreter reduces the chance of mis-communication that may result from using an untrained interpreter, such as a patient's family member.
- If a member declines interpreter services, please document the refusal in the medical record, as required by the California Department of Health Care Services and the California Managed Risk Medical Insurance Board.

HOW TO ORDER FACE-TO-FACE INTERPRETER SERVICES

- The Alliance covers any language, including American Sign Language.
- Call the Alliance Member Services department at **510-747-4567** to schedule an interpreter.
- You may also use the Request for Interpreters Form and fax it to Alliance Member Services at **1-855-891-7172.**
- We ask for **72 hours advance notice**. Same day requests may be possible for urgent situations.

HOW TO ORDER TELEPHONIC INTERPRETER SERVICES

- Call the Alliance's interpreter vendor, International Effectiveness Centers (IEC), at **1-866-948-4149**
- When prompted for a provider ID number, inform the IEC representative that you are an Alliance provider.
- Provide the IEC representative with the member' s 9-digit Alliance ID number

Alameda Alliance for Health

ALAMEDA ALLIANCE PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form, fields with an asterisk (*) are required
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed
- Multiple "LIKE" claims are when the claim is for the same provider, same dispute, and different member

Mail the completed form to: Alameda Alliance for Health, P. O. Box 2460, Alameda, CA 94501-2460

PROVIDER INFORMATION			
***PROVIDER NPI:**		***PROVIDER TAX ID:**	
***PROVIDER NAME:**			
PROVIDER ADDRESS:			

PROVIDER TYPE: ☐MD ☐ASC ☐Hospital ☐Home Health ☐Mental Health Institutional
☐SNF ☐DME ☐Rehab ☐Ambulance ☐Mental Health Professional
☐Other ______________________________ (please specify type of "other")

CLAIM INFORMATION ☐Single ☐Multiple "**LIKE**" Claims (Complete attached spreadsheet) Number of Claims: ___	
***Patient Name:**	Date of Birth:
*Health Plan ID Number:	Patient Account Number:
Original Claim ID Number (If multiple claims, use attached spreadsheet)	Service "From/To" Date: (*Required form Claim, Billing, and Reimbursement of Overpayment Disputes)
Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

☐Claim
☐Appeal of Medical Necessity / UM Decision
☐Disputing Request For Reimbursement Of Overpayment
☐Seeking Resolution Of A Billing Determination
☐Contract Dispute
☐Other: ________________________________

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

______________________________ **Contact Name (please print)**

______________________________ **Title**

(   ) ______________________ **Phone Number**

______________________________ **Signature**

______________________________ **Date**

(   ) ______________________ **Fax Number**

☐**CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

For Health Plan/RBO Use Only
TRACKING NUMBER: ____________________ *PROV ID#* _______________
CONTRACTED _____ *NON-CONTRACTED* _____

ALAMEDA Alliance FOR HEALTH

ALAMEDA ALLIANCE PROVIDER DISPUTE RESOLUTION REQUEST

(For use with multiple "LIKE" claims)

Number	*Patient Name		Date of Birth	*Health Plan ID Number	Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

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Page _____ of _____

POLICY AND PROCEDURE

Policy Number	PDR-001
Policy Name	Provider Dispute Resolution Mechanism
Department Name	Compliance
Department Officer	Chief Compliance Officer
Policy Owner	Manager, Provider Dispute Resolutions
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	9/27/2016
Approval/Revision Date	9/27/2016

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") will maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes in accordance with California Code of Regulations, Title 28 §1300.71, 1300.71.38, 1300.71.4 and 1300.77.4.

PROCEDURE

I. Notice to Provider of Dispute Resolution Mechanism(s)

The Alliance will inform the provider of the availability of the provider dispute mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute whenever the Alliance adjusts or denies a claim.

II. Submission of Provider Disputes

Provider disputes must be submitted utilizing the same number assigned to the original claim; the Alliance will process and track the provider dispute in a manner that allows the Alliance, the provider and the Department of Managed Health Care ("DMHC") to link the provider dispute with the number assigned to the original claim.

For contracted provider disputes, at a minimum, the following information must be submitted:

- the provider's name
- the provider's identification number
- contact information; and:
    - 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 the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon; and
    - If the dispute involves an enrollee or group of enrollees: the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

For non-contracted provider disputes, at a minimum, the following information must be submitted:

- the provider's name,
- the provider's identification number,
- contact information and:
    - If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect.
    - If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

The Alliance will resolve any provider dispute submitted on behalf of an enrollee or a group of enrollees treated by the provider in the Alliance's grievance system process and not as a provider dispute resolution. The Grievance and Appeals Department verifies the member's authorization with the grievance prior to processing the grievance. When a provider submits a dispute on behalf of the member, the provider will be assisting the member within accordance with section 1368 of the Health and Safety Code.

III. Time Period for Submission, Acknowledgement, Resolution and Written Determination

	Description	Turnaround Timeframe
Deadline for Plan Receipt of Provider Dispute	Dispute related to an individual claim, billing dispute, or contractual dispute; OR Dispute related to a demonstrable and unfair payment pattern by the Plan	Within **365 days** of the plan's capitated provider's action or inaction
	Amended Provider Dispute	Within **30 working days** of the date of provider's receipt of a returned dispute with written Plan notice
Acknowledgement of Provider Dispute	Electronic Provider Dispute	Provided within **2 working days** of the date of receipt of the electronic provider dispute
	Paper Provider Dispute (mail, fax, e-mail, physical delivery)	Provided within **15 working days** of the date of receipt of the paper provider dispute
Resolution and Written Determination	Resolution and issuance of written determination for each provider dispute or amended provider dispute	Resolve and issue written determination within **45 working days** after the date of receipt of the provider dispute or the amended provider dispute
Outstanding Monies Determined to be Past Due, including Interest and Penalties	Resolution of a dispute involving a claim, which is determined in whole or in part in favor of the provider, shall include the payment of any outstanding monies determined to be due and all interest due	Issue payment with the resolution letter and in all cases payment will be made no later than within **5 working days** of the issuance of the written determination Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" of the complete claim

The Alliance will return any provider dispute lacking the information required for submission, if the information is in the possession of the provider and is not readily accessible to the Alliance. Along with any returned provider dispute, the Alliance will either call the provider for missing information or clearly identify in writing the missing information necessary to resolve the dispute. Except in a situation where the claim documentation has been returned to the provider, the Alliance will not request the provider to resubmit claim information or supporting documentation that the provider previously submitted to the Alliance as part of the claims adjudication process.

IV. Designation of Plan Officer

The Compliance Officer maintains oversight of the provider dispute resolution mechanism, for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, relations with the Alliance providers, claims payment procedures and member's care.

V. No Discrimination

The Alliance will not discriminate or retaliate against a provider who files a contracted provider dispute or a non-contracted provider dispute.

VI. Dispute Resolution Costs

A provider dispute will be received, handled and resolved by the Alliance without charge to the provider. In addition, the Alliance will have no obligation to reimburse a provider for any costs incurred in connection with utilizing the provider dispute resolution mechanism.

VII. Required Reports

The Alliance will submit an "Annual Plan Claims Payment and Dispute Resolution Mechanism Report" to the DMHC no more than fifteen (15) days after the close of the calendar year that will include the following:

- Information on the number and types of providers using the dispute resolution mechanism;
- A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and
- A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans. The information provided pursuant to this paragraph shall be submitted with, but separately from the other portions of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant section 1007 of title 28.

DEFINITIONS / ACRONYMS

1. *"Contracted Provider Dispute"* means a contracted provider's written notice to the Alliance 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 a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim.
2. *"Non-Contracted Provider Dispute"* means a non-contracted provider's written notice to the Alliance challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim.
3. *"Date of receipt"* means the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the Alliance's designated dispute resolution office or post office box.
4. *"Date of Determination"* means the date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record.

AFFECTED DEPARTMENTS/PARTIES

- Compliance Department
- Provider Relations Department
- Claims Department
- Medical Services Department

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Provider Dispute Resolution Form
- Provider Dispute Resolution Workflow
- PDR Audit Universe Template
- PDR Audit Tool

REVISION HISTORY

REFERENCES

- CA Health and Safety Code 1367(h)
- CA Health and Safety Code 1371.38
- 28 CCR 1300.71(g)(3) and (l)
- 28 CCR 1300.71.38

MONITORING

1. Internal Auditing
   a. Auditing is done on a quarterly basis by the Compliance Department
      i. An universe is requested the month after the end of the quarter (See Attachment – PDR Audit Universe Template);
      ii. Compliance conducts a 30 file review audit (See Attachment – PDR Audit Tool);
      iii. Audit Findings are sent to the Manager of Provider Dispute Resolutions for response if required;
      iv. Responses on the findings are sent to Compliance 30 days after the request;
      v. The audit findings are also reporting during the quarterly Compliance Committee.
2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Provider Dispute Resolutions or the Director of Complaints and Resolutions. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

Patient Health Education

Do you use patient handouts?

Health education is an important part of preventive and primary health care visits. Patient handouts are great tools for enhancing health education at your practice. Here is a checklist of items to consider when you distribute handouts to make sure they meet your patient's readability and cultural needs.

- ❑ Use 12 point or greater font size (this type is 12 point Ariel) 14 point for seniors
- ❑ Limit number of concepts per page. Keep the sentences simple and in the active voice.
- ❑ Define technical terms and acronyms
- ❑ Aim for 30% white space and layout that guides the reader
- ❑ Organize text with headings or subheadings; use bullets or numbers for lists
- ❑ Keep visuals relevant to text and simple
- ❑ Ensure visuals represent your patients, culturally and otherwise. Do not reinforce stereotypes.
- ❑ Include topic-specific cultural references such as foods and exercise habits
- ❑ Ensure content is up-to-date and passes medical review if needed
- ❑ Review materials periodically to ensure accuracy and relevance
- ❑ Provide translated materials to non-English speaking patients.

If you are looking for materials that follow these best practices, find Alliance handouts on many topics at https://www.alamedaalliance.org/live-healthy. Our handouts are in English, Spanish, Chinese and Vietnamese. Topics include:

- Asthma
- Baby & Breastfeeding
- Diabetes
- Injury Prevention
- Healthy Weight
- Mental Health
- Parenting
- Pregnancy
- Quit Smoking
- Sexual Health
- Substance and Alcohol Addiction

Have questions? Looking for additional topics? Contact Alliance Health Education at livehealthy@alamedaalliance.org. Or call Linda Ayala, Health Educator at 510-747-6038.

Alameda Alliance for Health

Ownership Form

OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

Alameda Alliance for Health discloses any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have a substantial financial interest:

a) Any person or corporation having 5% or more ownership or controlling interest in the practice

b) Please Submit this form with a current W9

Note: The Ownership data requested below is required per the Federal regulations set forth in 42 CFR 455.104 – Disclosure by Medicaid providers and fiscal agent. The State Medicaid agency mandates Health Plans to submit Provider data, including this information monthly via ASC X12 274 transaction file.

	***Individual Name** *(required)*	**Rendering NPI Number (If Applicable)**	***PERCENT (%) OF OWNERSHIP OR CONTROL** *(required)*	***Billing NPI Number** *(required)*	***SSN/TIN Number Associated** *(required)*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					

Ownership Code: *REQUIRED

- ☐ Gov-Multiple Owners
- ☐ Gov-State & City/County
- ☐ Gov-City
- ☐ Gov-City-County
- ☐ Gov-County
- ☐ Gov-Federal
- ☐ Gov-Hospital District
- ☐ Gov-State
- ☐ N/A – The individual only practices as part of a group, e.g., as an employee
- ☐ Proprietary-Corporation
- ☐ Proprietary-Individual
- ☐ Proprietary-Multiple owners
- ☐ Proprietary-Other
- ☐ Proprietary-Partnership
- ☐ Proprietary-Government
- ☐ Voluntary – multiple owners
- ☐ Voluntary – Non-Profit/Other
- ☐ Voluntary – Non-Profit/Religious
- ☐ Voluntary – Proprietary
- ☐ Voluntary – Government

For questions please call Provider Relations at (510) 747-4510

Please fax this document along with a current W9 to dedicated fax # (855) 891-7257