2021 Quarter 1 Provider Packet

In-Person Visits Have Been Suspended due to Shelter-in-Place Orders

The Alliance is available to support and assist our providers during the shelter-in-place orders that have been enacted in our community to prevent the spread of the Coronavirus (COVID-19).

Here are ways that you can access Alliance updates and reach out to us for assistance:

- Contact your Provider Relations Representative directly by email or phone
  - Errin Poston-McDaniels: **eposton-mcdaniels@alamedaalliance.org**, **1.510.747.6291**
  - Stacey Woody: **swoody@alamedaalliance.org**, **1.510.747.6148**
  - Tom Garrahan: **tgarrahan@alamedaalliance.org**, **1.510.747.6137**
  - Leticia Alejo (Delegated Groups/Hospitals): **lalejo@alamedaalliance.org**, **1.510.373.5706**
- Email us at **providerservices@alamedaalliance.org**
- Contact our Provider Call Center at **1.510.747.4510**
- Visit the provider section of our website at **www.alamedaalliance.org/providers**

THIS PACKET INCLUDES:

- Vendor Disclosure of Ownership Form
- Provider Demographic Attestation Form
- Medical Records Reminder Notice
- Update on Electronic Remittance Advices (ERA) & ERA Form
- Transportation Reminder & Form
- Help Your Patients Stay Ready for Public Safety Power Shutoffs
- Blood Lead Screening Requirements
- Important Update on Member Satisfaction
- Member Satisfaction Provider Notice
- Health Homes Program Overview
- Preventive Services Guidelines Update –January 2021
- Alliance Tobacco Provider Guide
- Alliance Language Services
- Interpreter Services Guide
- Interpreter Services Request Form

☐ Accepting New Patients ☐ Accepting Existing Patients ☐ Not Accepting Patients

Comments: _____

_____

Provider/Office Staff Print: _____

Provider/Office Staff Signature: _____

Provider/Office Staff Print: _____

Vendor Disclosure of Ownership Form

I. Instructions

This form must be completed and submitted to Alameda Alliance for Health (Alliance) by all providers and subcontractors. A new Disclosure Form is required and must be submitted in the event of renewal or extension of the contract or within 35 days after any information in your original form has changed. This Disclosure Form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership, control and management; and (2) exclusions of individuals and entities from government programs as set forth in your contract with the Alliance and the Alliance's administrative requirements.

The disclosure, reporting, and exclusion requirements apply to partnerships on both non-profit and for-profit corporations, including without limitation limited liability companies. Governmental entities, such as counties organized as corporations are required to complete all sections of this Disclosure Form. Counties that are not organized as corporations are only required to complete Sections II, III, and VI of the Disclosure Form. The definitions are based on law, regulation, and instructions from regulatory authorities.

Important Note: For the purposes of this Disclosure Form, the term "Person with an Ownership or Control Interest" is not limited to persons or corporations with an ownership interest. For example, it also includes:

- **(I) Officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and**
- **(II) Partners of a partnership, including without limitation limited liability partnerships.**

See Section VII for a complete definition of "Person with an Ownership or Control Interest" as well as definition of other key terms such as "Managing Employee," "Provider," and "Agent."

Please complete this Disclosure Form whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this Disclosure Form, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As), if applicable		
ADDRESS			NPI/UMPI
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER
FEDERAL EMPLOYER ID (FEIN)	TAX ID		

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship	☐ Partnership	☐ Other Partnership (i.e., LP, LLP, LLLP)	☐ Limited Liability Co.
☐ For Profit Corporation	☐ Non-Profit Corporation	☐ Public Corporation	☐ State
☐ Incorporated County	☐ Unincorporated County (You may advance to Section VI for Certification)		☐ Other

IV. Ownership, Control and Management Information

A. Please provide the following information for each **Managing Employee** and **Person or Entity with an Ownership or Control Interest** in your business, and any Sub-Subcontractor in which you have direct or indirect ownership of 5% or more. All applicable fields must be completed. The date of birth and social security number (SSN) are required if a *person's* name is provided, and the federal employer identification (FEIN) number is required if an *entity's* name is provided. A non-profit entity must disclose all required information applicable to the entity. Please review the definitions in Section VII.

No.	Full Legal Name and Title	Address Individuals – list home address Entities – list primary business address, every business location and P.O. Box	Date of Birth	SSN or FEIN	% Ownership Interest, if applicable
1.					
2.					
3.					

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in subsection IV (A) as a spouse, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name and Title	SSN	Name of Person Related To	Related Person's SSN	Relationship
1.					
2.					
3.					

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in a disclosing entity other than that indicated in subsection IV (A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name and Title	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1.					
2.					
3.					

V. Excluded Individuals or Entities

A. Are there any of your employees, Persons or Entities with an Ownership or Control Interest in your business, or any of your Managing Employees, Affiliates, or Agents who are or have ever:

- Been excluded from participation in Medicare, any of the State health care programs, or Federal health care program under sections 1128 and 1128A of the Social Security Act?

☐ Yes ☐ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in California or any other state or jurisdiction since the inception of these programs?

☐ Yes ☐ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

☐ Yes ☐ No

- Entered into a settlement in lieu of conviction involving fraud or abuse of any government program?

☐ Yes ☐ No

- Been debarred, suspended, or otherwise excluded for participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

☐ Yes ☐ No

B. Do you have any agreements for the provision of items or services related to the Alliance's obligations under its contracts with the State or the Centers for Medicare and Medicaid Services (CMS) with an individual or entity who: (i) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in California or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and the social security number (SSN) or federal employer identification number (FEIN) of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in, or exclusion from participation in, Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1.			
2.			
3.			
4.			

VI. Certification

I am authorized to bind the entity named in this document and I certify that the above information is true and correct. I will notify the Alliance of any changes to this information as outlined in Section I.

NAME (print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Return a completed, signed Disclosure Form to the Alliance as follows:

Please print single-sided and fax the completed form to the Alliance Provider Services Department:
Fax: **1.855.891.7257**

You may also mail the form to:
Alameda Alliance for Health
ATTN: Provider Services Department
1240 South Loop Road
Alameda, CA 94502

If you have any questions, please contact the Alliance Provider Services Department:
Phone Number: **1.510.747.4510**
Email: **deptproviderrelations@alamedaalliance.org**

VII. Definitions

For the purpose of this disclosure, the following definitions apply:

1. **Act** means the Social Security Act.

2. **Affiliate** means associated business concerns or individuals if, directly or indirectly:
   A) Either one controls or can control the other; or
   B) A third party controls or can control both.

3. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider or Subcontractor.

4. **Disclosing Entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. For purposes of this Disclosure Form, Disclosing Entity shall also include Provider, Other Disclosing Entity, Subcontractor, and Sub-Subcontractor.

5. **Other Disclosing Entity means** any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

   A) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
   B) Any Medicare intermediary or carrier; and

C) Any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges, for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

6. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider or Subcontractor, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider or Subcontractor, or part thereof.

7. **Person or Entity with an Ownership or Control Interest** means a person or corporation that:
   A) Has an ownership interest, directly or indirectly, totaling 5% or more in the Provider or Subcontractor;
   B) Has a combination of direct and indirect ownership interests equal to 5% or more in the Provider or Subcontractor;
   C) Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider or Subcontractor, if that interest equals at least 5% of the value of the property or assets of the Provider or Subcontractor;
   D) Is an officer or director of Subcontractor or a Provider organized as a corporation (this includes officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
   E) Is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.

8. **Provider** means an individual or entity that: A) is engaged in the delivery of health care services and is legally authorized to do so by the state in which the individual or entity delivers services; and B) has entered into an agreement with the Alliance to provide health care services to Alliance members, including members enrolled through the Alliance's contracts with the State. For purposes of this disclosure, "Provider" also means a vendor providing non-health care services through an agreement with the Alliance to members enrolled through the Alliances' government program contracts with the State, provided those services are significant and material to the Alliance's obligations under the respective government program contract.

9. **State** means the California Department of Health Care Services (DHCS).

10. **Subcontractor** means an individual, agency, or organization that has a contract with the Alliance that relates directly or indirectly to the performance of the Alliance's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the Alliance.

11. **Sub-subcontractor** means:
   A) An individual, agency, or organization to which a Disclosing Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
   B) An individual, agency, or organization with which a fiscal agent or Disclosing Entity has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Provider Demographic Attestation Form

INSTRUCTIONS:

1. Please print clearly.
2. Please return form by fax to Alameda Alliance for Health (Alliance)
   Fax Number: **1.855.891.7257**

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

PROVIDER INFORMATION	
PROVIDER/CLINIC NAME	PROVIDER TAX ID
SITE ADDRESS	
MAIN PHONE NUMBER	FAX NUMBER
HOURS OF OPERATION	
CLINIC EMAIL ADDRESS	
LANGUAGES SPOKEN	ACCEPTING PATIENTS ☐ YES ☐ NO ☐ ONLY EXISTING

PROVIDER NAME	PROVIDER NPI	IS THIS PROVIDER STILL AFFILIATED WITH THIS PRACTICE?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

Date Update Completed *(MM/DD/YYYY)*: _____ / _____ / _____

Notes:

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

C&O Reviewed 04/19

Medical Record Request Reminder

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. We have an important reminder that we would like to share with you.

The Alliance requires the assistance of all our provider partners to respond to medical record requests in a timely manner. When medical records are requested, the participating provider will receive a request indicating the information and/or documentation needed, including the due date. Providers must respond by the due date or reach out to the requestor as soon as the request is received to clarify any questions so that they can be submitted on time.

The Alliance Departments that frequently request medical records are:

- Compliance
- Grievance and Appeals
- Healthcare Analytics (for HEDIS retrievals)
- Quality Improvement
- Utilization Management

Providers who fail to respond within the indicated time frames may violate relevant portions of their Provider Agreement and/or our Provider Manual. If you have questions regarding the information contained in this update, please contact your Provider Relations Representative or the Provider Services Department at **1.510.747.4510**.

Thank you for your continued partnership. We appreciate you for all of your hard work and for providing high-quality care to our members and community. Together, we are creating a healthier community for all.

Important Update on 835 Electronic Remittance Advice (ERA)

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community. We would like to share an important update with you related to ERAs. **The Alliance is now offering to send your 835 ERAs to your Clearing House.**

Why set up 835 ERA?

The electronic remittance advice (835) is formatted in a standard computer language (ANSIx12835/835 format) designed to load directly into the electronic medical record and/or medical software that supports the standard format. ERAs are received quickly and save processing time.

What to do if you are already set up for 835 ERA?

If you are currently set up for 835's and receiving them via SFTP and wish to start retrieving them through your Clearing House instead, please fill out the attached ERA form noting reason as **"Change"** and select the new Clearing House option. (The ERA form must be filled out by the Provider directly and not third-party service providers)

What to do if you would like to newly enroll in 835 ERA?

If you are currently not set up for 835's and wish to start retrieving them from your Clearing House, please fill out the attached ERA form noting **"New"** set up request and select the new Clearing House option. (The ERA form must be filled out by the Provider directly and not third-party service providers)

When are 835 ERA's sent to my Clearing House?

The Alliance check runs take place weekly, on Wednesday, and 835 ERAs are generated weekly on Thursday and sent to our Clearing House SSI-Claimsnet as soon as they are generated. SSI-Claimsnet will then route the 835 ERA to your Clearing House. Please allow adequate processing time before requesting the status of an 835 ERA from the Alliance.

Please Note: 835 ERA's are routed from the Alliance back to the provider following the reverse path of the inbound 837 claim. Please make sure you have filled out the appropriate 835 Set Up forms provided by your Clearing House. If you have enrolled for 835s with the Alliance but are not receiving your 835 files, please open a support ticket with your Clearing House (**the Alliance Claimsnet Payer Tax ID = 95327**).

Thank you for your continued partnership. We appreciate you for all of your hard work and for providing high-quality care to our members and community. Together, we are creating a healthier community for all.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

Electronic Remittance Advice (ERA) Enrollment Form

Thank you for your interest in receiving Electronic Remittance Advice (ERA) from Alameda Alliance for Health (Alliance). The first step in the ERA onboarding process is the completion of the ERA Enrollment Form and Trading Partner Agreement below.

Please complete the forms and mail, fax or email them to:

Alameda Alliance for Health
ATTN: IT Department – EDI Enrollment
1240 South Loop Road
Alameda, CA 94502
Fax: **1.510.747.4290**
Email: **edisupport@alamedaalliance.org**

For any questions, please call the Alliance Electronic Data Interchange Department at **1.510.373.5757**.

PLEASE NOTE: A group (bulk) claim payment remittance advice is performed by Tax Identification Number (TIN) match. ERA testing cannot be initiated until the Alliance has received your completed ERA Enrollment Form and Trading Partner Agreement.

PROVIDER INFORMATION		
Company/Provider Name:		
Doing Business As (DBA) *(Trade name, or fictitious business name, under which the business or operation is conducted and not the legal name of the legal person(s) who own/and are responsible for it)*:		
Tax Identification Number (TIN):		
National Provider Identifier(s) (NPI):		
Group NPI: ☐ Yes ☐ No	Individual NPI: ☐ Yes ☐ No	
Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	

PROVIDER CONTACT INFORMATION	
Name *(Name of a contact in provider office for handling ERA issues)*:	
Phone Number/Ext:	Fax Number:
Email Address:	
Method of Retrieval *(select one)*: ☐ Retrieval from your Clearing House *(Requires Authorization)* ☐ Download from the Alliance Secure File Transfer Protocol site *(Requires Network Form)*	
Reason for Enrollment Submission *(select one)*: ☐ New Enrollment ☐ Change Enrollment ☐ Delete Enrollment	

PROVIDER'S CLEARING HOUSE/AUTHORIZATION
Provider Authorizes Alliance/SSI Claimsnet to Send 835's for TIN (You may supply more than one (1) TIN):
To Clearing House (Name):
As of Date (MM/DD/YYYY):
Please Note: ERAs/835s will be routed from the Alliance back to the provider following the reverse path of the inbound claim/837 file. As a result, if you have enrolled for 835s with the Alliance but are not receiving these files, please open a support ticket with your clearinghouse.

TRADING PARTNER AGREEMENT

(This should be signed by the provider)

This agreement is made between Alameda Alliance for Health ("Plan") and _____

("Trading Partner") as of _____day of _____, 20___. This agreement provides the terms and conditions governing electronic transfers of data between Plan and Trading Partner (collectively "Parties"). Both Parties acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Both Plan and Trading Partner agree to take steps reasonably necessary to ensure that electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan's Electronic Data Interchange (EDI) Enrollment Form, and the then current version of the Plan companion guides. This agreement will remain in effect until terminated according to the terms listed in this agreement. This agreement cannot be altered or amended without a written statement signed by both Parties.

I. Term and Termination

This agreement will remain effective indefinitely beginning on the effective date of this agreement. Either Party may voluntarily terminate this agreement by providing written notice to the other Party thirty (30) days in advance of the termination date. If a Party breaches any material obligation of this agreement, the other Party may terminate this agreement immediately upon providing written notice to the other Party.

II. Obligations of the Parties

1. Each Party will be responsible for and take reasonable care to ensure that the information submitted in each electronic transaction by itself, its employees, or its agents is accurate, complete and truthful.
2. Each Party will take reasonable precautions to limit the disclosure of the electronic data to authorized personnel on a need-to-know basis. Company and Trading Partner will notify the other Party of a termination of its relationship with a previously authorized employee or vendor (i.e., clearinghouse), that may require action to foreclose submission and receipt of transactions by person or vendor no longer authorized to act on its behalf.
3. Parties will not disclose the electronic data to any other person or organization without the express written permission of the subject of the data (i.e., the Plan's member or the Trading Partner's patient/customer) unless such disclosure is permissible by State or Federal law. Plan and Trading Partner will notify the other Party if it becomes aware of any use or disclosure that is not expressly permitted by this agreement.
4. Each Party will treat the information sent and received electronically as proprietary and will not use the information for any purpose or in a manner that would violate any privacy, security, or confidentiality laws or regulations including, but not limited to, the HIPAA law. Each party will put appropriate safeguards in place to protect patient specific data from improper access and will maintain the confidentiality of any security access codes.
5. Both Parties must agree that adequate testing has been completed before "live," production submissions will be transmitted or accepted to or from the other Party.
6. Plan and Trading Partner will not consider the other Party's electronic submission "received" (and will not "date stamp" the transaction) until the file has passed the Plan's initial edits.
7. Each Party will pay its own costs, charges, or fees it may incur as a result of transmitting electronic transactions to, or receiving electronic transactions from, the other Party.
8. Each Party will retain all original source documentation that supports the electronic data submission for at least six years and as required by applicable state and federal laws. Plan and Trading Partner shall have access to the other Party's original source documentation for auditing and verification purposes. Both Parties will research and correct any data discrepancies at its own expense. If a discrepancy is identified in either Party's original source documentation, both Parties agree to implement corrective action that will ensure an accurate and prompt resolution which may include adjusting any incorrect payments identified as a result of such audit. Anyone who misrepresents or falsifies information relating to a claim may, upon conviction, be subject to fines and/or imprisonment under Federal law.
9. Plan and Trading Partner will notify the other Party promptly if any transmitted data is received in an unintelligible or garbled form. Both Parties agree to retransmit the original transmission if a data transmission is lost or indecipherable.
10. Plan agrees to provide an acknowledgement of receipt of the Trading Partner's electronic data submission.

III. Indemnification

Plan and Trading Partner shall hold harmless and indemnify the other Party from any and all claims, liabilities, judgments, damages or judgments asserted against, imposed upon or incurred due to its own negligence, intentional wrongdoing, or violation of this agreement.

IV. Authorized Signature

I am authorized to sign this agreement on behalf of said Trading Partner. I have read and agree to the foregoing provisions and acknowledge the same by signing below.

Alameda Alliance for Health Trading Partner

Signature: _____

(This must be signed by the ultimate Trading Party, not a third party representative.)

Printed Name: _____

Printed Title: _____

Date: _____

Questions? Please contact the Alliance Electronic Data Interchange Department
Monday – Friday, 9 am – 5 pm
Phone Number: **1.510.373.5757**
Email: **edisupport@alamedaalliance.org**
www.alamedaalliance.org

Are you a Candidate for Electronic Remittance Advice (ERA)?

What is ERA?

Alameda Alliance for Health (Alliance) offers both paper remittance advices (RAs), and electronic remittance advices (ERAs) to our contracted providers. ERAs are formatted in a standard computer language (ANSIx12835/835 format). ERAs are designed to load directly into an EMR/medical software that supports the standard 835 format. ERAs are received more quickly, and saves you processing time.

How does ERA work?

The Alliance currently has two (2) options to provide 835s for providers to select from:

1. ERAs are sent to the Trading Partner's Clearing House.
2. A Secure File Transfer Protocol (SFTP) location is set up where Trading Partners can log in to download their files.

Is your practice a candidate for ERA?

In order to receive ERAs, you must meet certain system/software requirements. Please answer following questions to ensure that your practice is a candidate to receive ERA's.

1. Does your EMR/medical software support electronic 835s in-house, and reconcile with submitted claims?

   ☐ **YES** ☐ **NO** *(If **NO**, your practice is **NOT** a candidate for ERA)*

2. Do you receive electronic 835s from other payers?

   ☐ **YES** ☐ **NO**

   If **YES**, how do you process them?

Questions? Please contact the Alliance Electronic Data Interchange Department
Monday – Friday, 9 am – 5 pm
Phone Number: **1.510.373.5757**
Email: **edisupport@alamedaalliance.org**
www.alamedaalliance.org

Important Reminder About Transportation Services

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. We have an important reminder that we would like to share with you.

The Alliance provides transportation benefits to Medi-Cal members for all medically necessary services covered by the Alliance and Medi-Cal.

Routine transportation services can be requested by an Alliance Medi-Cal member or provider. **We require at least three (3) business days in advance notice.** You or an Alliance Medi-Cal member can make a request for transportation by calling our transportation services, toll-free at **1.855.891.7171**.

For further details on coverage for Medi-Cal and Group Care members, please refer to the Evidence of Coverage (EOC) or Member Handbook on our website at **www.alamedaalliance.org**.

Thank you for your continued partnership. We appreciate you for all of your hard work and for providing high-quality care to our members and community. Together, we are creating a healthier community for all.

Please Note: This communication does not apply to Alliance Group Care.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

Physician Certification Form – Request for Transportation

For NEMT only, the physician must sign this form where indicated below. Please print clearly.

Please complete the form and fax it to ModivCare (formerly Logisticare):

ModivCare
ATTN: Utilization Review
Fax Number: **1.877.457.3352**

Fields with a (*) must be completed.

PATIENT INFORMATION	
*Patient Name:	*Patient DOB:
*Patient ID Number/CIN#:	Patient Contact Number:
DIAGNOSIS	
Diagnosis:	ICD Code:

***TRANSPORTATION NEEDS** **(Please check ONLY ONE level of service in either NEMT or NMT section)**	
Non-Emergency Medical Transportation (NEMT) NEMT includes transportation by ambulance, wheelchair, and gurney vans for medically necessary covered services, specifically when the patient is non-ambulatory. Check the applicable level of service needed: ☐ Wheelchair Van ☐ Ambulance/Litter Van/Gurney Van (Patient bed bound) ☐ ALS (Patient requires ALS services/ availability) ☐ CCT/SCT (Patient requires cardiac monitoring) ☐ LS (Patient requires oxygen not self-administered or regulated) ☐ Air Transport	**Non-Medical Transportation (NMT)** NMT includes transportation provided via taxi, car or other public conveyances for medically necessary covered services. *No signature is required for NMT*. Check the applicable level of service needed: ☐ Public Transportation/Mass Transit ☐ East Bay Paratransit ☐ Curb-to-Curb Vehicle Transportation (Taxicab) ☐ Door-to-Door Vehicle Transportation ☐ Private Vehicle arranged by patient* **Additional verification information needed for approval.*

***DURATION** **(Based on medical necessity and continued health plan eligibility)**				
☐ 30 Days	☐ 60 Days	☐ 90 Days	☐ 6 Months	☐ 12 Months

*FUNCTION LIMITATIONS JUSTIFICATION

When transportation is requested for an ongoing basis, the chronic nature of the patient's medical, physical, or mental health condition must be indicated in the treatment plan. A diagnosis alone will not satisfy this requirement. Treatment plan should include the medical, behavioral health, or physical condition that prevents normal public or private transportation. **NMT services do not require physician signature and will be approved based on the least costly method of transportation that meets the member's needs.**

PLEASE INCLUDE YOUR JUSTIFICATION BELOW:

CERTIFICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION

The provider responsible for providing care for the member is responsible for determining the medical necessity for transportation. This certificate can be completed and signed by a MD, DO, PA, or NP, CNM, Physical Therapist, Speech Therapist, Occupational Therapist, or Mental Health or Substance Use Disorder Provider who is employed or supervised by the hospital, facility, or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate, except for requests relating to hospice or home health services, which must be signed by an MD or DO.

Provider Name & Credential (Print):	
Phone Number:	Date:
Provider Signature:	

Questions? Please call Alliance Transportation Services toll-free at **1.855.891.7171**.

Help Your Patients Stay Ready for Public Safety Power Shutoffs

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We would like to share this important update about helping your patients stay ready for the PG&E Public Safety Power Shutoffs program.

The PG&E Public Safety Power Shutoffs PSPS program helps keep our communities safe by reducing the risk of wildfires. PSPS may interrupt electrical service in parts of Alameda County during hot, dry, and windy weather to reduce the risk of its equipment sparking a wildfire. Unplanned power outages may also occur due to weather, fire, or other reasons.

If your patients use power-dependent durable medical equipment, **please encourage them to register for the PG&E Medical Baseline Program today by contacting these resources:**

Call Toll-Free: **1.800.743.5000**
Visit: **https://bit.ly/3sseDhR**

The PG&E Medical Baseline Program is available to PG&E customers at no cost. This program shares additional notifications in advance of a PSPS and may help lower the rate of your patients' monthly energy bill.

During the COVID-19 public health emergency and shelter-in-place requirements, **your patients can self-certify their eligibility to enroll in the Medical Baseline Program.** PG&E is also suspending all program recertifications and customer removals during this time. For more information, please visit: **www.pge.com**

Thank you for the continued partnership and all of your hard work to protect and improve health in our community.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

Blood Lead Screening Requirements

Protecting children from lead exposure is important to a lifetime of good health. Assembly Bill No. 2276 was passed in September 2020, adding more oversight from the State to ensure that young children in the Medi-Cal program are screened for blood lead poisoning.

What's new?
Starting no later than January 2021, managed care plans like the Alliance must identify at least quarterly all child members under the age of six (6) years old who have no record of receiving a blood lead screening test.

The Alliance will be required to notify the providers responsible for the care of the children missing their blood lead screening test of their requirement to test the child and provide anticipatory guidance to the parent or guardian.

Requirements for Providers
Providers must follow current federal and state laws and industry guidelines for health care providers issued by Childhood Lead Poisoning Prevention Branch (CLPPB). CLPPB guidelines can be referenced at **www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx**.

These laws and guidelines include:

- Oral or written anticipatory guidance at *each* periodic health assessment from 6 months to 72 months of age (i.e., 6 years old).
- Blood lead screening test at 12 *and* 24 months of age, catch up testing after 12 months, and testing of any child who is at risk.
- Blood lead screening according to CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

The exceptions are 1) the risk of screening is greater than the risk of lead poisoning, or 2) the parent or guardian refuses to consent to the screening. This reason must be noted in the child's medical record, with a signed statement of voluntary refusal from the parent or guardian.

Documentation
Providers who conduct an in-office blood lead screening test using a capillary or finger prick and a point of care (POC) device, please use the CPT code 83655.

Resources
Patient health education materials
www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/edmatls.aspx

Alameda County Lead Poisoning Prevention Program
www.achhd.org/medicalproviders/hsp.htm

Department of Health Care Services All Plan letter
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf

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Important Update on Member Satisfaction

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction.

Each quarter, the Alliance surveys members to gather information about member experience with health care. All health plans in California are required to maintain procedures to monitor waiting times in providers' offices, telephone calls (to answer and return), and time to obtain various appointment types[1].

About This Survey

Providers: Alliance network providers include primary care providers (PCPs).

Methodology: The Alliance contacts a randomized sample of members who visited their PCP in the past six (6) months. Surveys are first mailed. If we do not receive a response, we will follow up with a phone call. Members are not surveyed more than once a year. Surveys are offered in English, Spanish, Chinese, and Vietnamese.

Questions: The survey questions are based on the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey, with additional questions to help us learn more about provider communication, appointment and office wait times, language access, and overall satisfaction from the member's perspective.

The survey provides a continued opportunity for the Alliance and our providers to receive feedback on ways we are meeting our members' needs and how we can improve.

Additionally, the Alliance surveys members annually through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to obtain feedback on member experience with the Alliance, health care, and their personal doctors. This provides the Alliance with additional opportunities for making improvements that lead to enhanced quality of care for our members.

On the next page, please find a table that outlines the required appointment timeframes.

Thank you for encouraging your patients to participate in these surveys if they are contacted.

Thank you for your continued partnership. We appreciate you for all of your hard work and providing high quality care to our members and community. Together, we are creating a healthier community for all.

[1] DHCS Exhibit A, Attachment 9, 3(C)

ALAMEDA Alliance FOR HEALTH

TIMELY ACCESS STANDARDS*

All Providers contracted with the Alliance are required to offer appointments within the following timeframes:

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service** Provider	15 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Appointment 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.	

***Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines**
PA = Prior Authorization

Urgent Care refers to 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 refers to routine appointments for non-urgent conditions.

Triage or Screening refers to 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.

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www.alamedaalliance.org

Health Homes Program Overview

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. We would like to share this important information about our Health Homes Program (HHP) with you. HHP is a Medi-Cal benefit covered by the Alliance for members who have certain chronic conditions. These services help them get the care they need to stay healthy.

To receive HHP services, your patient must:

- Have Medi-Cal coverage and be enrolled with the Alliance.
- Have certain chronic health conditions (such as asthma, diabetes, kidney or liver disease, heart failure, etc.).
- Have been in the hospital, had visits to the emergency department (ED), or be chronically homeless.

The Interventions Highlight

- People who join HHP are given a care team in the community that may consist of a community health worker supported by a nurse, social worker, or housing navigator.
- The care team helps the Alliance member:
    - Find doctors and get appointments.
    - Coordinate the care they receive from different providers.
    - Understand their prescription drugs.
    - Get follow-up services after they leave the hospital.
    - Connect to community and social services, such as food and housing.

Referrals

Alliance members can self-refer.

You can advise your patient to call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

For more information, please view the Medi-Cal HHP Provider Guide at **www.alamedaalliance.org**.

Thank you for your continued partnership and for providing high-quality care to our members and community. Together, we are creating a healthier community for all.

Questions? Please call the Alliance Provider Services Department
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www.alamedaalliance.org

Preventive Services Guidelines Update – January 2021

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important update we would like to share with you.

At the Alliance, we require that all network and delegated providers follow the most current Preventive Care Guidelines.

For adults ages 21 and older, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) clinical preventive services to adults ages 21 and older. All preventive services identified as USPSTF "A" and "B" recommendations must be provided. For a list, please visit **www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.**

For children and adolescents under 21 years old, Alliance providers are required to follow the Bright Futures/American Academy of Pediatrics periodicity schedule, which can be found at **downloads.aap.org/AAP/PDF/periodicity_schedule.pdf**

We are sharing this update to ensure that our provider community is aware of the most recent changes. Listed below are USPSTF recommendation updates from July to December 2020.

Topic	Description	Grade	Release Date
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	B	November 2020 *
Screening for Hepatitis B Virus Infection in Adolescents and Adults: adolescents and adults at increased risk for infection	The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. See the Practice Considerations section for a description of adolescents and adults at increased risk for infection.	B	December 2020 *

*Previous recommendation was an "A" or "B"

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www.alamedaalliance.org

Alliance Tobacco Provider Guide

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. We have a helpful update that we would like to share with you.

The Alliance has been working to promote tobacco cessation education and referrals with staff, members, and providers. Providers can now access information about tobacco cessation services and other helpful resources on the Alliance website. Check out the Alliance Tobacco Provider Guide at **www.alamedaalliance.org/providers/provider-resources/tobacco-provider-guide**.

Topics covered include:

- Pregnant women
- Resources on vaping
- School-aged children and adolescents
- Tobacco assessment
- Tobacco cessation counseling
- Tobacco cessation medications
- Trainings for providers

Thank you for your continued partnership and for providing high-quality care to our members and community. Together, we are creating a healthier community for all.

Questions? Please call the Alliance Provider Services Department
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www.alamedaalliance.org

Alliance Language Services

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important reminder we would like to share with you.

Alliance Interpreter Services
The Alliance offers interpreter services, including American Sign Language (ASL), for Alliance members who are receiving covered services. This includes administrative communication such as scheduling appointments. Most needs can be met through telephonic services.

To access:

1) On-demand telephonic interpreters are available 24/7. Please have the Alliance member ID number ready and call **1.510.809.3986**. Then enter the corresponding pin and the language you need:
   Beacon Providers – **1003**
   CFMG Providers – **1002**
   CHCN Providers – **1001**
   Other Alliance Providers – **1004**
2) **In-person interpreters** are available for ASL, and sensitive and complex services. Please submit an Alliance Interpreter Services Request Form at least **five (5) business days** in advance.
3) If you need an interpreter for a **language of lesser diffusion**, please consider using the Interpreter Services Request form to pre-schedule an interpreter.

Provider Language Proficiency Required Documentation
Many of our providers and their staff are bilingual and provide essential cultural and linguistic services. Please remember that all Alliance bilingual providers need to keep documentation of bilingual staff's language proficiency. Proficiency includes conversational fluency as well as knowledge of medical terminology for medical staff and non-medical staff.

Informing Patients How To Request Language Services
The Alliance offers a flyer you can post in your office which states: "Point to your language! We will get you an interpreter" in multiple languages. This can assist in identifying the language your patients speak. You can also order "I Speak cards" that members can take to ancillary or specialty appointments to assist in interpreter access. To request these cards, please email Alliance Health Programs at **livehealthy@alamedaalliance.org**.

Written Translation and Alternate Formats For Member Materials
Members can request written member materials in a language or alternate format they need, such as braille or audio tapes.

To request, members can call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

For more information on Alliance Language Services, including the Interpreter Services Guide, the Interpreter Services Request Form, and Point to your Language! flyer, please visit **www.alamedaalliance.org/providers/provider-resources/language-access**.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

ALAMEDA ALLIANCE FOR HEALTH
INTERPRETER SERVICES GUIDE

At Alameda Alliance for Health (Alliance), we are committed to continuously improve our provider and member customer satisfaction. The Alliance provides no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week.

Effective Monday, June 1, 2020, please use this guide to better assist Alliance members with language services. Please confirm your patient's eligibility before requesting services.

TELEPHONIC INTERPRETER SERVICES

Common uses for telephonic interpreter services:

- Routine office and clinic visits.
- Pharmacy services.
- Free standing radiology, mammography, and lab services.
- Allied health services such as physical occupational or respiratory therapy.

To access telephonic interpreters:

1. Please call **1.510.809.3986**, available 24 hours a day and 7 days a week.
2. Provide the nine-digit Alliance member ID number.
3. For communication with a patient who is deaf, hearing or speech impaired, please call the California Relay Service (CRS) at **7-1-1.**

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 diagnosis (Examples: cancer, chemotherapy, transplants, etc.)
- Highly sensitive issues (Examples: sexual assault or end of life)
- Other conditions by exception. Please include your reason in the request.

To request in-person interpreters:

1. You must schedule in-person interpreter services at least **five (5) business days** in advance. For ASL, **five (5) days** is recommended, but not required.
2. Please complete and fax the **Interpreter Services Appointment Request Form** to the Alliance at **1.855.891.9167**. To view and download the form, please visit **www.alamedaalliance.org/providers/provider-forms**.
3. The Alliance will notify providers by fax or phone if for any reason we *cannot* schedule an in-person interpreter.
4. 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**.

PLEASE NOTE:
The Alliance discourages the use of adult family or friends as interpreters. Children should not interpret unless there is a life-threatening emergency and no qualified interpreter is available. If a patient declines interpreter services, please document the refusal in the medical record.

Questions? Please call Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone number: **1. 510.747.4510**

ALAMEDA Alliance FOR HEALTH

QI_PRVDRS_INTERP SVCS GUIDE 06/2020
HED_INTERP SVCS GUIDE 07/2020

Interpreter Services Request Form

At Alameda Alliance for Health (Alliance), we provide no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week. Please confirm your patient's eligibility before requesting services. Please complete this form to request interpreter services.

INSTRUCTIONS

1. Please print clearly, or type in the fields below, and return by fax to **1.855.891.9167**.
2. Forms must be submitted by fax at least **five (5) working days** prior to the appointment date. For ASL, **five (5) working days** is recommended, but not required.

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

SECTION 1: PATIENT INFORMATION

Last Name: _____ First Name: _____

Alliance Member ID #: _____ Date Of Birth (MM/DD/YYYY): _____

Home Phone Number: _____ Cell Phone Number: _____

SECTION 2: INTERPRETER SERVICE TYPE (CHECK ONLY ONE TYPE OF SERVICE)

☐ Telephone Interpreting By Appointment ☐ In-Person Interpreting

☐ Video Interpreting By Appointment *(if available at clinic location)*

Language: _____ Special Requests (optional): _____

SECTION 3: APPOINTMENT DETAILS

For in-person appointments, please include address information.
For prescheduled video or telephonic appointments, please provide call-in information and/or link.

Date (MM/DD/YYYY): _____ Start Time: _____ Duration: _____

Provider Name: _____ Provider Specialty: _____

Address (*include dept./floor/suite*): _____

City: _____ State: _____ Zip Code: _____

Call-In Information/Link: _____

Please complete if requesting an in-person interpreter:

What is the nature of the request?

☐ Complex course of therapy or procedure including life-threatening diagnosis *(Examples: cancer, chemotherapy, transplants, etc.)*

☐ Highly sensitive issues (*Examples: sexual assault/abuse or end-of-life*)

☐ Other condition *(please include justification)*: _____

SECTION 4: REQUESTOR INFORMATION

Name: _____ Email: _____

Phone Number: _____ Fax: _____ Date: _____

Telephonic interpreter services are available for Alliance members at anytime, 24 hours a day, 7 days a week without an appointment at **1.510.809.3986**.

To view and download this form, please visit **www.alamedaalliance.org/providers/provider-forms**.