Alameda Alliance for Health New Provider Orientation

Alameda Alliance Wellness (HMO D-SNP)

Alliance Mission, Vision, and Values

Our Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Our Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of life.

Our Core “TRACK” Values

- **Teamwork:** We actively participate, support each other, develop local talent, and interact as one team.
- **Respect:** We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people’s health and well-being.
- **Accountability:** We work to create and maintain efficient processes and systems that minimize barriers, maximize access and sustain high quality.
- **Commitment & Compassion:** We are empathic and care for the communities we serve including our members, providers, community partners and staff.
- **Knowledge & Innovation:** We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.

Welcome to the Alliance Network!

Alliance Providers

- As a provider with the Alliance, you are contracted to provide services for our members within the scope of your specialty as defined in your contract for the following program:
  - Alameda Alliance Wellness (HMO D-SNP)
    - → Health care coverage for Medicare + Medi-Cal Benefits Dual Eligible Special Needs Plan members

Who We Are

- In 2026, the Alliance will be celebrating its 30th year as an organization.
- We are a local, not-for-profit Knox-Keene licensed health plan.
- Created by and for Alameda County residents.
- We hold open board meetings and are accountable to the community.
- We are committed to making high-quality health care accessible and affordable to residents of Alameda County.

More About the Alliance

- Alameda Alliance Wellness is a Health Maintenance Organization (HMO) Dual Eligible Special Nees Plan (D-SNP) plan with a Medicare contract and a contract with the California State Medi-Cal (Medicaid) Program. Enrollment in Alameda Alliance Wellness depends on contract renewal on an annual basis.
- Alameda Alliance Wellness includes prescription drug coverage (Medicare Part D). Alameda Alliance Wellness offers the convenience of having both medical and prescription drugs covered through one plan.
- To join Alameda Alliance Wellness, the member must have both Medicare Part A and Medicare Part B, be eligible for full Medi-Cal (Medicaid), and live in our service area.
- Our service area includes all of Alameda County.

Maintaining Your Alliance Contract

- Please provide timely notification to Alliance Provider Services of all changes (practice name, phone, language capacity, address, taxpayer identification number (TIN), effective or termination date, etc.).
- Notify the Alliance Provider Services Department of new providers and terminated providers who join or leave your practice. A roster or an electronic provider data submission is preferred (e.g., 274 provider flat file).
- Providers must be credentialed by the Alliance to receive the rates agreed upon in your Alliance contract.
- Complete the Facility Site Review (FSR) and Medical Record Review (MRR) process every three (3) years (for primary care providers (PCPs) only).
- Providers must complete the re-credentialing process every three (3) years.

Three (3) Easy Ways to Verify Member Eligibility

1. Visit our Provider Portal (the best way!) through our website at **www.alamedaalliance.org**.
2. Call the Alliance Provider Services Department at **1.510.747.4510.** This includes a 24/7 automated system.
3. Call the Alameda Alliance Wellness Member Services Department to speak with a friendly representative at **1.888.88A.DSNP (1.888.882.3767)**.

Why It’s Important to Verify Eligibility

- A member’s eligibility and PCP/Medical Group assignment can change from month to month.
- Alliance members may request to change their assigned PCP. If a member is not assigned to you and they want change their PCP assignment, please direct them to call the Alameda Alliance Wellness Member Services Department at **1.888.88A.DSNP (1.888.882.3767)**. In most cases, the PCP change will be effective the first day of the following month after the request.
- A referral or authorization doesn’t guarantee that a member is eligible at the time of service.

Timely Access Requirements

Appointments Wait Time (D-SNP)	
Appointment Type:	**Appointment Within:**
Urgently needed services or emergency that do not require PA	Immediately
Non-Urgent **Primary Care** Appointment	Seven (7) business days of request
Routine or preventive care	30 business days of request
All Provider Wait Times/Telephone/Language Practices	
Timely Access Category:	**Timely Access Standard:**
In-office wait time	60 minutes
Call return time	One (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.	

Long-Term Services and Supports (LTSS) Timely Access Network Standards

Provider Type:	Standard:
Skill Nursing Facility	Within five (5) business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within five (5) business days of request
Community Based Adult Services (CBAS)	
Initial	Within five (5) business days acknowledge receipt of request from CBAS center
F2F Eligibility Assessment	Completed within 30 days
IPC by CBAS Center	Within 90 days
Reassessment	Six (6) months
Hospice	
Hospice Care Services	Within 24 hours of request

Timely Access Definitions

- **MA D-SNP =** Medicare Advantage Dual Special Needs Plan
- **Non-urgent Care** – Routine appointments for non-urgent conditions.
- **PA** = Prior Authorization
- **Triage (or screening)** – 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 triage or screen and determine the urgency of the member's need for care.
- **Shortening or Extending Appointment Timeframes** – The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.
- **Urgent Care (or urgent services)** – 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).

Timely Access Standards Exceptions

Exceptions to the Appointment Availability Standards
Preventive Care Services and Periodic Follow-Up Care: Preventive care services and periodic follow-up care are not subject to the appointment availability standards. These services may be scheduled in advance, consistent with professionally recognized standards of practice, as determined by the treating licensed health care provider acting within the scope of their practice. Periodic follow-up care includes, but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.
Shortening or Extending Appointment Waiting Time: The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.
Advanced Access: The primary care appointment availability standard in the chart may be met if the primary care physician (PCP) office provides "advanced access." "Advanced Access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

After Hours Access to Care

- PCPs, specialists, and behavioral health care providers are required to have after-hours phone coverage 24 hours a day, 7 days a week.
- After-hours access must include triage and screening (waiting time does not exceed 30 minutes) for emergency care and direction to dial **9-1-1** for an emergency medical condition.
- A physician or mid-level provider must be available for contact after-hours, either in person or via telephone.

Urgent Care

- Alliance members may seek care from Alliance contracted Urgent Care facilities for non-emergency or life-threatening conditions.
- Alliance members who need urgent care out of the area, can go to the nearest urgent care facility.
- Alliance members can call their PCP, or the Advice Nurse Line, 24 hours a day, 7 days a week, toll-free at **1.888.433.1876,** if they cannot reach their PCP to learn the level of care that is best for them.
- Members may also call Teladoc toll-free at **1.800.TELADOC (1.800.835.2362)** or schedule a video chat on the Teladoc app to treat non-emergency medical issues.
- Most urgent care appointments do not require authorization and are available within 48 hours of the request for an appointment and may include:
  - A cold
  - Sore throat
  - Fever
  - Ear pain
  - Sprained muscle
  - Maternity services
- If the urgent care services require pre-approval, an appointment will be offered within 96 hours of the request.

Emergency Services

- Alliance members may seek care at any hospital Emergency Room (ER) for an emergency medical condition without authorization.
- ER services also include an evaluation to determine if a psychiatric emergency exists.
- Any prudent layperson may determine if an ER visit is warranted. An emergency medical condition (including labor and delivery) is defined by Title 22, CCR, Section 51056 and Title 28, CCR, Section 1300.71.4.(b)(2) as one that is manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
  - Placing the member's health in serious jeopardy
  - Serious impairment to bodily function
  - Serious dysfunction of any bodily organ or part
  - Death

Cultural and Language Services

- 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.
- To access telephonic interpreters at any time, 24 hours a day, 7 days a week, please call **1.510.809.3986**.
- For communication with a patient who is deaf, hearing, or speech impaired, please call the California Relay Service (CRS) at **7-1-1.**
- Providers can request in-person interpreter services for ASL, complex, and sensitive services. Find the guidelines and request form at **www.alamedaalliance.org**, Language Access. Please request five (5) business days in advance.
- Members can call the Alliance Member Services Department to request materials in their preferred language, or materials in audio, Braille, large print, or other alternative formats.
- Document in the health record if a patient refuses professional interpreter assistance.
- Keep on file documentation of language proficiency for any office staff who communicates with members in non-English languages.
- Update the Alliance on any changes in your office's language capacity.
- Members can request interpreter assistance or plan information in their preferred language by calling the Alameda Alliance Wellness Member Services Department at **1.888.88A.DSNP (1.888.882.3767)**.

Cultural and Language Services (cont.)

- The Alliance is committed to providing quality healthcare to its culturally diverse membership and provides content and images that reflect the diversity of our membership.
- To ensure access for members of all cultures, we:
  - Offer providers cultural sensitivity training:
    - Training is available on our website and through bulletins and faxes.
    - Training covers the use of language services, cultural impact on healthcare, working with members with disabilities, LGBTQIA+, aging, refugees & immigrants, and more.
    - Providers are required to complete cultural sensitivity training upon joining the Alliance network and regularly thereafter.
  - Communicate updates on our membership population, noting changes in language, ethnicity, age, and gender.
  - The Alliance encourages providers to report provider race/ethnicity data. The data is not displayed in our public-facing directory but may help us provide a network mindful of our members' cultural and linguistic needs.
  - Provide plan materials and education in our member's primarily preferred languages:
    - Alameda Alliance Wellness: English, Spanish, Chinese, Vietnamese, Farsi, and Tagalog
  - Promote culturally sensitive care that recognizes the use of home remedies, cultural preferences, health literacy challenges, privacy concerns, and the complex nature of health care structure.

Alliance Provider Portal

- Visit **www.alamedaalliance.org** and click the Provider Portal button on the upper right-hand side of the web page.
- After you create an account in the Alliance Provider Portal, and you can:
  - Verify member eligibility
  - Submit electronic professional claims.
  - Check claim status and view remittance advice statements.
  - Submit an electronic Provider Dispute Resolution Request (Claims Dispute).
  - PCPs can view their Alliance member rosters and gap-in-care reports.
  - Also, much more!
- The Provider Portal Instruction Guide is available on the sign in page of the Provider Portal.

Services That Require a PCP Referral*

Services That Require A Referral From A Member's PCP	Services That Require a Prio Authorization
• Second opinions provided by specialists contracted with the Alliance • Specialty care referrals to Alliance contracted specialists, including consults and in-office procedures • PCPs can make standing referrals for specific conditions and diseases	• Diagnostic imaging studies at any facility contracted with the Alliance • Outpatient elective surgery at any facility contracted with the Alliance • For a list of all services that require a prior authorization please visit **www.alamedaalliance.org/providers/authorizations**

* Referral requirements may vary depending on the member's assigned Alliance Medical Group. Please contact the member's assigned medical group to find out if a referral or authorization are requiring for a particular service.

*PCP referral is not required for a mental health evaluation with a contracted in-network mental/behavioral health provider.

Authorization Process Overview

- The authorization process described in this presentation applies to authorization requirements for providers who are contracted directly with the Alliance.
- The Alliance processes authorization requests in a timely manner and in accordance with state and federal requirements.
- To submit an authorization request, the Authorization Request forms are available to download from the Alliance website, download from the Secure Provider Portal, and, in some instances, can be submitted electronically through the Secure Provider Portal.

Submitting Authorization Request Forms

- The Alliance Utilization Management (UM) Department updated all of the Authorization Request Forms effective Thursday, January 1, 2026.
- There are a total of five (5) UM Authorization Request Forms:
  - Pre-Service Authorization Request Form (most common)
  - Home Health Authorization Request Form
  - Palliative Care Authorization Request Form
  - Inpatient Acute Authorization Request Form
  - Post Acute Care Authorization Request Form
- Please complete the Authorization Request forms completely and attach all supporting clinical documentation.
- Each form indicates the fax number to use for authorization submission to the various departments within the Alliance UM Department.

Requesting Criteria

- Providers may contact the Alliance Authorizations Department to request a copy of the criteria used to make a decision about an authorization request at **1.510.747.4540**.

Mental Health Authorization Process Overview

- Outpatient Mental Health (MH) services do not require prior authorization.
- Members can self-refer by using our Provider Directory and/or call the Alameda Alliance Wellness Member Services Department at **1.888.88A.DSNP (1.888.882.3767)** for assistance in finding a provider.
- MH providers are required to complete the **MH Initial Evaluation Form** through the Alliance Provider Portal once they have seen a new patient for their first visit.
- The **MH Initial Evaluation Form** is available under the forms section of the Provider Portal.

Long-Term Supportive Services (LTSS)

- LTSS can help members stay at home and avoid a hospital or skilled nursing facility stay.
- Members have access to certain LTSS through our plan, including:
  - Community Based Adult Services(CBAS) also known as adult day health care
  - Community Supports
  - Nursing facility care
  - Another type of LTSS, the In-Home Supportive Services program (IHSS), is available through the county social service agency.
  - For questions, Alliance members can call the Alameda Alliance Wellness Member Services Department at **1.888.88A.DSNP (1.888.882.3767)**.

Nursing Facility Care

- The Alliance covers, for members who qualify, the following types of nursing care facilities or homes:
  - Skilled nursing facility services as approved by the Alliance
  - Subacute care facility services (including adult and pediatric) as approved by the Alliance
  - Intermediate care facility services the Alliance approves, including:
    - Intermediate care facility/developmentally disabled (ICF/DD)
    - Intermediate care facility/developmentally disabled-habilitative (ICF/DD-H)
    - Intermediate care facility/developmentally disabled-nursing (ICF/DD-N)
- If the member qualifies for nursing facility care, the Alliance will make sure they are placed in a health care facility or home that gives the level of care most appropriate to their medical needs.

Community-Based Adult Services (CBAS)

- CBAS includes:
  - Family and Caregiver training and support
  - Nutrition services
  - Other services for members who qualify
  - Outpatient, facility-based services for skilled nursing care
  - Personal care
  - Social services
  - Therapies
  - Transportation

In-Home Supportive Services (IHSS)

- The Alameda County IHSS Program will help pay for services provided to members to help them remain safely in their home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.
- The types of services which can be authorized through IHSS are:
  - Accompaniment to medical appointments
  - Grocery shopping
  - Housecleaning
  - Laundry
  - Meal preparation
  - Personal care services (such as bowel and bladder care, bathing, grooming and paramedical services)
  - Protective supervision for the mentally impaired
- If the member meets the criteria for any of the LTSS programs, a care coordinator from the Alliance can help them apply to ensure they have the needed care and support at home.

California Integrated Care Management (CICM)

- For members of all ages who have certain care needs and require community support services, such as:
  - Alliance Medi-Cal members who have certain health conditions; and
  - Who has been in the hospital or emergency room; or
  - Without stable housing.
- You can refer an Alliance member to us:

  Alliance Case Management Department
  Monday – Friday, 8 am – 5 pm
  Phone Number: **1.510.747.4512**
  Toll-Free: **1.877.251.9612**
  People who cannot hear or speak well (CRS/TTY): **711**

You can also submit an authorization request for these services. A copy of the form is found in the attachments section.

Community Supports (CS)

- Alliance members can receive Community Supports (CS) Services. The Alliance currently offers the following services:
  - Asthma Remediation
  - (Caregiver) Respite Services
  - Community Transition Services/Nursing Facility Transition to a Home
  - Environmental Accessibility Adaptations (Home Modifications)
  - Housing Deposits
  - Housing Tenancy and Sustaining Services
  - Housing Transitions Navigation Services
  - Medically Tailored Meals/Medically-Supportive Food
  - Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
  - Personal Care & Homemaker Services
  - Recuperative Care (Medical Respite)

- You can refer an Alliance member to us:

  Alliance LTSS Department
  Monday – Friday, 8 am – 5 pm
  Phone Number: **1.510.747.4545**
  Fax: 1.510.995.3726
  E-mail: CSDept@alamedaalliance.org

Community Supports Authorization forms can be found here at **www.alamedaalliance.org/providers/provider-forms**.

Medical Inpatient Admission Authorization Process

- Emergent inpatient admissions do not require *prior* authorization. However, hospitals must notify the Alliance Authorizations Department of an emergency inpatient admission within one (1) working day.
- The Alliance Authorization Department clinical staff will concurrently review the hospital stay and coordinate care with the facility to determine the appropriate level of care and assist with discharge planning.
- Hospitals and treating providers are reimbursed by the Alliance as long as timely notification of an admission has been received and meets medical necessity.

***Hospitals must notify the appropriate Alliance medical group of admissions for their members.**

Hospital Observation Status

- In-Network Observation admissions do not require prior authorization. However, hospitals must notify the Alliance Authorizations Department of an observation admission within one (1) working day.
- The Alliance Authorization Department clinical staff will coordinate care with the facility to determine the appropriate level of care and assist with discharge planning.
- Hospitals and treating providers are reimbursed by the Alliance as long as timely notification of an admission has been received and meets medical necessity.

Behavioral Inpatient Admission Authorization Process

- For Alameda Alliance Wellness members, this is covered directly by the Alliance*.
  - Emergent inpatient admissions do not require prior authorization. However, hospitals must notify the Alliance Authorizations Department of an emergency inpatient admission within one (1) working day.
  - The Alliance Authorization Department clinical staff will concurrently review the hospital stay and coordinate care with the facility to determine the appropriate level of care and assist with discharge planning.
  - Hospitals and treating providers are reimbursed by the Alliance as long as timely notification of an admission has been received and meets medical necessity.

***Hospitals must notify the Alliance**

Authorization Turnaround Times

Request Type	Authorization Processing Timeframes for Medi-Cal and Group Care
Medically Urgent	A decision is made within 72 hours of receipt. Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within 24 hours of the decision.
Routine Pre-Authorization	A decision is made within seven (7) calendar days of receipt. Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within 24 hours of the decision.
General Inpatient Hospice Care (GIP)	Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within 24 hours of receipt.
Retrospective*	A decision is made within 30 calendar days of receipt. Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within 30 calendar days of receipt. *Submissions within 90 days from the date of service (when there is no claim on file) will be processed through the UM Department. Submissions > 90 days with be processed with claim submission via the Retrospective Claims Review Process.

Physician Administered Drugs (PAD)

- PAD drugs have specific turnaround times dependent on the line of business.
  - For D-SNP, routine requests are approved within 72 hours, and urgent requests are approved within 24 hours.

	Medi-Cal	Group Care	D-SNP (Alliance Wellness)
☐ Routine (Approval based on Alliance clinical review)	24 hours	5 business days	72 hours
☐ Urgent (Inappropriate use will be monitored)	24 hours	72 hours	24 hours

Authorization Contact

Health Plan	Address	Authorization Department Numbers	Alliance Program
Alameda Alliance for Health (Alliance)	1240 South Loop Road Alameda, CA 94502 **www.alamedaalliance.org/providers/authorizations**	Phone: **1.510.747.4540 ext.5** Fax: **1.855.891.7174** Main Number: **1.510.747.4500**	Alameda Alliance Wellness (HMO D-SNP)

Member Benefits

All Alliance members receive:

- Dental care
- Interpreter services
- Lab tests
- Over-the-counter (OTC) allowance
- Prescription medication
- Routine care with doctor
- Specialty care
- Transportation
- Vision care
- More information can be found in our Provider Manual

Member Benefits: Behavioral Health

- All Alliance members have access to outpatient and inpatient behavioral health (BH) care, including mental health and substance abuse treatment.
- PCPs and specialists can encourage members in need of behavioral health care to access this covered and confidential benefit.
- Alameda Alliance Wellness members
  - Services are provided by the Alliance for all services. The Alliance manages the administration and claims for all members.
    - Members can self-refer for most services by calling the Alameda Alliance Wellness Member Services Department at **1.888.88A.DSNP (1.888.882.3767)**.

Member Benefits: Lab Services

- Alliance members must receive **outpatient** lab services and specimen readings from Quest Diagnostics, except for:
  - HIV testing
  - Genetic, chromosomal and alpha-fetoprotein prenatal testing
  - Renal tests performed at dialysis centers
- Members who are assigned to Alameda Health System (AHS) for PCP or specialty care must use an AHS lab.
- Providers may contact Quest Client Services toll-free at **1.800.288.8008** to find a Quest lab.
- For courier services, immediate (STAT) pickup, or will call, providers may contact Quest toll-free at **1.800.288.8008**, **Option 3**.

Member Benefits: Dental Services

- Alameda Alliance Wellness partners with Liberty Dental to provide dental benefits.
  - Members can self-refer for dental services and should call toll-free at **1.888.704.9838** for assistance.

Member Benefits: Vision Services

- Vison Service Plan (VSP) administers vision benefits for Alameda Alliance Wellness members.
- Members may self-refer to VSP providers, or a PCP can refer a member to a participating VSP provider.
- For questions regarding vision benefits or to find a VSP provider, please contact VSP toll-free at **1.855.492.9028** or visit **www.vsp.com/advantageonly**.
- Please note that ophthalmology care is a medical benefit through the Alliance and there is no age restriction for these services for members. A PCP referral is required, and the care must be provided by Alliance-contracted ophthalmologists.

Outpatient Pharmacy Benefit

- The Alliance Pharmacy Benefit Manager is PerformRx, and they are responsible for:
  - Processing authorization requests in a timely manner
  - Pharmacy contracting and oversight (there are over 200 local and large chain pharmacies.)
  - Pharmacy claims processing
  - Formulary management
    - → Our formulary can be found on our website at **www.alamedaalliance.org**.

Alliance Pharmacy Services Program

- Program Goal
  - To ensure that Alliance members receive therapeutically appropriate and cost-effective drug therapy. Adherence to the Alliance's formularies assists with meeting this goal.
- Pharmacy Services Department
  - Manages the program
  - Phone Number: **1.510.747.4541**
- Pharmacy & Therapeutics Committee (P&T) Committee
  - Is comprised of contracted physicians, pharmacists, and behavioral health providers.
  - Reviews and approves changes to the Alliance's formularies.

Initial Health Appointment (IHA)

- PCPs must provide each new Alliance member with an initial health appointment (IHA) within 120 days after enrolling with the Alliance or being assigned to their PCP.
- Pregnant women must have their IHA as soon as an appointment can be scheduled.
- Reasonable attempts (at least three (3)) must be made to schedule an IHA.
- The IHA includes, but is not limited to (and documented in the medical record):
  - Age-appropriate assessment for preventive screens or services
  - Comprehensive physical and mental health history and exam
  - Diagnoses and plan for treatment of any diseases and/or abnormal lab results/assessment findings
  - Health education/anticipatory guidance
  - Identification of risks
- For more information, please visit **www.alamedaalliance.org/providers/initial-health-assessment**.

Initial Preventive Physical Exam (IPPE) and Annual Wellness Exam (AWE)

- PCPs must provide each new Alliance member with an:
  - Initial Preventive Physical Exam (IPPE) within the first 12 months of Medicare enrollment.
  - Annual Wellness Exam (AWE) yearly.
- Pregnant women must have their IPPE and AWE as soon as an appointment can be scheduled.
- The IPPE and AWE should follow appropriate preventive health guidelines and should include a physical and mental health examination, identification of risks, health education, diagnoses and plan of care, including referrals for lab work and tests as indicated, immunizations, and follow-up services.

Claims Overview

- Claims are considered timely if they are submitted within 180 calendar days post-service, or post-Explanation of Benefits (EOB) if other coverage exists.
- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines and requires no further information, adjustment, or alteration for payment.
- Claims will be paid or denied with an EOB within 30 business days of the submission date.
- All requests for reconsideration or claim disputes must be received within 120 Calendar Days from the original date of notification of payment or denial.
- Reconsideration or claims disputes must be submitted by completing a Notice of Provider Dispute (NOPD or PDR) form.
  - When completing the PDR form, supporting documentation may also be attached and submitted to the Alliance Claims Department
  - Provider Dispute Resolution (PDR) form can be found at **www.alamedaalliance.org/providers/billing/claims**.
  - This can also be done by completing the form electronically through our Provider Portal.

Claims Overview (cont.)

- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments.
- Providers may not balance bill members for any differential.
- Please refer to our Provider Manual for more detailed and helpful information about our claims policies. **www.alamedaalliance.org/providers/alliance-provider-manual**.

Electronic Billing, Payment, and RA

- You can sign up to bill electronically (EDI), get paid faster with Electronic Fund Transfer (EFT), and receive an Electronic Remittance Advice (ERA).
- If you work with a clearing house, please contact us to enroll in our Electronic Data Interchange (EDI) program.
- To access the EDI Enrollment Form, please visit **www.alamedaalliance.org/providers/provider-forms**.
- This will speed up claim processing and help get you paid faster.

Electronic Billing, Payment, and RA (cont.)

- EFT allows payments to be made electronically to your bank.
- ERA allows you to receive an RA automatically and electronically.
- You can also submit claims electronically through our Provider Portal (including secondary claims and attach the EOB).
- The enrollment forms can be found at: **www.alamedaalliance.org/providers/provider-forms**.
- To learn how to enroll in any of these services, please call the Alliance Provider Services Department at **1.510.747.4510** or visit **www.alamedaalliance.org**.

Claims Requirements for Injectables

- Claims for physician administered drugs (PAD) must include the National Drug Code (NDC) for each drug.
- Claims for PAD will be reimbursed in one of the following ways:
  - Medicare rates for Alameda Alliance Wellness members.
  - If a Medi-Cal or Medicare rate does not exist for a particular drug, please refer to your contract for the Average Wholesale Price (AWP) percentage.

Where to Send Your Medical Claims

Claim Type	Member's Health Plan/Medical Group	Address
Professional Medical Service	Alameda Alliance Wellness	Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460
Professional Behavioral Health	Alameda Alliance Wellness	Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460
Institutional (Hospital, SNF, etc.)	Alameda Alliance Wellness	Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460
Home Health	Alameda Alliance Wellness	Alameda Alliance for Health PO Box 2460 Alameda, CA 94501-0460

Appeals and Grievances Process

Member Complaints/Grievances/Appeals

- Members may report complaints, grievances, or appeals by calling the Alameda Alliance Wellness Member Services Department at **1.888.88A.DSNP (1.888.882.3767)**.
- Providers may provide members with a Grievance Form that can be mailed or faxed to the Alliance.
- Once the member's complaint, grievance, or appeal is logged by the Alameda Alliance Wellness Member Services Department, our Grievances and Appeals Department will investigate the situation and provide the member with a resolution.
- In some cases, the Alliance Grievance and Appeals Department may request information from our providers to assist with reviewing a member's complaint, grievance, or appeal.

Appeals and Grievances Process (cont.)

Provider Complaints/Grievances/Appeals

- Appeals of **claims** decisions must be submitted via the NOPD or PDR form process. Please complete the PDR form, attach supporting documentation, and submit it to the Alliance Claims Department as referenced in Claims Overview.
- Appeals of **authorization decisions** must be submitted to the Alliance Grievances and Appeals Department. Please include supporting clinical documentation with each appeal.
- Grievance and Appeals contact:

  Alliance Grievance and Appeals Department
  Monday – Friday, 8 am – 5 pm
  Phone Number: **1.510.747.4531**

- Other provider complaints can be submitted to the Alliance Provider Services Department.

Member Discharge Process Overview

- Another form of a provider grievance is a member discharge.
- Providers have the right to discharge members from their care due to unruly behavior, threatening remarks, frequently missed appointments, fraud, etc.
- Document the patient's behavior in medical record progress notes.
- A member may **not** be discharged due to their medical condition, frequent visits, or high cost of care.
- Member discharge requests must be submitted in writing to the Alliance Provider Services Department **prior** to discharging a member.
- Please refer to Part One of the Alliance Provider Manual for a complete description of the member discharge process requirements.

Quality Improvement (QI): PQI's

- The Alliance maintains a systematic mechanism to identify, analyze and resolve potential quality of care and service issues (PQIs) to ensure that services provided to members meet established quality of care and service standards.
- PQIs can be identified in several ways, including:
  - Encounter data, including medical and pharmacy claims
  - Inpatient notifications
  - Member or provider complaints
- The Alliance QI Department reviews and resolves PQIs in a timely manner and may request information from Alliance providers to assist with the review process.

Quality Improvement: HEDIS®

- The California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) require that the Alliance participate in the annual Healthcare Effectiveness and Data Information Set (HEDIS) process.
- HEDIS measures are developed by a national group of health care experts, issued annually, and used as a standard across the country. Using HEDIS measures, the Alliance can compare its performance against other managed care plans. HEDIS study methodology and results are also validated and audited by an external agency.
- HEDIS studies use claims and encounter data submitted by providers and may be supplemented with data retrieved from providers' medical records. The Alliance makes every effort to request records or schedule HEDIS data retrieval for all measures.

Health Education

- The Alliance has health information, self-management tools, and referrals to programs and classes for all members at no cost.
- Health topics include:
  - Conditions like diabetes and hypertension
  - Healthy weight, nutrition, and exercise
  - Pregnancy, breastfeeding (lactation consultants), and parenting
  - Smoking cessation, Diabetes Prevention Program (DPP), and much more!
- The ***Provider Resource Directory**** lists classes, programs, and community referrals available to Alliance members at no cost.
- Members can complete the ***Member Wellness Programs & Materials Request Form**** or call Alliance Health Programs at **1.510.747.4577** to request class listings and materials in our threshold languages (English, Spanish, Chinese, Vietnamese, Farsi, and Tagalog).
- Providers can refer using the ***Provider Wellness Programs & Materials Fax Request Form****.

*Directory and forms are available at **www.alamedaalliance.org/live-healthy/classes** and with your orientation packet.

Alameda Alliance Wellness D-SNP Model of Care (MOC) Training & Attestation

- As part of Alameda Alliance Wellness Dual Eligible Special Needs Plan (D-SNP) operations and CMS requirements, providers and their staff who interact with D-SNP members must complete initial and annual MOC training and submit an attestation upon completion.
- What the Training Covers:
  - Overview of the D-SNP population and unique clinical/social needs
  - Interdisciplinary Care Team (ICT) model
  - Comprehensive Health Risk Assessments (HRAs) and Individualized Care Plans (ICPs)
  - Care coordination and communication requirements
  - Provider responsibilities in implementing the MOC
- Staff required for training completion include:
  - Contracted providers and clinical staff who deliver services to Alameda Alliance Wellness D-SNP members
  - Key staff who are integral to members care coordination and care transition
  - Sub-contracted entities or delegated provider groups who coordinate and/or deliver services and benefits to Alameda Alliance Wellness D-SNP members

Model of Care (MOC) Training & Attestation (cont.)

- Attestation Requirement:
  - Upon completion of the training, please submit the MOC Training Attestation Form electronically through the link provided on the training webpage
  - This attestation confirms that your organization has reviewed and understood the Alameda Alliance Wellness D-SNP MOC
  - If you have questions or need assistance accessing the training or submitting your attestation, please contact the Alliance Provider Services Department at **1.510.747.4510**
- Access the Training & Attestation Form:
  - **https://aahportal-forms.alamedaalliance.org/moctraining**
  - **https://aahportal-forms.alamedaalliance.org/moctraining**
- Additional Training Opportunities:
  - Visit our website for other available trainings
  - **https://alamedaalliance.org/providers/provider-resources/training-and-technical-assistance-opportunities/**

Get Involved!

- Join an advisory committee to the Alliance Board of Governors:
  - Community Advisory Committee (CAC)
    - → Call the Alliance Provider Services Department at **1.510.747.4510**
  - Peer Review & Credentialing Committee (PRCC)
    - → Call the Alliance Credentialing Department at **1.510.747.6176**
  - Pharmacy & Therapeutic Committee (P&T)
    - → Call the Alliance Pharmacy Services Department at **1.510.747.4541**
  - Quality Improvement Health Equity Committee (QIHEC)
    - → Call the Alliance Credentialing Department at **1.510.747.6176**

We're Here For You!

At **www.alamedaalliance.org** you can:

- Access the Provider Portal
- Check our online provider directories
- Download forms
- View clinical practice guidelines
- View our online provider manual
- View updates
- Also, much more!

Your Provider Services Department

- Please contact us:
  Office hours: **Monday – Friday** from **7:30 am – 5 pm**
  Office: **1.510.747.4510**
  Fax: **1.855.891.7257**
  Email: **providerservices@alamedaalliance.org**
- Contact your Provider Relations Representative directly:

  Elbrain Macasiljig
  Email: **emacasiljig@alamedaalliance.org** | Phone Number: **1.510.373.5605**

  Errin Poston
  Email: **eposton@alamedaalliance.org** | Phone Number: **1.510.747.6291**

  Shawanna Emerson
  Email: **semerson@alamedaalliance.org** | Phone Number: **1.510.995.1202**

  Maria Rivera
  Email: **mrivera@alamedaalliance.org** | Phone Number: **1.510.747.6094**

  Rosa Sanchez
  Email: **rsanchez@alamedaalliance.org** | Phone Number: **1.510.373.5664**