2025 P4P PROGRAM GUIDELINES

OVERVIEW

The Alameda Alliance for Health (Alliance) 2025 Pay-for-Performance (P4P) program offers performance-based incentive payments for delivered services to in-network Medi-Cal providers. Through this program, contracted primary care providers (PCPs) and PCP Groups are rewarded for superior performance and yearly improvement. The goal of the 2025 P4P program is to improve the quality, performance, and health outcomes of our Medi-Cal and In-Home Supportive Services (IHSS) Group Care members.

PROVIDER ELIGIBILITY AND PARTICIPATION

PCP Groups are defined as solo practitioners or multi-provider practices contracted for primary care services and are categorized as Family Practice, Internal Medicine, or Pediatric. PCP Groups are eligible to participate in the P4P program if they meet the following criteria:

1. Must be in good standing with the Alliance and Medi-Cal at the time of the payment distribution; and
2. Must be directly contracted with the Alliance for at least nine (9) months during the measurement year and through the date of payment.

TIMELINE AND PAYMENT METHODOLOGY

Program Timeline

Measurement Period: January 1, 2025 – December 31, 2025

Payment Date: September 2026

Pool Dollars and Payment Methodology

The total payment pool consists of the Alliance Board-approved budgeted amount. This amount is subject to adjustment depending on the financial performance of the Alliance. The potential dollars for a PCP Group will be based on its percentage of member months compared to the total member months of the Alliance.

MEASURE DOMAINS

The Alliance 2025 P4P program is divided into the following four (4) domains:

1. **Clinical Quality Measures:** Standard Healthcare Effectiveness Data and Information Set® (HEDIS®) process and outcomes measures that are based on the specifications published by the National Committee for Quality Assurance (NCQA).
2. **Other Measures:** Non-HEDIS® measures that focus on utilization and member satisfaction.
3. **Monitoring Measures:** Measures that the Alliance is evaluating to potentially include in future P4P programs.
4. **Health Information Exchange (HIE):** Participation in the Manifest MedEx HIE with continuous data submission throughout the measurement year.

2025 P4P PROGRAM GUIDELINES

BENCHMARKS AND IMPROVEMENT TARGETS

Benchmarks and improvement targets are derived from a combination of several factors, including:

- National performance benchmarks for HEDIS® metrics
- Prior year performance

ADDITIONAL RESOURCES

Please visit the Alliance website at **www.alamedaalliance.org** to access the following additional resources:

- Measure Details
- Manifest MedEx Health Information Exchange (HIE) Participation Benefits
- Program Summary
- Provider Attestation
- Quick Reference Guide for Billing Staff
- Quick Reference Guide for Providers

WE ARE HERE TO HELP

If you have any questions, please call:

Alliance Provider Services Department

Monday – Friday, 7:30 am – 5 pm

Phone Number: **1.510.747.4510**

2025 P4P PROGRAM SUMMARY (FOR AHS)

MEASURES	POINTS	GOAL
Well-Child Visits in the First 15 Months of Life: Six (6) or More Visits	10	100% of points awarded per measure if the NCQA 75th Percentile is met. 75% of points awarded per measure if the NCQA 50th Percentile is met. If below 50th Percentile: 3% increase from prior year = 20% of points 6% increase from prior year = 40% of points A minimum of 15 members is required in the measure eligible population. Members with dual Medi-Cal/Medicare coverage are excluded from HEDIS® measures. *A lower rate is better. Points are earned the same as above, but the rate must be below the NCQA 50th Percentile or decrease from the prior year's rate.
Well-Child Visits for Age 15 Months to 30 Months: Two (2) or More Visits	5	
Child and Adolescent Well-Care Visits	10	
Lead Screening in Children	5	
Breast Cancer Screening	10	
Cervical Cancer Screening	10	
Colorectal Cancer Screening	5	
Glycemic Status Assessment for Patients with Diabetes (>9%)*	5	
Controlling High Blood Pressure (<140/90)	5	
Follow-up After Emergency Department (ED) Visit for Mental Illness – 30 Days	5	
Clinical Quality Measures Total Points:	**70**	

MEASURES	POINTS	GOAL
Initial Health Appointment (IHA)	10	Points awarded based on % increase from prior year rate: 1% increase = 20% of points 2% increase = 40% of points 3% increase = 60% of points 4% increase = 80% of points 5% increase = 100% of points *A minimum of 25 new or re-enrolled members assigned to provider is required to qualify for this measure.
Acute hospital stay discharges which had a follow-up ambulatory visit within seven (7) days post-hospital discharge	10	Points awarded based on % increase from prior year rate: 0.5% increase = 1/3 of the points 1.0% increase = 2/3 of the points 1.5% increase = Full points
Member Satisfaction Survey: Urgent Appointment Availability	5	Full points awarded if 70% of responses indicate member was able to get a urgent appointment within 48 hours (a state requirement). 50% of the points awarded if there is a 3% improvement from prior. A minimum of 10 responses is required.
Member Satisfaction Survey: Non-Urgent Appointment Availability	5	Full points awarded if 80% of responses indicate member was able to get a non-urgent appointment within 10 business days (a state requirement). 50% of the points awarded if there is a 3% improvement from prior. A minimum of 10 responses is required.
Other Measures Total Points:	**30**	
TOTAL	**100**	

2025 P4P PROGRAM SUMMARY (FOR AHS)

<table>
<tr><th colspan="2">Health Information Exchange (HIE)</th></tr>
<tr><th>MEASURES</th><th>MANIFEST MEDEX</th></tr>
<tr><td>Health Information Exchange (HIE) Participation</td><td>Participate in the Manifest MedEx HIE with continuous data submission throughout the measurement year. Payment will be based on MMS at the end of the measurement year using the following payment tiers:
<table>
<tr><th>Member at the end of the Measurement Year</th><th>15-999</th><th>1000-4999</th><th>5000-14999</th><th>15000+</th></tr>
<tr><td>New Participant</td><td>$2,000</td><td>$3,000</td><td>$5,000</td><td>$10,000</td></tr>
<tr><td>Ongoing Participant</td><td>$1,000</td><td>$1,500</td><td>$2,500</td><td>$5,000</td></tr>
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</td></tr>
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2025 P4P PROGRAM QUICK REFERENCE GUIDE FOR PROVIDERS

MEASURE TYPE	MEASURE	DESCRIPTION	DOCUMENTATION
Clinical Quality Measure	**Childhood Immunizations: Combo 10**	Children who turned two (2) during the measurement year and received the following immunizations by their 2nd birthday: • Four (4) DTaP (Diphtheria, Tetanus, Acellular Pertussis) • Three (3) IPV (Polio) • One (1) MMR (Measles, Mumps, Rubella) or history of Measles, Mumps, **and** Rubella • Three (3) HiB (H Influenza Type B) • Three (3) HepB (Hepatitis B) One (1) VZV (Varicella) or History of Chicken Pox • Four (4) PCV (Pneumococcal Conjugate) • One (1) HepA (Hepatitis A) • RV (Rotavirus): 2-dose or 3-dose schedule • Two (2) Influenza – One (1) of the two (2) can be an LAIV vaccination administered on their 2nd birthday	• Based on claims data and California Immunization Registry (CAIR) data. • Document all immunizations in the chart and in CAIR.
Clinical Quality Measure	**Immunizations for Adolescents: Combo 2**	Adolescents who turned 13 during the measurement year and received the following immunizations by their 13th birthday: • One (1) Meningococcal Serogroups A, C, W, Y • One (1) Tdap (Tetanus, Diphtheria, Acellular Pertussis) • Two (2) HPV at least 146 days apart or three • (3) HPV between their 9th and 13th birthday	• Based on claims data and California Immunization Registry (CAIR) data. • Document all immunizations in the chart and in CAIR.
Clinical Quality Measure	**Well-Child Visits in the First 15 Months of Life: Six (6) or More Visits**	Children who turned 15 months old during the measurement year and had six (6) or more well-child visits with a PCP during their first 15 months of life.	Follow the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.
Clinical Quality Measure	**Well-Child Visits for Age 15 Months to 30 Months: Two (2) or More Visits**	Children who turned 30 months old during the measurement year and had two (2) or more well-child visits with a PCP between their 15-month birthday plus one (1) day and their 30-month birthday.	Follow the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.
Clinical Quality Measure	**Child and Adolescent Well-Care Visits**	Members 3-21 years of age who had one (1) or more well-care visits with a PCP or OB/GYN during the measurement year.	Follow the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.

MEASURE TYPE	MEASURE	DESCRIPTION	DOCUMENTATION
Clinical Quality Measure	**Lead Screening in Children**	Children two (2) years of age who had one (1) or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday.	Follow the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.
Clinical Quality Measure	**Developmental Screening in the First Three (3) Years of Life**	Children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday during the measurement year.	The following tools meet the measure criteria and are included in the Bright Futures Recommendations for Preventive Care: • Ages and Stages Questionnaire – 3rd Edition (ASQ-3) • Parents' Evaluation of Developmental Status (PEDS) – Birth to age eight (8) • Parent's Evaluation of Developmental Status – Developmental Milestones (PEDS-DM) • Survey of Well-Being in Young Children (SWYC) Ensure appropriate code is used when screening is conducted.
Clinical Quality Measure	**Breast Cancer Screening**	Women 50-74 years of age who had a mammogram between October 1, 2023 and December 31, 2025.	Based on claims data.
Clinical Quality Measure	**Cervical Cancer Screening**	Women 21-64 years of age who were screened for cervical cancer by one (1) of the following criteria: • Women 21-64 years of age who had cervical cytology performed within the last three (3) years (2023-2025). • Women 30-64 years of age who had human papillomavirus (HPV) testing or cervical cytology/HPV co-testing performed within the last five (5) years (2021-2025) and who were 30 years or older on the date of the test.	• When the screening is completed offsite, obtain the record and results to ensure the medical record is complete. • If the member had a hysterectomy, document the date, type of surgery (TAH, complete), and absence or presence of cervix. • If the date of hysterectomy is unknown, document the year.
Clinical Quality Measure	**Colorectal Cancer Screening**	Members 45-75 years of age who had appropriate screening for colorectal cancer. Qualifying screenings include: • Fecal occult blood test • Stool DNA • Flexible sigmoidoscopy • CT colonography • Colonoscopy	• When the screening is completed offsite, obtain the record and results and document in the member's chart to ensure the medical record is complete. • Document if the member has had a total colectomy at any time during the member's history. • Based on claims data.
Clinical Quality Measure	**Glycemic Status Assessment for Patients with Diabetes**	Members 18-75 years of age with diabetes (type 1 and type 2) whose most recent glycemic status (HbA1c) or glucose management indicator (GMI) test during the measurement year shows poor control (>9%). A lower rate is better.	• Document the HbA1c or GMI test in the measurement year along with the result. Goal is <8.0%. • Repeat labs indicating poor control (>9.0%) later in the measurement year. • When the service is completed off-site, obtain the record and results to ensure the medical record is complete.

MEASURE TYPE	MEASURE	DESCRIPTION	DOCUMENTATION
Clinical Quality Measure	**Controlling High Blood Pressure**	Members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	Use the appropriate CPT II codes to document the lowest systolic and diastolic reading from the visit: • Systolic <130: 3074F • Systolic 130-139: 3075F • Systolic ≥140: 3077F • Diastolic <80: 3078F • Diastolic 80-89: 3079F • Diastolic ≥90: 3080F
Clinical Quality Measure	**Follow-up After Emergency Department (ED) Visit for Mental Illness – 30 Days**	ED Visits for members six (6) years of age and older with a principal diagnosis of mental illness or any diagnosis of intentional self-harm, who had a follow-up visit for mental illness within 30 days.	Based on claims data a member had a follow-up service for mental health within 30 days after the ED Visit.
Other Measure	**Initial Health Appointment (IHA)**	New or re-enrolled members who had one (1) PCP visit or two (2) documented outreach attempts within 120 days of provider assignment.	• Based on claims data. • Visit must be in an outpatient setting – e.g., Office POS • 11, FQHC POS 50. • Visit must be with a provider that is contracted as a PCP or mid-level with the Alliance.
Other Measure	**Acute hospital stay discharges which had a follow-up ambulatory visit within seven (7) days post-hospital discharge**	Members seen by a PCP within seven (7) days after being discharged from an acute hospital stay.	Please ensure timely follow-up with members who have been discharged from an acute hospital stay.
Other Measure	**Member Satisfaction Survey: Urgent Appointment Availability**	Survey responses received during the measurement year that indicate the member was able to schedule an urgent appointment within 48 hours.	Survey question: In the last six (6) months, when you made an appointment either in person or by telephone for urgent care that you needed right away, when was your appointment either in person or by telephone scheduled? a. 0-2 business days b. 3-4 business days c. More than 4 business days
Other Measure	**Member Satisfaction Survey: Non-Urgent Appointment Availability**	Survey responses received during the measurement year that indicate the member was able to schedule a non-urgent appointment within 10 business days.	Survey question: In the last six (6) months, when you made an appointment either in person or by telephone for a check-up or routine care with this provider, when was your appointment either in person or by telephone scheduled? a. 0-10 business days b. More than 10 business days

MEASURE TYPE	MEASURE	DESCRIPTION	DOCUMENTATION
Monitoring Measure	**Avoidable Emergency Department (ED) visits per 1000**	Members who had avoidable ED visits during the measurement year, using the John Hopkins ACG criteria for either "Emergent, primary care treatable" or "Non-emergent" visits.	Based on claims data.
Monitoring Measure	**Depression Screening and Follow-Up for Adolescents and Adults**	Members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • Depression Screening – The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-up on Positive Screening – The percentage of members who received follow-up care within 30 days of a positive depression screening.	Use a standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments: • PHQ-9 • PHQ-2 • Beck Depression Inventory-Fast Screen • Center for Epidemiologic Studies Depression Scale – Revised • Edinburgh Postnatal Depression Scale • PROMIS Depression Ensure appropriate code is used when screening is conducted.
Monitoring Measure	**Non-Utilizers**	Assigned members that did not receive services in the last 12 months but visited a PCP during the measurement year.	Based on claims data. Visit must be in an outpatient setting – e.g., Office POS 11, FQHC POS 50. Visit must be with a provider that is contracted as a PCP or mid-level with the Alliance.
Monitoring Measure	**Topical Fluoride for Children**	Children ages 1-20 who received at least two (2) topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services during the measurement year.	Provide topical fluoride varnish to pediatric members ages 1-5 during routine office visits.

2025 P4P PROGRAM QUICK REFERENCE GUIDE FOR BILLING STAFF

MEASURE TYPE	MEASURE	DESCRIPTION	DOCUMENTATION
Clinical Quality Measure	**Childhood Immunizations: Combo 10**	Children who turned two (2) during the measurement year and received the following immunizations by their 2nd birthday: • Four (4) DTaP (Diphtheria, Tetanus, Acellular Pertussis) • Three (3) IPV (Polio) • One (1) MMR (Measles, Mumps, Rubella) or history of Measles, Mumps, **and** Rubella • Three (3) HiB (H Influenza Type B) • Three (3) HepB (Hepatitis B) • One (1) VZV (Varicella) or History of Chicken Pox • Four (4) PCV (Pneumococcal Conjugate) • One (1) HepA (Hepatitis A) • RV (Rotavirus): 2-dose or 3-dose schedule • Two (2) Influenza - One (1) of the two (2) can be an LAIV vaccination administered on their 2nd birthday	**DTaP CPT:** 90697,90698, 90700, 90723 **IPV CPT:** 90697, 90698, 90713, 90723 **MMR CPT:** 90707, 90710 **History of Measles - ICD-10 Dx:** B05.0 – B05.4, B05.81, B05.89, B05.9 **History of Mumps - ICD-10 Dx:** B26.0 – B26.3, B26.81 – B26.85, B26.89, B26.9 **History of Rubella - ICD-10 Dx:** B06.00- B06.02, B06.09, B06.81, B06.82, B06.89, B06.9 **HiB CPT:** 90644, 90647, 90648, 90697,90698, 90748 **HepB CPT:** 90697,90723, 90740, 90744, 90747, 90748 **History of HepB - ICD-10 Dx:** B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11 **VZV CPT:** 90710, 90716 **History of Chicken Pox - ICD-10 Dx:** B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21-B02.24, B02.29, B02.30-B02.34, B02.39, B02.7, B02.8, B02.9 **PCV CPT:** 90670 **HepA CPT:** 90633 **History of HepA - ICD-10 Dx:** B15.0, B15.9 **RV CPT:** 90681 (2-dose schedule), 90680 (3-dose schedule) **Influenza CPT:** 90756, 90674, 90689, 90687, 90688, 90685, 90686, 90657, 90655, 90673, 90672, 90660 **Influenza LAIV CPT:** 90660, 90672
Clinical Quality Measure	**Immunizations for Adolescents: Combo 2**	Adolescents who turned 13 years of age during the measurement year and received the following immunizations by their 13th birthday: • One (1) Meningococcal Serogroups A, C, W, Y • One (1) Tdap (Tetanus, Diphtheria, Acellular Pertussis) • Two (2) HPV at least 146 days apart or three (3) HPV between their 9th and 13th birthday	**Meningococcal CPT:** 90619, 90733, 90734, 90623 **Tdap CPT:** 90715 **HPV CPT:** 90649, 90650, 90651
Clinical Quality Measure	**Well-Child Visits in the First 15 Months of Life: Six (6) or More Visits**	Children who turned 15 months old during the measurement year and had six (6) or more well-child visits with a PCP during their first 15 months of life.	**CPT:** 99461, 99385, 99384, 99382, 99381, 99383, 99395, 99394, 99392, 99391, 99393 **Or ICD-10 Dx:** Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z76.1, Z76.2, Z02.84
Clinical Quality Measure	**Well-Child Visits for Age 15 Months to 30 Months: Two (2) or More Visits**	Children who turned 30 months old during the measurement year and had two (2) or more well-child visits with a PCP between their 15-month birthday plus one (1) day and their 30-month birthday.	**CPT:** 99461,99385, 99384, 99382, 99381, 99383, 99395, 99394, 99392, 99391, 99393 **Or ICD-10 Dx:** Z00.121, Z00.129, Z00.2, Z76.1, Z76.2
Clinical Quality Measure	**Child and Adolescent Well-Care Visits**	Members 3-21 years of age who had one (1) or more well-care visits with a PCP or OB/GYN during the measurement year.	**CPT:** 99382-99385, 99392-99395 **Or ICD-10 Dx:** Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.2

2025 P4P PROGRAM QUICK REFERENCE GUIDE FOR BILLING STAFF

MEASURE TYPE	MEASURE	DESCRIPTION	DOCUMENTATION
Clinical Quality Measure	**Lead Screening in Children**	Children two (2) years of age who had one (1) or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday.	**CPT:** 83655 **Or LOINC:** Codes submitted by lab
Clinical Quality Measure	**Breast Cancer Screening**	Women 50-74 years of age who had a mammogram between October 1, 2023, and December 31, 2025.	Codes submitted by imaging center.
Clinical Quality Measure	**Cervical Cancer Screening**	Women 21-64 years of age who were screened for cervical cancer by one (1) of the following criteria: • Women 21-64 years of age who had cervical cytology performed within the last three (3) years (2023-2025). • Women 30-64 years of age who had human papillomavirus (HPV) testing or cervical cytology/HPV co-testing performed within the last five (5) years (2021-2025) and who were 30 years or older on the date of the test.	**Cervical Cytology** **CPT:** 88141-88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174, 88175 **Or LOINC:** Codes submitted by lab **HPV Test** **CPT:** 87624, 87625 **Or LOINC:** Codes submitted by lab
Clinical Quality Measure	**Colorectal Cancer Screening**	Members 45-75 years of age who had appropriate screening for colorectal cancer. Qualifying screenings include: • Fecal occult blood test • Stool DNA • Flexible sigmoidoscopy • CT colonography • Colonoscopy	Codes submitted by lab company or specialist.
Clinical Quality Measure	**Glycemic Status Assessment for Patients with Diabetes**	Members 18-75 years of age with diabetes (type 1 and type 2) whose most recent glycemic status (HbA1c) or glucose management indicator (GMI) (>9%). A lower rate is better.	**CPT II:** **HbA1c level <7.0:** 3044F **HbA1c level ≥7.0 and <8.0:** 3051F **HbA1c level ≥8.0 and ≤9.0:** 3052F **HbA1c level >9.0**: 3046F
Clinical Quality Measure	**Follow-up After Emergency Department (ED) Visit for Mental Illness – 30 Days**	ED Visits for members six (6) years of age and older with a principal diagnosis of mental illness or any diagnosis of intentional self-harm, who had a follow-up visit for mental illness within 30 days.	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 99221-99223, 99231-99233, 99238, 99239, 99251-99255 Visit must have a diagnosis of a mental health disorder and must be in an outpatient setting – e.g., Office POS 11, FQHC POS 50
Clinical Quality Measure	**Controlling High Blood Pressure**	Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	**CPT II:** • **Systolic <130:** 3074F • **Systolic 130-139:** 3075F • **Systolic ≥140:** 3077F • **Diastolic <80:** 3078F • **Diastolic 80-89:** 3079F • **Diastolic ≥90:** 3080F

2025 P4P PROGRAM QUICK REFERENCE GUIDE FOR BILLING STAFF

MEASURE TYPE	MEASURE	DESCRIPTION	DOCUMENTATION
Clinical Quality Measure	**Developmental Screening in the First Three (3) Years of Life**	Children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday during the measurement year.	**CPT:** 96110
Other Measure	**Initial Health Appointment (IHA)**	New or re-enrolled members who had one (1) PCP visit or two (2) documented outreach attempts within 120 days of provider assignment.	**Behavioral Health CPT Code:** 96156 **OB/GYN CPT Codes**: 59400, 59425, 59426, 59430, 59510, 59610, 59618 **OB/GYN Z Codes:** Z1000, Z1008, Z1020, Z1032, Z1034, Z1036, Z1038 **PCP CPT Codes:** 99202-99205, 99461, 99211-99215, 99381-99387, 99391-99397 **PCP Z Codes:** Z1000, Z1008, Z1020, Z1032, Z1034, Z1036, Z1038, Z1016, Z00.01, Z00.110, Z00.111, Z00.8, Z02.1, Z02.3, Z02.5 We will accept telehealth visits with a Place of Service Code 02 or Modifier 95. To submit evidence of two outreach attempts or a completed IHA within the last 12 months use CPT code 99080 with ICD-10:Z76.89
Other Measure	**Acute hospital stay discharges which had a follow-up ambulatory visit within seven (7) days post-hospital discharge**	Members seen by a PCP within seven (7) days after being discharged from an acute hospital stay during the measurement year.	**CPT:** 99201-99499, if covered Medi-Cal code Visit must be in an outpatient setting – e.g. Office POS 11, FQHC POS 50. Visit must be with a provider that is contracted as a PCP or mid-level.
Monitoring Measure	**Avoidable Emergency Department (ED) visits per 1000**	Members who had avoidable ED visits during the measurement year, using the John Hopkins ACG criteria for either "Emergent, primary care treatable" or "Non-emergent" visits.	Codes submitted by hospital.
Monitoring Measure	**Depression Screening and Follow-Up for Adolescents and Adults**	Members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care during the measurement year. • Depression Screening – The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-up on Positive Screening – The percentage of members who received follow-up care within 30 days of a positive depression screening.	**Billing Codes for Numerator 1:** Use the specific LOINC code that specifies the assessment used and share the total score from the assessment. • **LOINC:** 89208-3, 89209-1, 89205-9, 90221-3, 90853-3, 71354-5, 48545-8, 48544-1, 55758-7, 44261-6, 89204-2, 71965-8, 71777-7 **Billing Codes for Numerator 2:** • **CPT Codes for Follow-up Visit:** 98960-98968, 99078, 99201-99205, 99211-99215, 92217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99441-99483 • F32.89, F32.9, F33.0–F33.3, F33.42, F33.9, F43.21, F43.23

MEASURE TYPE	MEASURE	DESCRIPTION	DOCUMENTATION
Monitoring Measure	**Non-Utilizers**	Assigned members that did not receive services in the last 12 months but visited a PCP during the measurement year.	**CPT:** 99201-99499, if covered Medi-Cal code • Visit must be in an outpatient setting – e.g., Office POS 11, FQHC POS 50. • Visit must be with a provider that is contracted as a PCP or mid-level.
Monitoring Measure	**Topical Fluoride for Children**	Children ages 1-20 who received at least two (2) topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services during the measurement year.	**CPT Code for 1-5 years of age:** 99188

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MANIFEST MEDEX HEALTH INFORMATION EXCHANGE (HIE) PARTICIPATION BENEFITS

Alameda Alliance for Health (Alliance) has contracted with Manifest MedEx, a Health Information Exchange (HIE), to improve our members' health and wellbeing through the sharing and exchange of data in a secure environment. Participation in the HIE creates new connections, efficiencies, and enables providers to work together to improve health outcomes. The Alliance is encouraging our provider network to participate in Manifest MedEx's HIE to improve care across the continuum and take advantage of participation benefits.

BENEFITS OF PARTICIPATING WITH MANIFEST

- Entities that participate can receive utilization data for their eligible/assigned members from all entities that participate in the HIE.
- Providers can receive real-time ADT notifications and access to medical records that include discharge summaries, clinical notes, and lab reports from hospitals that participate in the HIE.
- Participation with Manifest will meet the California Data Exchange Framework (DxF requirements under AB133.
- No cost for ambulatory providers.
- Eliminates the need for providers to submit custom electronic medical record (EMR) extracts to the Alliance for Healthcare Effectiveness Data and Information Set (HEDIS®).
- Fewer individual medical record requests from the Alliance for HEDIS®.
- Manifest MedEx has experience working with over 90 Electronic EMR systems including OCHIN Epic, Epic, eClinicalWorks, NextGen, etc.
- Providers can identify high-risk patients, reduce readmissions, and proactively monitor and support their patients by using Manifest MedEx's MX Notify and MX Access tools:
    - Receive real-time hospital event notifications and immediate follow-up without spending time on faxes and calls
    - Optimize care with easy access to comprehensive patient history drawn from claims and clinical data
    - Streamline HCC/RAF follow-up with a complete list of diagnoses and accurate data
    - Identify and close gaps in care
- Manifest MedEx is only focused on the California market and is based in Alameda County.
- Manifest MedEx participates in eHealth Exchange and is connected to the Carequality Framework.
- Manifest MedEx is the only data aggregator in California with NCQA-validated data, providing health plans access to standard supplemental data for HEDIS®.
- Manifest MedEx is HiTrust certified.

MANIFEST MEDEX HEALTH INFORMATION EXCHANGE (HIE) PARTICIPATION BENEFITS

OVERVIEW OF MANIFEST MEDEX

As the largest nonprofit health data network in California, Manifest MedEx is an integral part of the state's health data infrastructure, combining and delivering crucial health information for more than 38 million Californians across every county throughout the state. Manifest MedEx has been designated as a Qualified Health Information Organization (QHIO) under the California Health and Human Services (CalHHS) Data Exchange Framework (DxF).

Current participants in the Manifest MedEx HIE:

- Over 3,100 California healthcare organizations
- Over 2,500 ambulatory providers
- 1.8 million admissions, discharge, and transfer (ADT) feeds shared per month
- 160 hospitals
- 17 California health plans including, Anthem Blue Cross, Blue Shield of California, Health Net, and Aetna

The Alliance is working with Manifest MedEx to onboard additional providers in the Alliance provider network.

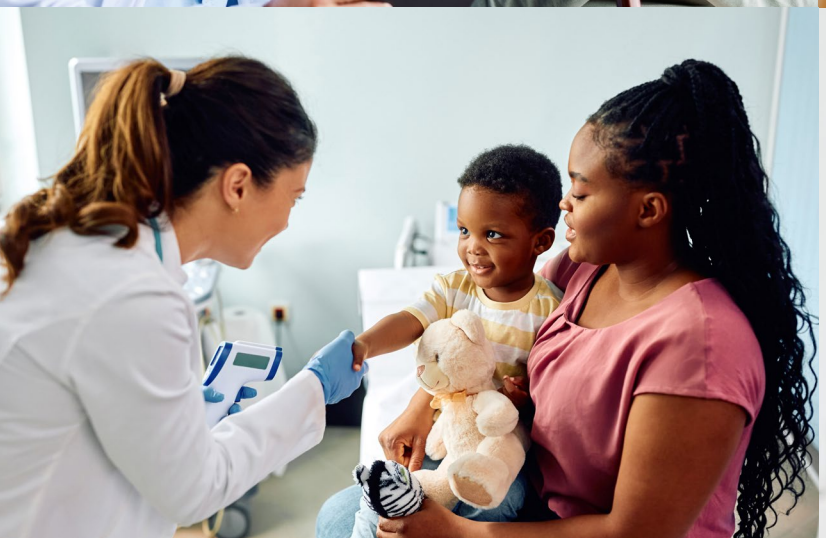
NEXT STEPS

If you want to participate or learn more about Manifest MedEx, please email the Alliance Performance and Analytics Department at **hedis@alamedaalliance.org**.

If you have any questions, please call:
Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

PAY-FOR-PERFORMANCE (P4P) PROGRAM MEASURE DETAILS



ALAMEDA Alliance FOR HEALTH

2025

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P4P PROGRAM OVERVIEW

This guide provides measure details on the Alameda Alliance for Health (Alliance) 2025 Pay-for-Performance (P4P) program.

The Alliance P4P program offers performance-based incentive payments for delivered services to in-network Medi-Cal providers. Through this program, contracted primary care providers (PCPs) and PCP Groups are rewarded for superior performance and yearly improvement. This handout is designed as a comprehensive reference for providers and their staff to understand the Alliance 2025 P4P Program.

WE ARE HERE TO HELP

If you have any questions, please call:

Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**

CLINICAL QUALITY MEASURES

Measures included in the Clinical Quality domain are HEDIS® or Core Measures that are based on the specifications published by NCQA or CMS.

CHILDHOOD IMMUNIZATIONS: COMBO 10 (CIS-10)

Methodology: HEDIS®

Measure Description: Measures the percentage of children who turned the age of two (2) in the measurement year and received the following immunizations by their 2nd birthday:

- Four (4) DTaP (Diphtheria, Tetanus, Acellular Pertussis)
- Three (3) IPV (Polio)
- One (1) MMR (Measles, Mumps, Rubella)
- Three (3) HiB (H Influenza Type B)
- Three (3) HepB (Hepatitis B)
- One (1) VZV (Varicella) or History of Chicken Pox
- Four (4) PCV (Pneumococcal Conjugate)
- One (1) HepA (Hepatitis A)
- RV (Rotavirus): 2-dose or 3-dose schedule
- Two (2) Influenza: One (1) of the two (2) can be an LAIV vaccination administered on their 2nd birthday

Denominator: Children who turned two (2) years of age during the measurement year.

Numerator: Members in the denominator who show timely completion of all vaccines by their 2nd birthday.

Billing Codes:

CRITERIA	CODES
DTaP CPT	90697,90698, 90700, 90723
IPV CP	90697, 90698, 90713, 90723
MMR CPT	90707, 90710
History of Measles - ICD-10 Dx	B05.0 – B05.4, B05.81, B05.89, B05.9
History of Mumps - ICD-10 Dx	B26.0 – B26.3, B26.81 – B26.85, B26.89, B26.9
History of Rubella - ICD-10 Dx	B06.00- B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
HiB CPT	90644, 90647, 90648, 90697,90698, 90748
HepB CPT	90697,90723, 90740, 90744, 90747, 90748
History of HepB - ICD-10 Dx	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
VZV CPT	90710, 90716

CRITERIA	CODES
History of Chicken Pox - ICD-10 Dx	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21-B02.24, B02.29, B02.30-B02.34, B02.39, B02.7, B02.8, B02.9
PCV CPT:	90670
HepA CPT:	90633
History of HepA - ICD-10 Dx:	B15.0, B15.9
RV CPT:	90681 (2-dose schedule), 90680 (3-dose schedule)
Influenza CPT:	90756, 90674, 90689, 90687, 90688, 90685, 90686, 9065, 90655, 90673, 90672, 90660
Influenza LAIV CPT:	90660, 90672

IMMUNIZATIONS FOR ADOLESCENTS: COMBO 2 (IMA-2)

Methodology: HEDIS®

Measure Description: Measures the percentage of adolescents who turned the age of 13 during the measurement year and received the following immunizations by their 13th birthday:

- One (1) Meningococcal Serogroups A, C, W, Y
- One (1) Tdap (Tetanus, Diphtheria, Acellular Pertussis)
- Two (2) HPV at least 146 days apart or three (3) HPV between their 9th and 13th birthday

Denominator: Children who turned 13 years of age during the measurement year.

Numerator: Members in the denominator who show timely completion of all vaccines by their 13th birthday.

Billing Codes:

CRITERIA	CODES
Meningococcal CPT	90619, 90733, 90734, 90623
Tdap CPT	90715
HPV CPT	90649, 90650, 90651

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE: SIX (6) OR MORE VISITS (W30 6+)

Methodology: HEDIS®

Measure Description: Measures the percentage of children who turned 15 months old during the measurement year and had six (6) or more well-child visits with a PCP during their first 15 months of life.

Denominator: Members who turned 15 months old during the measurement year.

Numerator: Members who received six (6) or more well-child visits on or before their 15th month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Billing Codes:

CRITERIA	CODES
CPT Codes	99461,99385, 99384, 99382, 99381, 99383, 99395, 99394, 99392, 99391, 99393
Or ICD-10 Dx	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z76.1, Z76.2, Z02.84

WELL-CHILD VISITS FOR AGE 15 MONTHS TO 30 MONTHS: TWO (2) OR MORE VISITS (W30 2+)

Methodology: HEDIS®

Measure Description: Measures the percentage of children who turned 30 months old during the measurement year and had two (2) or more well-child visits with a PCP between their 15-month birthday plus one (1) day and their 30-month birthday.

Denominator: Members who turned 30 months old during the measurement year.

Numerator: Members in the denominator who received two (2) or more well-child visits between the child's 15 month plus one (1) day and 30 months of life. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Billing Codes:

CRITERIA	CODES
CPT Codes	99461,99385, 99384, 99382, 99381, 99383, 99395, 99394, 99392, 99391, 99393
Or ICD-10 Dx	Z00.121, Z00.129, Z00.2, Z76.1, Z76.2

CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

Methodology: HEDIS®

Measure Description: Measures the percentage of members 3-21 years of age who had one (1) or more well-care visits with a PCP or OB/GYN during the measurement year.

Denominator: Members who turned 3-21 years old in during the measurement year.

Numerator: Members in the denominator who had one (1) or more well-care visits with a PCP or an OB/GYN during the measurement year.

Billing Codes:

CRITERIA	CODES
CPT Codes	99382-99385, 99392-99395
Or ICD-10 Dx	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.2

CLINICAL QUALITY MEASURES

LEAD SCREENING IN CHILDREN (LSC)

Methodology: HEDIS®

Measure Description: Measures the percentage of children two (2) years of age who had one (1) or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday.

Denominator: Children who turn two (2) during the measurement year.

Numerator: Members in the denominator who had at least one (1) lead capillary or venous blood test on or before their 2nd birthday.

Billing Codes:

CRITERIA	CODES
CPT Code	83655
Or LOINC	Codes submitted by lab

BREAST CANCER SCREENING (BCS-E)

Methodology: HEDIS®

Measure Description: Measures the percentage of women 50-74 years of age who had a mammogram between October 1, 2023 - December 31, 2025.

Denominator: Women 52-74 years of age.

Numerator: Members in the denominator who had one (1) or more mammograms any time on or between October 1, two (2) years prior to the measurement year (2023), and December 31st of the measurement year (2025).

Billing Codes: Codes submitted by imaging center

CERVICAL CANCER SCREENING (CCS)

Methodology: HEDIS®

Measure Description: Measures the percentage of women 21-64 years of age who were screened for cervical cancer by one (1) of the following criteria:

- Women 21-64 years of age who had a cervical cytology performed within the last three (3) years (2023-2025).
- Women 30-64 years of age who had human papillomavirus (HPV) testing or cervical cytology/HPV co-testing performed within the last five (5) years (2021-2025) and who were 30 years or older on the date of the test.

Denominator: Women 24-64 years of age.

Numerator: Women in the denominator who received a timely screening for cervical cancer.

Billing Codes:

CRITERIA	CODES
Cervical Cytology CPT Codes	88141-88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174, 88175
Or LOINC	Codes submitted by lab
HPV Test CPT Codes	87624, 87625
Or LOINC	Codes submitted by lab

COLORECTAL CANCER SCREENING (COL-E)

Methodology: HEDIS®

Measure Description: Measures the percentage of adult members 45-75 years of age who had appropriate screening for colorectal cancer.

Qualifying screenings include:

- Fecal occult blood test
- Stool DNA
- Flexible sigmoidoscopy
- CT colonography
- Colonoscopy

Denominator: Members 45-75 years of age.

Numerator: Members in the denominator who had one (1) or more screenings for colorectal cancer.

Any of the following meet criteria:

- Fecal occult blood test during the measurement year (2025).
- Flexible sigmoidoscopy during the measurement year (2024) or four (4) years prior to the measurement year (2021).
- Colonoscopy during the measurement year (2025) or the nine (9) years prior to the measurement year (2016).
- CT colonography during the measurement year (2025) or the four (4) years prior to the measurement year (2021).
- Stool DNA with FIT test during the measurement year (2025) or two (2) years prior to the measurement year (2023).

Billing Codes: Codes submitted by lab company or specialist

CLINICAL QUALITY MEASURES

GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)

Methodology: HEDIS®

Measure Description: Measures the percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent glycemic status (HbA1c) or glucose management indicator (GMI) test uring the measurement year shows poor control (>9%). A lower rate is better.

Denominator: Members 18-75 years of age.

Numerator: Members in the denominator who had the most recent HbA1c or GMI >9% during the measurement year.

Billing Codes:

CPT II	CODES
HbA1c level <7.0	3044F
HbA1c level ≥7.0 and <8.0	3051F
HbA1c level ≥8.0 and ≤9.0	3052F
HbA1c level >9.0	3046F

DEVELOPMENTAL SCREENING IN THE FIRST THREE (3) YEARS OF LIFE (DEV)

Methodology: CMS Child Core Set

Measure Description: Measures the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday in the measurement year.

Denominator: Children who turn ages 1, 2, or 3 by December 31st, of the measurement year.

Numerator: Children who were screened for risk of developmental, behavioral, and social delays on or before the child's first, second, or third birthday. Examples of developmental screening tools include but are not limited to:

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS)
- Parents' Evaluation of Developmental Status – Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC)

Billing Codes:

CRITERIA	CODES
CPT Code	96110

CLINICAL QUALITY MEASURES

CONTROLLING HIGH BLOOD PRESSURE (CBP)

Methodology: HEDIS®

Measure Description: Measures the percentage of members 18-85 years of age who have a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg).

Denominator: Members 18-85 years of age who have been diagnosed with HTN.

Numerator: Member in the denominator who had a BP reading taken during the measurement year. The most recent BP of the measurement year will be used to determine compliance with this measure.

Billing Codes:

CPT II	CODES
Systolic <130	3074F
Systolic 130-139	3075F
Systolic ≥140	3077F
Diastolic <80	3078F
Diastolic 80-89	3079F
Diastolic ≥90	3080F

FOLLOW-UP AFTER ED VISIT FOR MENTAL ILLNESS (FUM) – 30 DAYS

Methodology: HEDIS®

Measure Description: Measures the percentage of ED Visits for members six (6) years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days.

Denominator: Members six (6) years of age and older who had an ED visit with a principal diagnosis of mental illness or intentional self-harm.

Numerator: Members in the denominator with a follow-up service for mental health within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

Billing Codes:

CRITERIA	CODES
CPT Codes	90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 99221-99223, 99231-99233, 99238, 99239, 99251-99255 • Visit must have a diagnosis of a mental health disorder and must be in an outpatient setting – e.g., Office POS 11, FQHC POS 50

OTHER MEASURES

Measures included in the Other Measure domain are non-HEDIS® measures that focus on utilization and member satisfaction.

INITIAL HEALTH APPOINTMENT (IHA)

Methodology: Alliance-defined measure

Measure Description: Measures the percentage of new or re-enrolled members who had one (1) PCP visit or two (2) documented outreach attempts within 120 days of provider assignment.

Denominator: New or re-enrolled members assigned to PCP Group during the measurement year.

Numerator: Members in the denominator who had one (1) PCP visit or two (2) documented outreach attempts within 120 days of provider assignment.

Billing Codes:

CRITERIA	CODES
Behavioral Health CPT Code	96156
OB/GYN CPT Codes	59400, 59425, 59426, 59430, 59510, 59610, 59618
OB/GYN Z Codes	Z1000, Z1008, Z1020, Z1032, Z1034, Z1036, Z1038
PCP CPT Codes	99202-99205, 99461, 99211-99215, 99381-99387, 99391-99397
PCP Z Codes	Z1000, Z1008, Z1020, Z1032, Z1034, Z1036, Z1038, Z1016, Z00.01, Z00.110, Z00.111, Z00.8, Z02.1, Z02.3, Z02.5

We will accept telehealth visits with a Place of Service Code 02 or Modifier 95.

To submit evidence of two outreach attempts or a completed IHA within the last 12 months use CPT code 99080 with ICD-10:Z76.89

MEMBER SATISFACTION SURVEY: URGENT APPOINTMENT AVAILABILITY

Methodology: CG-CAHPS

Measure Description: On a quarterly basis, members who have had a visit with a PCP are randomly selected for a satisfaction survey. This measure calculates the percentage of survey responses received during the measurement year that indicate the member was able to schedule an urgent appointment within 48 hours.

The survey question reads:

"In the last six (6) months, when you made an appointment either in person or by telephone for urgent care that you needed right away, when was your appointment either in person or by telephone scheduled?"

a. 0-2 business days

b. 3-4 business days

c. More than 4 business days

OTHER MEASURES

MEMBER SATISFACTION SURVEY: NON-URGENT APPOINTMENT AVAILABILITY

Methodology: CG-CAHPS

Measure Description: On a quarterly basis, members who have had a visit with a PCP are randomly selected for a satisfaction survey. This measure calculates the percentage of survey responses received during the measurement year that indicate the member was able to schedule a non-urgent appointment within 10 business days.

The survey question reads:

"In the last six (6) months, when you made an appointment either in person or by telephone for a check-up or routine care with this provider, when was your appointment either in person or by telephone scheduled?"

a. 0-10 business days

b. More than 10 business days

ACUTE HOSPITAL STAY DISCHARGES WHICH HAD A FOLLOW-UP AMBULATORY VISIT WITHIN SEVEN (7) DAYS POST-HOSPITAL DISCHARGE

Methodology: HEDIS®

Measure Description: Measures the percentage of members seen by a PCP within seven (7) days after being discharged from an acute hospital stay.

Denominator: The number of live discharges from acute care hospitals among enrolled Alliance members during the measurement period.

Numerator: The number of acute care hospital live discharges among enrolled Alliance members during the measurement year with an ambulatory visit within seven (7) days post hospital discharge.

Billing Codes:

CRITERIA	CODES
CPT Codes	99201-99499, if covered Medi-Cal code • Visit must be in an outpatient setting – e.g., Office POS 11, FQHC POS 50. • Visit must be with a provider that is contracted as a PCP or mid-level.

MONITORING MEASURES

Measures included in the Monitoring Measures domain include HEDIS® and non-HEDIS® measures that the Alliance is evaluating to potentially include in future P4P programs.

AVOIDABLE EMERGENCY DEPARTMENT (ED) VISITS PER 1,000

Methodology: Alliance-defined measure

Measure Description: Measures the percentage of members who had an avoidable ED visit, using the Johns Hopkins ACG criteria for either "Emergent, primary care treatable" or "Non-emergent" visits during the measurement year.

Denominator: Claims received for members with an ED visit during the measurement year.

Numerator: Claims received for members whose ED visit meets the Johns Hopkins ACG criteria for either "Emergent, primary care treatable" or "Non-emergent" visit.

Billing Codes: Codes submitted by the ED.

DEPRESSION SCREENING AND FOLLOW-UP FOR ADOLESCENTS AND ADULTS (DSF-E)

Methodology: HEDIS®

Measure Description: Members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

- Depression Screening – The percentage of members who were screened for clinical depression using a standardized instrument.
- Follow-Up on Positive Screening – The percentage of members who received follow-up care within 30 days of a positive depression screening.

Denominator: Members 12 years of age or older at the start of the measurement year.

Numerator 1: Depression screened members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period.

Numerator 2: Follow-up on positive screened members who received follow-up care on or up to 30 days after the date of the first positive screening (31 total days).

Billing Codes for Numerator 2:

CRITERIA	CODES
CPT Codes for Follow-up Visit	98960-98968, 99078, 99201-99205, 99211-99215, 92217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99441-9948
ICD-10 Codes	F01.51, F32.0–F32.5, F32.81, F32.89, F32.9, F33.0–F33.3, F33.42, F33.9, F43.21, F43.23

NON-UTILIZERS

Methodology: The Alliance

Measure Description: Assigned members that did not receive services in the last 12 months but visited a PCP during the measurement year.

Denominator: Assigned members who have not received any services in the last 12 months.

Numerator: Assigned members identified in the denominator who receive a PCP visit in the measurement year.

Billing Code:

CRITERIA	CODES
CPT Codes	99201-99499, if covered Medi-Cal code • Visit must be in an outpatient setting – e.g., Office POS 11, FQHC POS 50. • Visit must be with a provider that is contracted as a PCP or mid-level.

TOPICAL FLUORIDE FOR CHILDREN (TFL-CH)

Methodology: Dental Quality Alliance

Measure Description: Children ages 1-20 who received at least two (2) topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services during the measurement year.

Denominator: Children 1-20 years of age.

Numerator: Children who received at least two (2) topical fluoride applications.

Billing Code:

CRITERIA	CODES
CPT Code for 1-5 years of age	99188

2025 P4P PROGRAM PROVIDER ATTESTATION

By signing below, I _____
Print Full Name

attest that I have received the following materials as they relate to the Alameda Alliance for Health (Alliance) Pay-for-Performance (P4P) Program for measurement year 2025:

- Measure Details
- Manifest MedEx Health Information Exchange (HIE) Participation Benefits
- Program Guidelines
- Program Summary
- Quick Reference Guide for Billing Staff
- Quick Reference Guide for Providers

I also attest that I have received information on whom to contact with any questions or if further assistance is needed.

Provider/Group Name (Print): _____

Signature of Person Attesting: _____

Date: _____

If you have any questions, please call:
Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

ALAMEDA Alliance FOR HEALTH