Alameda Alliance for Health New Provider Orientation

ALAMEDA Alliance FOR HEALTH

1.
Welcome to the Alliance Network!

Alliance Providers

- As a provider with Alameda Alliance for Health (Alliance), you are contracted to provide services within the scope of your specialty and as defined in your contract to members for our two programs:
  - Medi-Cal
    - → Health coverage for underserved individuals and families
  - Alliance Group Care
    - → Health coverage for Alameda County In-Home Supportive Services (IHSS) workers

Who we Are

- The Alliance has been in business since 1996
- We are a local, not-for-profit Knox-Keene licensed health plan
- Created by Alameda County residents 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

- Alliance Medi-Cal is comprehensive health coverage for Medi-Cal beneficiaries who have no share of cost and who live in Alameda County
- Medi-Cal beneficiaries can choose between Alliance Medi-Cal, Regular Medi-Cal and Blue Cross Medi-Cal
- Medi-Cal beneficiaries join the Alliance by completing the Medi-Cal Choice Form

More About the Alliance, cont.

- Some Medi-Cal beneficiaries must be enrolled in a health plan and may be automatically enrolled into the Alliance by the State
- By enrolling in the Alliance for Medi-Cal, beneficiaries enjoy a large network of providers, assistance with care coordination, and a health plan that is local and accountable to the community

Alliance Program Membership

- **The Alliance provides comprehensive health care coverage to over 259,147 members through two programs:**
  - Medi-Cal
    - → 253,255 members
  - Alliance Group Care
    - → 5,892 members

Source: Alameda Alliance for Health Board of Governors Regular Meeting – Operations Dashboard. May 2019

Alliance Medical Groups

- The Alliance is contracted with three medical groups:
  - Children First Medical Group (CFMG)
  - Community Health Center Network (CHCN)
  - Kaiser Permanente (Kaiser)
- Each group manages the authorizations, referrals, and claims of any Alliance member who chooses a PCP who belongs to that group – except for DME authorizations
- If you receive a referral for an Alliance member assigned to one of the Alliance's medical groups, please:
  - Contact the member's assigned medical group before providing care to the member, *OR*
  - Refer the member back to his/her PCP for a referral to a provider within the medical group

Alliance Medical Group Relationships

- **Children First Medical Group (CFMG)**
  - Medi-Cal
- **Community Health Center Network (CHCN)**
  - Medi-Cal and Alliance Group Care
- **Kaiser Permanente**
  - Medi-Cal

Maintaining Your Alliance Contract

- Please provide timely notification to Alliance Provider Services of all changes (practice name, phone, language capacity, address, TIN, etc.).
- Notify Alliance Provider Services of new providers and terminated providers who join or leave your practice.
- Providers must be credentialed by the Alliance to receive the rates agreed upon in your Alliance contract.
- Complete the Facility Site Review and Medical Record Review process every three years (for PCPs and OBs only).
- Please complete the re-credentialing process every three years.

3 Easy Ways to Verify Member Eligibility

- Visit our secure website (the best way!) at www.alamedaalliance.org
- Call our Automated Eligibility Line at **1.510.747.4505**
- Call the Alliance Member Services department to speak with a friendly representative at **1.510.747.4567**

Why It's Important to Verify Eligibility

- A member's eligibility and PCP/Medical Group assignment can change from month to month.
- A referral or authorization doesn't guarantee that a member is eligible at the time of service.
- It is important to know if a member is assigned to a medical group because the group is responsible for authorization, referral, and claims processing for their assigned members.

Timely Access Standards

Timely Access Regulations[1] – Appointment Availability Standards	
Appointment Type:	**Offer the Appointment Within:**
Non-urgent appointments with Primary Care Physicians	10 business days of request
Non-urgent appointments with Specialist Physicians	15 business days of request
Urgent care appointments that do not require prior authorization	48 hours of request
Urgent care appointments that require prior authorization	96 hours of request
Non-urgent appointments for ancilary services (for diagnosis or treatment of injury, illness or other health condition)	15 business days of request
Non-urgent appointments with a non- physician mental health care provider	10 business days of request

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 his or her 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.
Extending Appointment Waiting Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.
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

- All PCPs 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 call 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.

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 FREE telephonic and in-person interpreter services, including American Sign Language, to all of our members for Alliance covered services.
- Call our Member Services department at **1.510.747.4567** to arrange for an in-person interpreter or to request plan materials in the members' language.
- Call our vendor, IEC, 24/7 at **1.866.948.4149** for telephonic interpretation.
- Document in the health record if a member 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.

Cultural & Linguistic Services, cont.

The Alliance is committed to providing quality healthcare to its culturally diverse membership. To ensure access for members of all cultures we:

- Offer providers cultural sensitivity training
  - Training available on our website and through bulletins and faxes
  - Training covers use of language services, culture's impact on healthcare, working with members with disabilities, LGBT, aging, refugees & immigrants and more
- Communicate updates on our membership's population noting changes in language, ethnicity, age, and gender
- Provide plan materials and education in our members' main languages
  - English, Spanish, Chinese (Group Care) and Vietnamese (Medi-Cal)
  - Content and images reflect the diversity of our membership
- Promote culturally sensitive care that recognizes use of home remedies, cultural preferences, health literacy challenges, privacy concerns and the complex nature of health care structure

Services that Require a PCP Referral*

Services that Require a Referral from a Member's PCP	Documentation Requirements

• Diagnostic imaging studies at any facility contracted with the Alliance
• Outpatient elective surgery at any facility contracted with the Alliance
• Second opinions provided by specialists contracted with the Alliance
• Specialty care referrals to Alliance contracted specialists, including consults and in-office procedures
• Sweet Success services for prenatal diabetic care
	• PCP may refer the member to specialty care in writing or by phone
	• Once the initial referral is made, additional referrals to the same specialist are not required for care related to that condition
	• PCPs may make standing referrals for specific conditions and diseases
	• The specialist is required to:
	  ◦ Verify the member's eligibility at the time of service
	  ◦ Verify the referral from the PCP
	  ◦ Provide feedback to the PCP
	  ◦ Document the referring PCP's name in Box 17 of the CMS 1500 or Box 82 of the UB-92 for ALL consults and procedures related to the referred condition
	  ◦ Claims that do not contain this information will be denied

*** 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 is required for a particular service.**

Authorization Process Overview

- The authorization process described in this presentation applies to members assigned to PCPs who are contracted directly with the Alliance or for members who have not yet been assigned to a PCP
- The Alliance processes authorization requests in a timely manner and in accordance with State and federal requirements
- To submit an authorization request, please complete the Alliance Authorization Request form (AAR), attach supporting clinical documentation, and fax it to the Alliance Authorizations department.
- 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**

Services that Require Authorization

- Please see Authorization Grid attached.

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's 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.**

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 5 business 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.
Inpatient Hospice Care	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 30 days from the date of service, (when there is no claim on file) will be processed through the UM Department. Submissions >30 days with be processed with claim submission via the Retrospective Claims Review Process.

Contacts for Authorizations

Health Plan/ Medical Group	Address	Authorization Department Numbers	Alliance Programs
Alameda Alliance for Health (Alliance)	1240 South Loop Road, Alameda, CA 94502 www.alamedaalliance.org	Phone: **1.510.747.4540** Fax: **1.877.747.4507** *Main Number:* ***1.510.747.4500***	Medi-Cal, Group Care
Children First Medical Group (CFMG)	1833 Alcatraz Ave, Berkeley, CA 94703 www.children-first-medical-group.com	Phone: **1.510.428.3489** Fax: **1.510.428.5868** *Main Number:* ***1.510.428.3154***	Medi-Cal,
Community Health Center Network (CHCN)	101 Callan Ave, 3rd Floor San Leandro, CA 94577 www.chcn-eb.org	Phone: **1.510.297.0220** Fax: **1.510.297.0222** *Main Number:* ***1.510.297.0200***	Medi-Cal, Group Care
Kaiser Permanente	www.kaiserpermanente.org	*Main Number:* ***1.800.464.4000***	Medi-Cal

Direct Access to OB/GYN Services

- Female members of the Alliance may self-refer for covered obstetrical and gynecological services from OB/GYNs participating within the Alliance or their medical group's network

*** 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 is required for a particular service.**

Sensitive Services

- Sensitive Services are those services designated by the State Medi-Cal program as available to members without a referral or authorization in order to protect patient confidentiality and promote timely access.
- Sensitive Services include family planning, screening and treatment for sexually transmitted diseases, HIV testing, and abortions.
- All Alliance Medi-Cal members may go outside of their medical group's network for sensitive services, which does not include prenatal care.
- Authorization is not required for prenatal care, but members must stay within their medical groups.
- Group Care members are encouraged to use family planning, HIV testing, and sexually transmitted disease services provided by the Alliance or their medical group, and referral or authorization may be required to access these services outside of the network.

Sensitive Services, cont.

- Abortion
- In-network abortion services are available to all Alliance members without referral or authorization.
- Abortion services from non-Alliance providers are also available to all Alliance members without referral or authorization.
- Group Care members are encouraged to use abortion services provided within the Alliance's or their medical group's network before seeking authorization to be seen by an out of network provider.
- Alliance Medi-Cal members may obtain abortion services from any Medi-Cal provider without a referral or authorization.

Member Benefits

All Alliance members receive:

- Regular medical exams & visits
- Immunizations
- Specialist care
- Inpatient hospital care
- Emergency services
- Free interpreter services
- Free health education materials and classes

Member Benefits: Medical

- For Alliance Medi-Cal and Group Care members, the Alliance covers medical services that are medically necessary and covered by the Medi-Cal program at the time of service
- Benefits include primary care, specialty care, durable medical equipment, home health, inpatient care, and skilled nursing care
- A complete list of covered services can be found in the Alliance
- Provider Manual
- Unless specifically indicated, the Alliance does not cover services that are not covered by Medi-Cal, including cosmetic services, infertility treatment, and experimental and investigational procedures

Member Benefits: Behavioral Health

- All Alliance members have access to outpatient and inpatient behavioral health care, which includes substance abuse treatment.
- PCPs and specialists can encourage members in need of behavioral health care to access this free and confidential benefit.
- **Access**: Alliance Medi-Cal members behavioral health services are provided by Alameda County Behavioral Health Care Services (BHCS). (moderate to high severity) Members can self-refer for most services and can contact BHCS at **1.800.491.9099**
- **Beacon:** Behavioral services provided by Beacon Health Strategies for Medi-Cal (mild to moderate and autism services) and Group Care members (all services). Members can self-refer for most services and can contact Beacon at **1.855.856.0577**

Member Benefits: Lab Services

- Alliance members must receive **outpatient** lab services and specimen readings from Quest Diagnostics, except for:
  - HIV testing
  - Renal tests performed at dialysis centers
  - Genetic, chromosomal and alpha-feto protein prenatal testing
  - Lab services performed at one of the following Alliance- contracted hospitals:
- Alameda County Medical Center (Fairmont and Highland Campuses)
- Children's Hospital Oakland
- Summit Medical Center
- Providers may contact Quest Client Services at **1.800.288.8008** to find a Quest lab.
- For Courier Services, STAT pickup, or Will Call, providers may contact Quest at **1.800.288.8008**, **Option 3**.

Member Benefits: Dental Services

- For Alliance Medi-Cal members who are pregnant, living in a skilled nursing facility or under age 21, dental services are provided by Denti-Cal.
- Members can self-refer for dental services and should call **1.800.322.6384** for assistance.
- A dental screening by the PCP is part of the Initial Health Assessment and CHDP check-ups.
- The IHSS Public Authority (PA) contracts with Delta Dental to provide dental care for Alliance Group Care members.
- Group Care members can contact the IHSS PA if they have questions regarding their dental coverage or need to enroll in the dental plan.
- Members can contact Delta Dental at **1.888.335.8227** to find a participating dental provider.

Member Benefits: Vision Services

- March Vision Care (MARCH) administers vision benefits for Alliance Medi-Cal members.
- Alliance Medi-Cal members may self-refer to MARCH providers or a PCP can refer a member to a participating MARCH provider.
- For questions regarding vision benefits or to find a MARCH provider, please contact MARCH at **1.844.336.2724** or visit www.marchvisioncare.com.
- Vision services for Alliance Group Care members are administered by the IHSS Public Authority (PA), which can be reached at **1.510.577. 3552**
- Please note that ophthalmology care is a medical benefit through the Alliance and there is no age restriction for these services for either of our plans. PCP referral is required and the care must be provided by contracted ophthalmologists.

Member Benefits: Transplants

- For Alliance Medi-Cal members, the Alliance covers kidney and corneal transplants
- All other organ transplants are covered by State Medi-Cal
- For Group Care the Alliance covers medically necessary organ and bone marrow transplants

Pharmacy Benefit Manager (PBM)

PerformRx is our PBM and is responsible for:

- Processing authorization requests in a timely manner
- Pharmacy contracting and oversight
- Pharmacy claims processing
- Formulary management
  - Our formulary can be found on our website at www.alamedaalliance.org

Pharmacy Network

- PerformRx is contracted with over 200 local and chain pharmacies in Alameda County, including:
  - CVS
  - Safeway
  - Target
  - Walgreens
  - Wal-Mart
- Our online Pharmacy Directory has a complete list of pharmacies and is available on our website at www.alamedaalliance.org

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 and can be reached at **1.510.747.4541**
- Pharmacy & Therapeutics Committee (P&T) Committee
  - Is composed of Alliance staff and Alameda County-based pharmacists and doctors
  - Reviews and approves changes to the Alliance's formularies

Initial Health Assessment (IHA)

- PCP's must provide each new Alliance members with an initial health assessment (IHA) as soon as possible after enrolling with the Alliance.
- The State Medi-Cal program mandates that all new Medi-Cal members have an IHA within 120 days from the member's enrollment date.
- Pregnant women must have their IHA as soon as an appointment can be scheduled.
- The IHA should follow appropriate preventive health guidelines and should include a physical examination with referrals for lab work and tests as indicated, immunizations, and a nutritional assessment.

Child Health & Disability Program (CHDP)

- The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal children and youth.
- The CHDP Program is responsible for ensuring that high quality preventative services are delivered and available to eligible children and youth.
- For Alliance Medi-Cal members, pediatric clinical preventive service encounters must be documented using the CHDP Confidential Screening/Billing Report (PM-160).

Child Health & Disability Program (CHDP),cont.

- Data submitted on PM-160 forms is used to develop an administrative data set for HEDIS® (Healthcare Effectiveness and Data Information Set)
- The form is then forwarded to the local CHDP Program on a monthly basis. Providers should attach the PM-160 forms to claims for pediatric preventative services and send them to:

Alameda Alliance for Health

Claims Department

P.O. Box 2460

Alameda, CA 94501-4506

Staying Healthy Assessment (SHA)

- Alliance PCP's are required to ask Alliance members to complete the Staying Healthy Assessment
- (IHEBA) at age-specific intervals.
- PCP's use the completed form to assess, inform and refer members on healthy living topics like tobacco use and nutrition.
- PCPs must complete a one-time training on the SHA.
- The Alliance covers extended counseling, intervention and referral for members who respond "yes" for tobacco or alcohol use.
- Find training webinars and links, forms, requirements and instructions at www.alamedaalliance.org for the Staying Healthy Assessment, SBIRT (for alcohol use disorders) and Tobacco Cessation.

California Children's Services (CCS)

- California Children's Services (CCS) provides medical care for children younger than 21 years of age who have physical disabilities and complex medical conditions.
- Services provided under the CCS program are reimbursed through the CCS program.
- The Alliance is not financially responsible for CCS services provided to its members.
- An Alliance member who is eligible for CCS services remains enrolled with the Alliance.
- Physicians, the Alliance, and medical group staff are responsible for identification, referral, and case management of members with CCS eligible conditions.

California Children's Services (CCS), cont.

- Until eligibility is established with the CCS program, the PCP, the Alliance, and medical group continue to provide medically necessary covered services related to the CCS eligible condition
- Eligible conditions include medical conditions such as sickle cell anemia, cancer, diabetes, HIV, and major complications of prematurity

Refer patients to CCS by contacting: California Children's Services

1000 Broadway, Suite 500

Oakland, CA 94607

Telephone: 1.510.208.5970 I Fax: 1.510.267.3254 or

www.dhcs.ca.gov/services.ccs

Early Start

- The Early Start program serves infants and toddlers three years old or younger who have:
- Significant developmental delays in cognitive, physical (motor, vision, and hearing), communication, social/emotional, and adaptive/self-help functions
- A diagnosed developmental disability that is expected to continue indefinitely
- A combination of biological and/or psychosocial factors which indicate a high risk for developmental disabilities
- Early Start provides a wide range of services including speech and hearing evaluations and treatment

Early Start, cont.

- The Alliance is not financially responsible for the Early Start services provided to its members.
- The member's PCP is responsible for providing the initial evaluation and treatment and referral to the local school district or regional center.
- An Alliance member who is eligible for Early Start services remains enrolled with the Alliance, and the PCP, the Alliance, and medical group remain responsible for coordination of services and for continued medical care.

Regional Center of the East Bay (RCEB)

Regional Center of the East Bay (RCEB) is a private, non-profit agency established to assist mentally disabled persons, individuals who are substantially handicapped by cerebral palsy, epilepsy or autism, and their families in locating services in their communities.

To be eligible, a member must meet the following criteria:

- Disability is due to mental retardation, cerebral palsy, epilepsy, autism or a condition similar to mental retardation
- Disability began prior to the age of 18
- Disability is likely to continue indefinitely and is substantially handicapping for the individual

Regional Center of the East Bay (RCEB), cont.

- RCEB provides members with the services they need to function independently. Main areas of assistance include:
  - Help finding housing
  - School or adult day programs and social activities
  - Transportation
  - Providing respite services, including child care
  - Durable medical equipment
  - Speech or P.T./O.T. services

Regional Center of the East Bay (RCEB), cont.

- The Alliance is not financially responsible for the RCEB services provided to Alliance members
- An Alliance member who is eligible for RCEB services remains enrolled with the Alliance, and the PCP, the Alliance, and medical group retain responsibility for coordination of services and for continued medical care.
- Refer patients to RCEB by contacting:

Regional Center of the East Bay

76777 Oakport Street, Suite 300

Oakland, CA 94621

1.510.383.1200 or visit **www.rceb.org**

Women, Infants and Children Program (WIC)

WIC is a nutrition/food program that helps pregnant, breastfeeding or postpartum women, and children less than 5 years of age to eat well and stay healthy.

- WIC eligibility is determined by federal income guidelines, and services include free food vouchers, nutrition education, and breast-feeding support.
- Patients can call WIC at **1.888.942.9675** to find their local WIC office or visit **www.calwic.org** to receive assistance with applying for this service.

Claims Overview

- Submit claims/encounter data using the following forms:
  - CMS 1500 (HCFA)
  - UB-92 (Facility Claims)
  - PM-330 (Sterilization Consent form)
- Claims are considered timely if they are submitted within 180 calendar days post-service, or post-EOB if other coverage exists
- Contact the Provider Services department at **1.510.747.4510** to learn how to submit claims electronically.
- To file an appeal, please complete a Notice of Provider Dispute form (NOPD) and submit it to the Alliance Claims department.

Claims Overview, cont.

- Use CPT and HCPCS Codes covered by Medi-Cal to bill for services provided to Alliance Medi-Cal and Group Care members.
- Please refer to our Provider Manual for more detailed and helpful information about our claims policies.

Claims Requirements for Injectables

- Effective September 1, 2009 claims for physician administered drugs must include the National Drug Code (NDC) for each drug.
- Claims for physician administered drugs will be reimbursed in one of the following ways:
  - Medi-Cal rates for Alliance Medi-Cal and Group Care members
  - Average Wholesale Price minus 15% (AWP-15%) if a Medi-Cal or Medicare rate does not exist for a particular drug

Where to Send Your Claims

Claim Type	Member's Health Plan/ Medical Group	Address
Professional Medical Service	Alameda Alliance for Health	Alameda Alliance for Health P.O. Box 2460, Alameda, CA 94501-0460
Professional Medical Service	Children First Medical Group	Children First Medical Group P.O. Box 981705 El Paso, TX 79998
Professional Medical Service	Community Health Center Network	Community Health Center Network 101 Callan Ave, 3rd Floor San Leandro, CA 94577
Institutional (Hospital, SNF, etc.)	Alameda Alliance for Health, Children First Medical Group, and Community Health Center Network	Alameda Alliance for Health P.O. Box 2460 Alameda, CA 94501-0460
Home Health	Alameda Alliance for Health, Children First Medical Group, and Community Health Center Network	Alameda Alliance for Health P.O. Box 2460 Alameda, CA 94501-0460

Complaint and Grievance Process

- **Member Complaints/Grievances/Appeals**
- Members may report complaints/grievances/appeals by calling Alliance Member Services at **1.510.747.4567.**
- Providers may provide members with a Grievance Form that can be mailed or faxed to the Alliance.
- Once the member's complaint/grievance/appeal is logged by Member Services, our Grievances and Appeals Unit will investigate the situation and provide the member with a resolution.
- In some cases, the Alliance Grievance and Appeals Unit may request information from our providers to assist with reviewing a member's complaint/grievance.

Complaint and Grievance Process, cont.

- **Provider Complaints/Grievances/Appeals**
  - Appeals of claims decisions must be submitted via the Notice of Provider Dispute (NOPD) process. Please complete the NOPD form, attach supporting documentation, and submit it to the Alliance Claims department.
  - Appeals of authorization decisions must be submitted to the Alliance Grievances and Appeals unit. Please include supporting clinical documentation with each appeal.
  - Other provider complaints can be submitted to Alliance Provider Services.

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 behavior in medical record progress notes
- A member may **not** be discharged due to his/her medical condition, frequent visits, or high cost of care
- Member discharge requests must be submitted in writing to Provider Services **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: PQI's

- The Alliance maintains a systematic mechanism to identify, analyze and resolve potential quality of care and service issues (PQI's) to ensure that services provided to members meet established quality of care and service standards
- PQI's can be identified in several ways, including:
  - Encounter data, including medical and pharmacy claims
  - Inpatient notifications
  - Member or provider complaints
- The Alliance Quality Management unit reviews and resolves PQI's 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 studies at the same time and only once each year.

Health Education

- The Alliance has FREE health information, self-management tools and referrals to programs and classes for all members
- Health topics include:
  - Conditions like diabetes, asthma and hypertension
  - Pregnancy, breastfeeding (lactation consultants) and parenting
  - Healthy weight, nutrition and exercise
  - Smoking cessation and much more!
- The ***Provider Resource Directory**** lists free classes, programs and community referrals available to Alliance members.
- Members can complete the ***Wellness Request Form**** or call Health Programs at **1.510.747.4577** to request class listings and materials in our threshold languages (English, Spanish, Chinese, & Vietnamese).
- Providers can refer using the ***Wellness Provider Fax Request Form*.***

*Directory and forms are available at **www.alamedaalliance.org** and with your orientation packet.

Get Involved!

- Participate! Join an advisory committee to the Alliance Board of Governors:
  - Peer Review & Credentialing Committee (PRCC)
  - Pharmacy & Therapeutic Committee (P&T)
  - Health Care Quality Committee (HCQC)

We're on the Web!

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

- Verify member eligibility
- Check claim status
- Download forms
- View our on-line provider manual
- View clinical practice guidelines
- Check our on-line provider directories

And much more!

Your Provider Services Department

- We're here to help, please contact us at:
- Office: **1.510.747.4510**
- Fax: **1.855.891.7257**
- Email: **providerservices@alamedaalliance.org**

Attachments and Forms

1. Sample Member Identification Cards
2. Provider Portal Sign-Up Instructions
3. Frequently Asked Questions About Claims
4. Interpreter Services Quick Guide
5. Interpreter Services Request Form
6. Alliance Authorization Request Form
7. Medication Request Form for Alliance Medi-Cal, Group Care
8. Alliance Specialty Pharmacy Program Drug List
9. Notice of Provider Dispute Form
10. Member Grievance Forms (English, Spanish, Chinese, Vietnamese)
11. Member Rights & Responsibilities
12. Timely Access Regulations
13. Health Education Forms and Documents
14. ICD-10 Communication
15. Nurse Advice Line for Medi-Cal and Group Care Members
16. Non-Emergent Ground Transport
17. HEDIS Guide
18. Quick Reference Card