ALAMEDA ALLIANCE FOR HEALTH
Long-Term Care Services for Medi-Cal Members
Provider FAQs

Overview

Effective Sunday, January 1, 2023, Alameda Alliance for Health (Alliance) will be responsible for covering long-term care (LTC) services for Medi-Cal members. Previously, LTC was carved out to the California Department of Health Care Services (DHCS), and the Alliance was responsible for the covering the month of and month after LTC services began, before the member was disenrolled to fee-for-service (FFS) Medi-Cal for coverage from DHCS.

Long-term care includes skilled nursing facilities (SNF) that offer custodial care, and Intermittent Care Facilities (ICF).

The Alliance will contract with facilities directly that will offer LTC.

Q: What is the effective date of this change?

A: Sunday, January 1, 2023.

Q: Who determines eligibility for Medi-Cal members?

A: The Alliance does not determine Medi-Cal eligibility. Medi-Cal eligibility and assignment to the Alliance are determined by the California Department of Social Services.

Q: What if I have questions about a member's eligibility?

A: It is important to check eligibility each time a member is accessing services. Eligibility can change from month to month.

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

1. For members who are Medi-Cal beneficiaries, please call:
   Automated Eligibility Verification System (AEVS)
   Toll-Free: **1.800.456.2387**
   www.medi-cal.ca.gov/Eligibility/Login.asp
2. Alliance Automated Eligibility Verification Line (available 24 hours a day, 7 days a week, please have your NPI or TAX ID number ready):
   Phone Number: **1.510.747.4505**
3. Alliance Provider Portal:
   Accessed through **www.alamedaalliance.org**
4. Please call us:
   Alliance Provider Services Department
   Monday – Friday, 7:30 am – 5 pm
   Phone Number: **1.510.747.4510**

Q: Do LTC services require authorization?

A: Yes, the Alliance requires authorization for LTC. Providers should request authorization for all LTC services.

Q: Do I continue to use a DHCS Treatment Authorization Request (TAR) Form?

A: No. The Alliance request for authorization form will replace the DHCS TAR 20-1 form. The Alliance form will be available before Sunday, January 1, 2023.

Q: When the LTC carve-in takes place in January, will my patients have to change facilities if their nursing home is not in the Alliance Network?

A: No. A beneficiary who is a long-term resident of a nursing facility prior to enrollment with the Alliance will not be required to change nursing facilities if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility and the Alliance agree to appropriate rates. The facility can contact us for more questions.

Q: When members are transitioned back to the Alliance, will their existing DHCS TARs be honored?

A: Yes. For nursing facilities with residents who are assigned to the Alliance, existing approved DHCS TARs will be honored for the duration of time in which the services are deemed medically necessary or for a period of 6-12 months.

Q: What nursing facility services will be authorized?

A: The Alliance authorizes nursing facility services for members when medically necessary. Applicable levels of care are maintained and consistent with policies established by the Centers for Medicare and Medicaid Services (CMS) and with the criteria for authorizing Medi-Cal services specified in Title 22 CCR §51003.

Q: When should we submit a nursing facility authorization and reauthorization request?

A: The request for authorization or reauthorization can be submitted when:

- An Alliance member is a new admission to the nursing facility.
- The member has exhausted Medicare benefits and will remain in the nursing facility for continued skilled care.
- Medicare benefits have been denied.
- The member has been readmitted from an acute care hospital and (did not return on day number eight (8)).
- The member has returned from an approved leave of absence, but the return date is beyond the approved time period allowed.
- A resident becomes an Alliance member while residing in the facility, as either a new Medi-Cal beneficiary or an existing Medi-Cal beneficiary, whose county of eligibility has changed (from another county to Alameda County and is an Alliance member).

Q: How long are authorizations valid?

A: Authorizations and reauthorizations for long-term care admissions are valid for up to two (2) years. Authorization numbers should be retained and submitted on the nursing facility's claims.

Q: When should the request for authorization and documentation be submitted?

A: The request should be sent to the Alliance within 24 hours of the member's admission. Nursing facilities are responsible for notifying the LTC nurse specialist if the 21-day limit expires.

Q: What happens if the request for authorization is not sent on time?

A: If the request for authorization is not submitted to the Alliance LTC team within 21 calendar days of the admission, the nursing facility is subject to denial or reduction of payment for days beyond the 21st day of admission.

Q: How will we be notified of the decision?

A: The Alliance LTC nurse specialist will notify the facility of the authorization decision within the regulatory requirement time in Alliance policies. If the member meets admission criteria, the LTC nurse specialist will contact the nursing facility with the assigned authorization number. If the member does not meet the admission criteria, the nursing facility will receive a denial notification and will not be paid from the date of admission.

Q: When should a reauthorization request be submitted?

A: A reauthorization request must be submitted to the Alliance prior to the expiration date of the active authorization (and up to 60 days prior to the active authorization expiration date.) Nursing facilities are responsible for notifying the LTC team before the authorization expires. If the request for reauthorization is not submitted to the Alliance prior to the expiration, the nursing facility is subject to denial or reduction of payment for days beyond the expiration date.

Q: When will the provider be notified of the authorization decision?

A: The same Medi-Cal timeframes apply.

Prior Authorization Request – Determination Turnaround Times	
Non-Urgent Requests	Within five (5) business days of receipt.
Urgent Requests	Within 72 hours of receipt.
Urgent Concurrent Decisions	Within 24 hours of notification, if clinical is available; 72 hours if clinical is requested.

Q: What if a member needs to be transitioned to skilled care?

A: If an LTC resident has a change in health status and requires skilled care services, the nursing facility must notify the assigned LTC nurse specialist of the transition of care within 24 hours or by the next business day. Nursing facilities must not withhold medically necessary services pending the Alliance authorization when the services are requested by a designated physician, or health care professional in lieu of emergency room transfers or acute care admissions. The Alliance or its delegate will provide post-service authorization for medically necessary services provided to members.

Q: Are bed holds and leaves of absence covered?

A: The Alliance provides, as a covered benefit, any bed holds or leaves of absence that a nursing facility provides in accordance with the requirements of Title 22 California Code of Regulations, §72520.

Q: How are claims submitted?

A: LTC providers rendering services to Alliance members must follow Medi-Cal rules and regulations for billing.

Claims may be submitted by mail or electronically:

Mail

Alameda Alliance for Health
P.O. Box 2460
Alameda, CA 94501-0460

Electronic Claims Submission and Payment:

- To submit a claim electronically, you can enroll in Electronic Data Interface (EDI).
- To receive payment electronically, you can enroll in Electronic Funds Transfer (EFT).
- To receive remittance advice statements electronically, you can enroll in Electronic Funds Transfer (EFT).

To obtain and complete the enrollment forms, please visit our website at **www.alamedaalliance.org/providers/provider-forms**.

Q: What is the process for submitting claims?

A: Long-term care providers rendering services to Alliance members must submit claims using the Institutional Provider Claim Form (UB-04). When submitting a claim, please be sure to include all required data elements in order to assure timely payment. To be processed, ensure the services on the claim match the services on the authorization. An initial claim submission must occur within six (6) months from the date of service. Providers should follow all Medicare and/or Medi-Cal rules for billing.

Q: How can I obtain a claims form?

A: A copy of the UB-04 with instructions may be downloaded from the CMS website at **www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf**

Q: Where can I find additional information regarding claims?

A: For additional information, please refer to our website at **www.alamedaalliance.org/providers/billing**.

Q: Who is responsible for Medicare co-insurance and deductibles?

A: The Alliance covers nursing facility Medicare co-insurance and deductibles and does not require members to pay co-insurance or deductibles for nursing facility services.

Q: When are claims paid?

A: The Alliance pays claims in accordance with regulatory timeliness guidelines, all clean claims will be processed within 45 working days from receipt.

Q: Will we be notified of the claim determination?

A: You can access a remittance advice statement through the Alliance Provider Portal. To sign up or log in, please visit **www.alamedaalliance.org** and select, **PROVIDER PORTAL** in the top right corner of the website.

For instructions on how to use the Alliance Provider Portal, please refer to the Provider Portal Instructions Guide on the home page of the Alliance Provider Portal.

Q: What if you need additional information to process the claim?

A: If your claim is submitted with incomplete information, or if the Alliance requires additional information, we will deny the claim and the provider will need to resubmit the claim. Upon receipt of the additional information, we will pay, deny, or adjust the claim from the date the additional information was received in order to review and process your claim. Interest will be paid on all late claims as mandated by State law.

Q: What if we do not agree with the claim determination?

A: If the nursing facility does not agree with a claim determination, the nursing facility may file a provider dispute resolution (PDR) request.

This can be completed by:

1. Electronically through the Alliance Provider Portal
2. Completing and mailing the Provider Dispute Resolution (PDR) Form. The form can be found on our website at **www.alamedaalliance.org/providers/provider-forms**

All disputes must be submitted within 365 days from the last dated action by the plan, usually, the Remittance Advice date, and will be resolved within 45 business days from the date of receipt.

Q: When can we expect claim payment?

A: The Alliance is required to reimburse institutional providers in accordance with the prompt payment provisions provided by DHCS, including the ability to accept and pay electronic claims.

Q: What should we do if we suspect fraud or waste?

A: Any potential issues related to Medicare or Medi-Cal fraud, waste, or abuse (FWA) should be reported.

Please report FWA immediately by using one of the following methods:

- Call the Alliance Compliance Department Hotline: **1.844.587.0810**
- Email the Alliance Compliance Department: **compliance@alamedaalliance.org**
- Submit an online report at **www.alamedaalliance.ethicspoint.com**
- Download and complete a Compliance Incident Report Form from our website at **www.alamedaalliance.org/fraud-prevention**.
- Call the Medi-Cal Fraud and Abuse Hotline: **1.800.822.6222**

Q: Can we request a reconsideration of a decision?

A: You can dispute a claim or an authorization decision by:

Claim disputes: Long-term care facilities may dispute a claim action taken by using the PDR process. The Alliance does not have a second-level appeal process, therefore the PDR decision is final.

Authorization disputes: If you receive a Notice of Action (NOA) letter and/or disagree with the level of care decision, you can follow the instructions on the notice and file an appeal. Upon receipt of an NOA, the member/member's representative or nursing facility on behalf of the member may request reconsideration (appeal) of a level of care decision to deny or modify a request for services.

Q: How is a complaint, grievance, or member dissatisfaction submitted?

A: Member grievances or grievances filed on behalf of the member can be submitted by calling the Alliance Member Services Department at **1.510.747.4567** or by submitting a completed Member Grievance Form that can be found on our website at **www.alamedaalliance.org**.

Q: What is the timeframe for resolving complaints, grievances, or member dissatisfactions?

A: Complaints relating to member's care are determined by the member or the member's physician and based on the urgency of the service.

The two (2) timeframe categories are:

- Expedited (Urgent) – Processing within 72 hours from the receipt
- Standard (Routine) – Processing within 30 calendar days from the receipt.

Q: What is considered a grievance?

A: Member grievances are defined as any expression (oral or written) of dissatisfaction related to care and/or services provided to a member. This includes any complaint, dispute, requests for reconsideration, or appeal made by a member.

Q: What if I have a problem while providing services to your member?

A: The Alliance will make every effort to assist you in the resolution of complaints or problems encountered while providing services to our members.

For assistance, you can contact us in the following ways:

1. Contact your Provider Relations representative.
2. Contact the Alliance:

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

Q: How will our provider network know about this change?

A: Providers will be informed through the following:

1. Alliance Provider Manual: **www.alamedaalliance.org/providers/alliance-provider-manual**
2. Alliance provider training and quarterly provider updates: **www.alamedaalliance.org/providers/alliance-provider-orientation-and-quarterly-visits**
3. Alliance website – provider section: **www.alamedaalliance.org/providers**

Q: Will LTC providers receive training about the Alliance and its benefits?

A: Yes. The Alliance will conduct training for all newly credentialed providers within 10 days of their effective date. Training materials will be made available and published on the Alliance website at **www.alamedaalliance.org**.

Q: Who can LTC providers or other providers contact for more information or if they have questions?

A: For questions or more information, providers may contact:

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