Central California Alliance for Health
Behavioral Health Informational Session

Updated May 2025

BH INFORMATIONAL SESSION

AGENDA:

1. Introduction to the Alliance
2. Member Benefits
3. Authorizations and Referrals
4. Claims
5. Care Management
6. Behavioral Health Team
7. Incentives
8. Other Services Provided

Welcome to the Alliance!

Who are we?

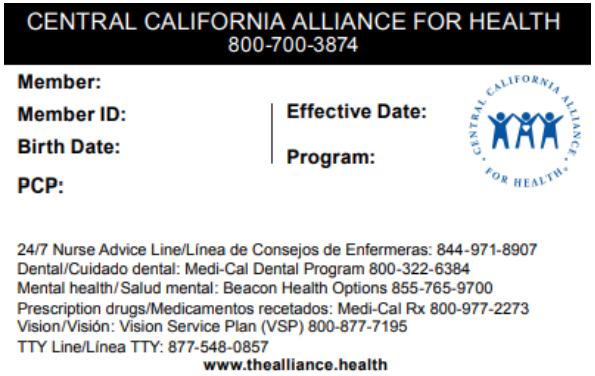
- Central California Alliance for Health (the Alliance)
- County Organized Health System
- Serve over 450,000 members in Santa Cruz, Monterey, Merced, Mariposa, San Benito, Counties
- Operate using the Managed Care Model

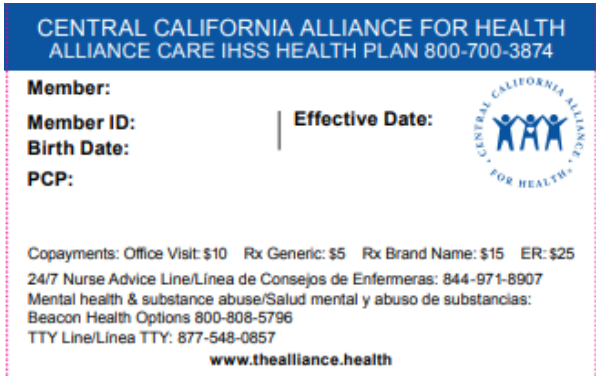
What programs do we cover?

- Medi-Cal
- Alliance Care IHSS (Monterey)

Membership Cards

New Member cards will be sent out with Alliance contact info for Mental Health





Member Eligibility

Prior to member visit:

1. Verify **eligibility** at every visit
2. Is member already receiving services?
3. If no, go ahead and see the member

How to verify eligibility?

Provider Portal: Available 24 hours a day. 7 days a week

Member Services :
(800) 700 3874
English: ext. 5505
Spanish: ext. 5508

Alliance automated system:
(800) 700 3874 ext. 5501

You will need the following information:

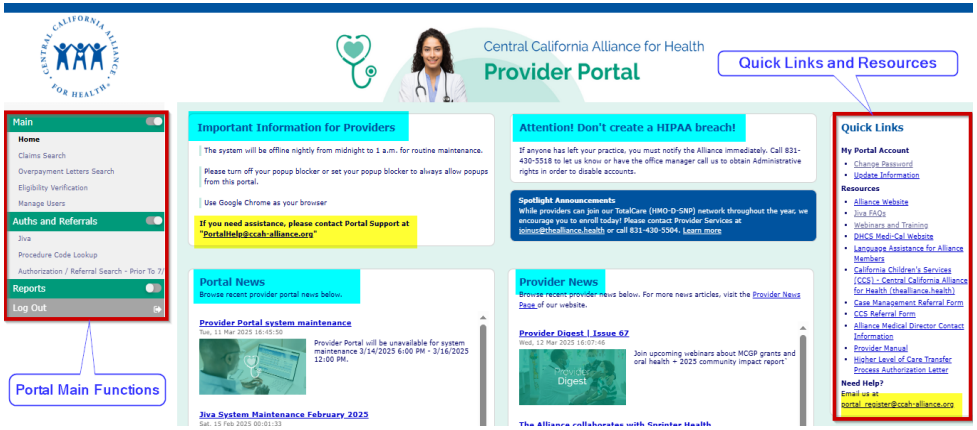
Member name

Member ID

Member birth date

Provider Portal

The **Provider Portal** is an online resource that has many valuable functions. It's a secure way to transfer information between the Alliance and the providers.



Some of the functions include:

- Member eligibility
- Search and submit requests
- Claims information
- Member reports
- Additional resources

The Alliance Provider Portal Login Page: https://provider.portal.ccah-alliance.org/

Using the Provider Portal: https://thealliance.health/for-providers/provider-portal/using-the-provider-portal/

Provider Portal New Account Request Form: https://thealliance.health/for-providers/provider-portal/provider-portal-account-request-form/

Provider Portal FAQs: https://thealliance.health/for-providers/provider-portal/using-the-provider-portal/provider-portal-frequently-asked-questions/

MEMBER BENEFITS

1. Benefits Overview
2. Benefits Not Covered

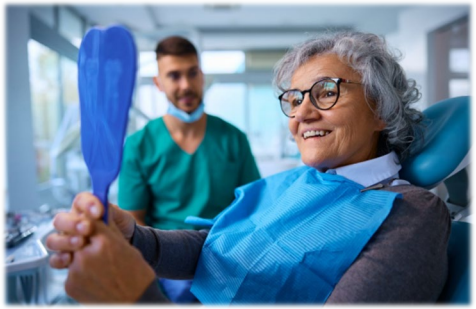
Member Benefits

- Behavioral Health Services (Mild to Moderate)
- Primary care
- Specialty care
- Allied services (PT, OT, ST, Acupuncture, Chiro)
- Durable Medical Equipment
- Self-referred services (OB Sensitive Services)
- Physician Administered Drugs
- Emergency & Urgent visits
- Inpatient and outpatient hospital care
- Diagnostic services (lab, x-ray, imaging)
- Enhanced Care Management (ECM)
- Community Supports
- Doula Services
- Vision Care
  - Covered through Vision Services Plan (VSP)
  - Toll-free access line Monday through Friday from 6:00 am to 7:00 pm Phone: 800-877-7195

Link: Benefit descriptions can be found in the Member Handbook on the Alliance website

Benefits Not Covered by the Alliance

The services listed here are covered for members by the stated entities:



- Inpatient Mental Health Services (State Medi-Cal)
- Specialty Mental Health Services (County BH Dept)
- Substance Use Disorder Treatment Services (Co. BH and State Medi-Cal)
- Dental Services (Denti-Cal)
- Local Education Authority Services (Regional Centers)
- Outpatient prescription drugs (Medi-Cal RX)
- Institutional long-term care (for stays longer than the month of entry)

AUTHORIZATIONS AND REFERRALS

1. Referral and Authorization Process

Provider Referral and Authorization Requirements

Service Type	Servicing Provider	Referral	Authorization
BH/MH	Contracted	No	No
BH/MH	Non-Contracted	No	**Yes**
BHT	Contracted	No	**Yes**
BHT	Non-Contracted	No	**Yes**

CLAIMS

1. Claims Department Overview
2. Timely Filing
3. Resolving Denials
4. Alliance Portal vs Change Echo

Claims

- Processed claims will be communicated on a “Remittance Advice” document that is sent to the provider in approximately **30 days** from received date.
- The Alliance accepts the CMS1500, UB04 claim forms for behavioral health services by mail or electronically through a clearing house.
- ATTN: CLAIMS Central California Alliance for Health, PO Box 660015 Scotts Valley, CA 95067-0015
- [Claims - Central California Alliance for Health]

Timely Filing

Claims must be received within 6 months from the date of service to be considered timely and payable at 100% of the allowed amount.

- Claims received 7-9 months after the date of service will be reimbursed at 75% of the allowed amount.
- Claims received 10-12 months after the date of service will be reimbursed at 50% of the allowed amount.
- Claims received more than a year after the date of service will be denied.

Resolving Denials

Contact the Claims Department

The Claims Customer service team is available from 8:30-4:30 Monday – Friday to answer your questions and help you resolve claims issues 831-430-5503. This line is closed from 11:30 – 12:30 for lunch

- Claim Number
- Member ID and Date of Service

Review your RA

Corrected Claims "Corrected Claim, claim number, What is being corrected"

Differences Between Alliance Portal vs Change Echo

CCAH Provider Portal

- Owned and maintained by CCAH.
- The site to check member eligibility, auth status and claim status requires a login given by CCAH
- Thealliance.health
- 800-700-3874

Echo

- Owned and maintained by the vendor Echo.
- The site to view and pull RA's and check information requires a login given by Echo
- Providerpayments.com
- 888-983-5574

Note: Initial payment is always made by Virtual Credit Card (VCC). Please let an Alliance representative know if you would like to opt out of VCC in favor of a paper check for your first payment. **We will need your NPI and your tax ID at the time you make your request**. This does not apply if you currently receive payments from the Alliance.

CARE MANAGEMENT

1. Care Management Team
2. Goals and Core Work
3. How Members Access Care
4. Referral Process

Behavioral Health Care Management (CM) Team

Rosa Linda Ogas, Behavioral Health Manager

Martha Rodriguez, Care Coordinator Care Coordination Supervisor Behavioral Health

Care Coordinator/Intake Coordinator (8 staff)

- Intake internal and external referrals
- Manage BH Referral Worklist
- Manage ACD line.
- Complete Screening Assessment and provider linkage.
- Provide follow-up.

Care Managers (5 staff)

- Manage High Risk Member care coordination
- Review assessments for appropriate level of care, refer to and connect to County Mental Health
- Complete Transition of Care Tool
- Coordinate access for additional support services
- Provide coordination for accessing community resources

Behavioral Health CM: Goals and Core Work

- Improve member overall experience by providing a person-centered approach and equitable delivery system.
- Increase member engagement to 100%.
- Ensure timely access to behavioral health services, First appointment scheduled within 10 business days from request.

Program	Goal
BH Specialty Mental Health (SMH)	Member outreach withing 24 hours. Refer member to County Mental Health. Closely monitor over the next 10 days to ensure linkage. Collaborate with County Mental Health for Closed Loop Referral process.
BH Non-Specialty Mental Health (NSMH)	Assist with provider linkage and scheduling appointment. Follow up within 5 days of scheduled appointment to confirm linkage of care and address any additional needs.
BH Continuity of Care (CoC)	Member may request up to 12 months of continuity of care with the provider.

How Members Access Care

Member in need of BH Services

- Member can self-refer by calling Alliance directly
- Member can call contracted BH provider directly for services and bypass Alliance
- Member can call/walk into local MHP access for screening and assessment
- PCP can access referral forms online at Behavioral Health - Central California Alliance for Health (will be updated for internal processes come 7/1/25)

MCP or MHP completes DHCS Screening Tool

- If member is referred to Alliance or the Mental Health Plan (MHP), a BH CM staff member will screen member for correct system of care and need and provide appropriate referrals within timely access requirement. The Alliance and our 5 MHPs coordinate daily on these referrals

Member Connected to Care

- Member will be offered appointment assistance and to be connected to a provider with an appointment within timely access requirements

Members can call 800-700-3874

Behavioral Health CM Referral

Providers can call the alliance case management line 800-700-3874 X5512

Providers can submit a care management referral form directly through the alliance website.

Referral via e-mail to list CM behavioral health team Listcmbehavioralhealthteam@thealliance.Health

BEHAVIORAL HEALTH TEAM

1. Team Introduction
2. Core Work and Functions

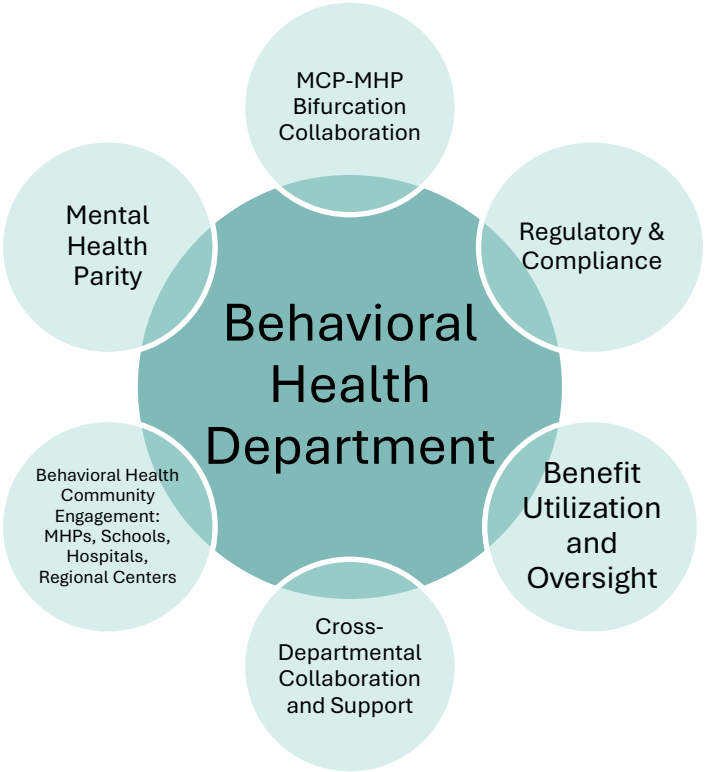
Behavioral Health Department Introduction

- The Behavioral Health (BH) Department provides regulatory oversight of behavioral healthcare benefits within the Managed Care Plan and ensures collaboration with outside stakeholders who provide other types of behavioral health services, such as our five County Mental Health Plans (MHP) and Regional Centers.

- The BH Department provides ongoing support and collaboration cross-departmentally in accordance with our Integrated Behavioral Health approach.

"We ensure timely and equitable provision of high-quality, accessible behavioral health care to all members through a collaborative and integrated approach to improve overall wellbeing."

Behavioral Health Core Work and Functions



Questions for the BH Department: listbh@thealliance.health

FINANCIAL INCENTIVES

1. Incentive Measures
2. Incentive Payment Specifications

Incentive Measures

	Measure	Goal
1	Coordination with Primary Care Provider	Increase data sharing and collaboration between BH providers and PCPs.
2	Provider Completion of Satisfaction Survey	Improve Provider Satisfaction Survey responsiveness
3	Provider Completion of DEIB Training	Provider training on Health Equity to meet heath equity accreditation and DHCS requirements.
4	Increase in Volume of Member Seen	Expand provider acceptance of members and increase number of members seen with timely access to care
5	Provider Completion of ACES Training and Attestation	Increase ACEs (adverse childhood experiences) screenings
6	Increase Access - Community Settings	Reduce access barriers and increase member access to care outside clinic settings/community setting.
7	Emergency Department Follow-Up Visit	Reduce ED utilization and inpatient admissions through FUA/FUM HEDIS
8	Annual Bilingual Bonus	Reduce equity and disparity gap
9	Bilingual Visit Add-On	Improve member quality of care

Incentive Payment Specification

	Measure	Requirement	Incentive Amount	Payment Frequency
1	Coordination with Primary Care Provider	Claim submission using code G9968 and modifier U3 signifying communication with PCP within 30 days of behavioral health visit.	$25 per member coordinated	Quarterly
2	Provider Completion of Satisfaction Survey	Completion of Provider Satisfaction Survey (actual survey responses are anonymous and reported to the Alliance at a summarized level).	$100 per survey response	Annual
3	Provider Completion of DEIB Training	Completion of Alliance DEIB training either in-person or through online learning management system (LMS). This measure will only be effective if DHCS makes it a requirement for Medi-Cal providers to complete health equity training within calendar year 2025.	$200 per provider	Annual
4	Increase in Volume of Member Seen	Claims data will be used to assess distinct members seen in measurement quarter against prior year quarter.	Improvement Tier / Rate Per Member: 1% to 5% — $50; 6% to 10% — $100; 11% to 15% — $150; 16%+ — $200	Quarterly
5	Provider Completion of ACES Training and Attestation	Achievement of a valid Adverse Childhood Experiences (ACEs) Training accompanied by the attestation of such training to DHCS.	$200 per provider	Quarterly

Incentive Payment Specification

	Measure	Requirement	Incentive Amount	Payment Frequency
6	Increase Access - Community Settings	Claim submission for community setting with the following place of service codes: ▪ 03 School ▪ 04 Homeless Shelter ▪ 09 Prison – Correctional Facility ▪ 12 Home ▪ 13 Assisted Living Facility ▪ 14 Group Home ▪ 15 Mobile Unit ▪ 16 Temporary Lodging ▪ 18 Place of Employment ▪ 27 Outreach Site/Street ▪ 31 Skilled Nursing Facility ▪ 32 Nursing Facility ▪ 33 Custodial Care Facility ▪ 34 Hospice	$25 per visit	Quarterly
7	Emergency Department Follow-Up Visit	Claim for service rendered within 30 days of a member discharge from an ED visit related to a mental health or substance abuse disorder.	$50 per visit	Annual
8	Annual Bilingual Bonus	Bilingual capability noted on credentialing application and submission of at least one claim in the measurement year.	$250 per provider	Annual
9	Bilingual Visit Add-On	Bilingual capability noted on credentialing application and claim submission for service rendered to member in member's preferred language.	$10 per visit	Quarterly

OTHER ALLIANCE SERVICES PROVIDED

1. Enhanced Care Management/ Community Supports
2. Requesting Transportation
3. Language Assistance Services
4. Nurse Advice Line (NAL)

CalAIM Enhanced Care Management and Community Supports

CalAIM is a multi year DHCS initiative to improve the quality of life and health outcomes for Medi Cal beneficiaries by implementing broad delivery system, program, and payment reforms.

 Enhanced Care Management (ECM)	Community Supports
• The ECM benefit will provide intensive whole-person care management and coordination to help address the clinical and nonclinical needs of Medi-Cal MCP's highest risk members. • MCPs will and oversee ECM benefits, identify target populations and assign them to ECM Providers who will be responsible for conducting outreach and coordinating and managing care across physical, behavioral and social service providers. • ECM services will be community-based with high-touch, on-the ground, face-to-face, and frequent interactions between members and ECM Providers.	• Community Supports are cost-effective, health-supporting and typically non-medical activities that may substitute for State Plan-covered services. • DHCS plans to authorize 14 Community Supports categories, including housing transition and navigation services, respite care, day habilitation programs, and nursing facility transition support to Assisted Living Facilities or a home. • Optional to MCPs - Highly encouraged by DHCS

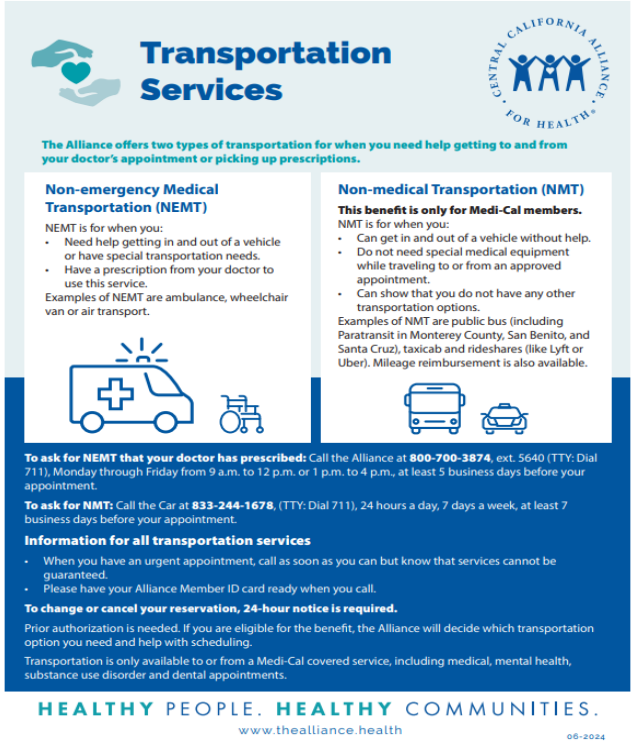
Referrals for ECM/ CS

No wrong door approach

The Alliance will accept requests for ECM/ CS from:

- Members interested in receiving ECM/ CS or their family members, guardian, authorized representative, caregiver, and/or authorized support person(s);
- Behavioral Health Providers;
- Social Service Providers;
- ECM Providers;
- Other Providers in the Alliance's contracted network;
- Community-based entities, including those contracted to provide Community Supports; and
- Other Providers not listed above.

Medical Transportation Services



Transportation Services

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

The Alliance offers two types of transportation for when you need help getting to and from your doctor's appointment or picking up prescriptions.

Non-emergency Medical Transportation (NEMT)

NEMT is for when you:

- Need help getting in and out of a vehicle or have special transportation needs.
- Have a prescription from your doctor to use this service.

Examples of NEMT are ambulance, wheelchair van or air transport.

Non-medical Transportation (NMT)

This benefit is only for Medi-Cal members.

NMT is for when you:

- Can get in and out of a vehicle without help.
- Do not need special medical equipment while traveling to or from an approved appointment.
- Can show that you do not have any other transportation options.

Examples of NMT are public bus (including Paratransit in Monterey County, San Benito, and Santa Cruz), taxicab and rideshares (like Lyft or Uber). Mileage reimbursement is also available.

To ask for NEMT that your doctor has prescribed: Call the Alliance at **800-700-3874**, ext. 5640 (TTY: Dial 711), Monday through Friday from 9 a.m. to 12 p.m. or 1 p.m. to 4 p.m., at least 5 business days before your appointment.

To ask for NMT: Call the Car at **833-244-1678**, (TTY: Dial 711), 24 hours a day, 7 days a week, at least 7 business days before your appointment.

Information for all transportation services

- When you have an urgent appointment, call as soon as you can but know that services cannot be guaranteed.
- Please have your Alliance Member ID card ready when you call.

To change or cancel your reservation, 24-hour notice is required.

Prior authorization is needed. If you are eligible for the benefit, the Alliance will decide which transportation option you need and help with scheduling.

Transportation is only available to or from a Medi-Cal covered service, including medical, mental health, substance use disorder and dental appointments.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

www.thealliance.health

06-2024

Providers can use the link below to access the electronic version of the non-emergency medical transportation (NEMT) request form for Alliance members.

Link: https://thealliance.health/wp-content/uploads/Transportation_Services_Request_Form.pdf

Language Assistance Services

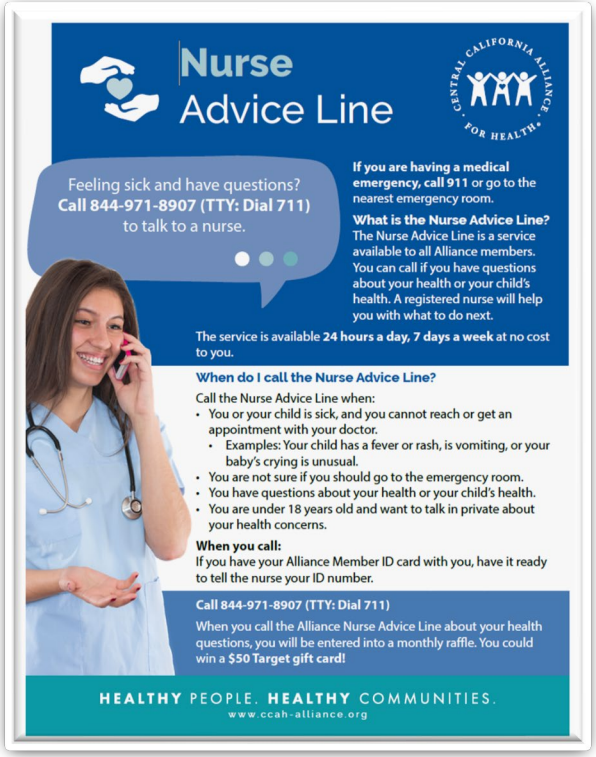
Telephonic Interpreting

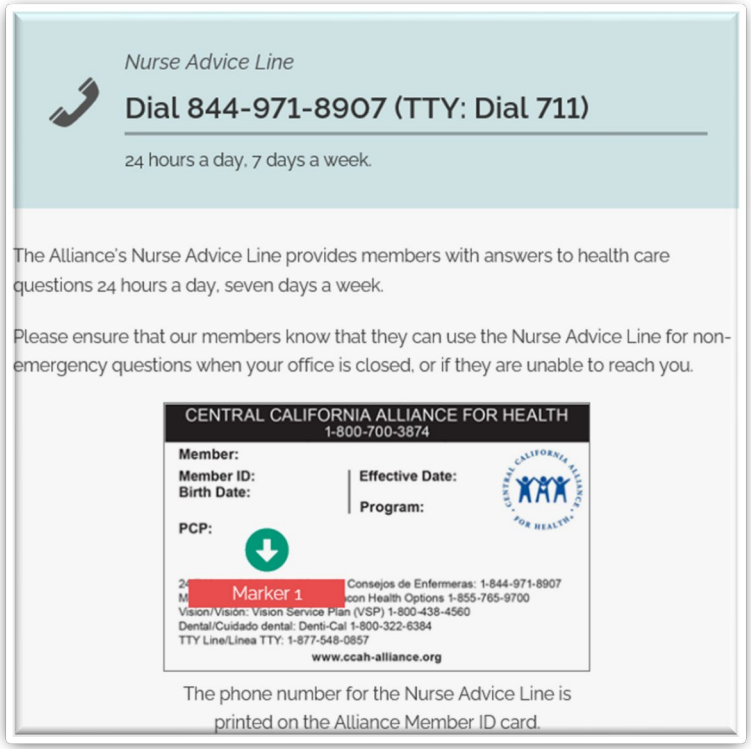
- Available 24/7 to support members at all points of contact
- No prior approval needed
- Over 200 foreign languages

Face-to-Face Interpreting

- For use when the following situations are present:
  - Members who are deaf or hearing-impaired.
  - End-of-life issues.
  - Abuse or sexual assault issues.
  - Complex procedures or courses of therapy.
- Prior approval is required to access all face-to-face interpreter services.
- American Sign Language (ASL) is available to deaf or hard-of-hearing members for all Alliance covered services.

Nurse Advice Line (NAL)





Link: https://thealliance.health/for-providers/manage-care/clinical-resources/nurse-advice-line/

Thank You!

APPENDIX

1. Accessibility Standards for Member Appointments
2. Fraud Waste and Abuse Compliance
3. CCS
4. Provider Disputes Instructions
5. Electronic Data Interchange
6. Referral Process for ECM/ CS

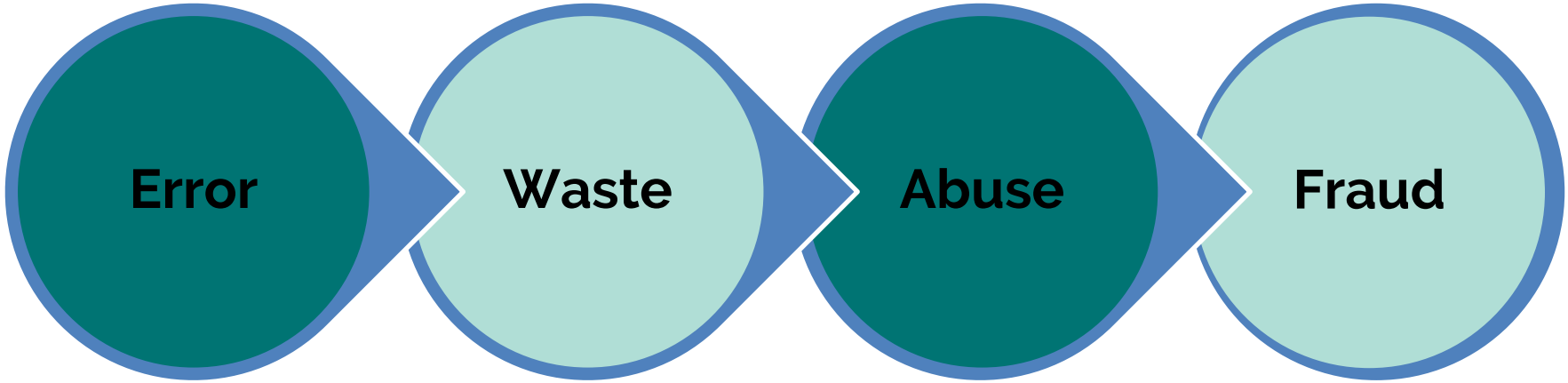
Accessibility Standards for Member Appointments

Category	Timely Access Standard
Urgent care appointment for which no prior authorization is required	24 hours
Urgent care appointment for services that do require prior authorization	96 hours from request
Non-urgent, primary care – including first pre-natal visit No authorization required	10 business days
Non-urgent, non-physician mental health providers	10 business days
Non-urgent follow-up appointment with a mental health care (non-physician provider) or substance use disorder provider.	10 business days from prior appointment
Non-urgent, Specialist care	15 business days
Non-urgent, ancillary services	15 business days
Mental Health Care	Refer to Carelon for screening. Mild to moderate levels of care will be referred to a Carelon provider. Severe levels of care referred to county mental health.

What is a Grievance or Appeal?

Member Grievance	• **Any expression of dissatisfaction**. Complaint about Alliance (or provider) benefits or services: quality of care, quality of service, long wait times, or communication issues.
Member Appeal	• When a member does not agree with an Alliance decision to deny or change services. Also called an Adverse Benefit Determination (ABD)
State Fair Hearing	• A formal process members may request when they do not agree with an individual Appeal decision. Medi-Cal members must first file an appeal with the Plan.

Fraud, Waste and Abuse (FWA)



Error	Waste	Abuse	Fraud
Mistakes *E.g. incorrect coding*	Consumption of resources due to mismanagement, inappropriate actions, inadequate oversight; inefficiency. Typically, not a result of criminal actions. *E.g. Ordering excessive diagnostic tests*	Activity inconsistent with sound fiscal, business, or medical practice resulting in unnecessary cost; bending the rules. *E.g. Improper billing practices*	Intentional deception or misrepresentation made with the knowledge that deception could result in unauthorized benefit. *E.g. Billing for services not provided*

Laws Relating to Fraud Waste and Abuse (FWA)

Laws to prevent engaging in fraudulent behavior and encouraging the reporting of suspected FWA:

Law / Requirement	Summary
Federal & California False Claims Act	• Prohibits the submission of fraudulent claims • Allows whistleblowers to be rewarded with a percentage of the money the government recovers
Anti-Kickback Statute	• Prohibits asking for / receiving anything of value in exchange for referrals of federal health care business
Physician Self-Referral Law	• Prohibits a physician from making referrals for certain designated health services to entities that they have a financial interest in
Medi-Cal Contract Requirements	• Requires health plans to report suspected FWA to the Department of Health Care Services

Link: Training materials available via Office of Inspector General Health Care Fraud Prevention & Enforcement Action Team

HIPAA Compliance

Providers are responsible for maintaining the confidentiality of Alliance member protected health information (PHI).

Law	Summary
Privacy Rule	• Ensures individuals' PHI is protected from unauthorized use/disclosure while allowing information flow needed to promote high quality care. • Includes: permitted / required disclosures, authorization to disclose information, patient right of access to records, etc.
Security Rule	• Establishes security standards for electronic PHI. • Includes: risk analysis, encryption, administrative / physical / technical safeguards to protect PHI
Breach Notification	• Requires Covered Entities to notify patients if their PHI has been breached; includes standards for determining if a breach occurred

Link: Training materials via the Office of Civil Rights

Reporting Compliance Concerns

Providers are our partners in ensuring compliance

Report HIPAA breaches and security incidents immediately, within the same business day that they're discovered

Report suspected FWA within 5 days of discovery

Reporting mechanisms:

Contact your Provider Services Representative

Email the Compliance Department: HIPAA@ccah-alliance.org

Complete form on Alliance Website

California Children's Services (CCS) Whole Child Model Program

California Children's Services (CCS) is a statewide program for children and young adults under the age of 21 with special health care needs.
The Whole Child Model (WCM) program was developed by the state of California to help CCS children and their families get better care coordination, access to care and health results

As of July 1, 2018, Alliance members receive their CCS care services through the Alliance's Whole Child Model program. Under the WCM, the Alliance will arrange for care for you and your child. The Alliance works closely with local county CCS programs and CCS-approved providers and will help families with both CCS care and Medi-Cal covered services.

- CCS is changed because of a new state law (SB586) that passed in 2016
- The intent is to improve coordination of primary, specialty, and behavioral health care by centralizing responsibility for services with the health plan.
- Most medical care will be authorized, covered and coordinated by the Alliance. Instead of arranging for care through two different systems, providers and families will work with one system.
- Under this model, the three counties in the Alliance service area will remain responsible for determining eligibility, transferring CCS cases between counties, serving non-Medi-Cal clients and those in FFS Medi-Cal and for the Medical Therapy Program. They will also retain oversight of services provided under the Pediatric Palliative Care Waiver, where it is available.
- The Alliance estimates approximately 6,000 Alliance members are currently receiving CCS services in our service area. This number remains dynamic as children fall on and off of CCS eligibility.
- There are a small number of children in each county who receive CCS services but who are not Alliance members. The county will continue to oversee authorization and case management for those children.

Santa Cruz County CCS	(831) 763-8000
Monterey County CCS	(831) 755-4747
Merced County CCS	(209) 381-1114

CCS Eligibility, Authorizations, Claims and Payment

- County CCS offices determine a child's eligibility for the program. Providers should send program referral to their respective county's CCS office:
  - Merced County
  - Monterey County
  - Santa Cruz

- The Alliance will review Referral Request and Treatment Authorization Request (TARs) to determine authorization for CCS-eligible members.
- The Alliance processes Claims for all CCS-eligible Medi-Cal members according to standard policies and procedures with the following additions:
  - CCS diagnosis code should only be listed on claims when treating the CCS condition
  - TAR or prior authorization numbers are required on the claim for claims processing

CCS Resources:

- **California Children's Services (CCS) (thealliance.health)**
- **Case Management Referral Form**
- **CCS Referral Form**

For more information please contact the Alliance Pediatric Case Management department at (800) 700-3874 ext. 5513

CCS Provider Paneling

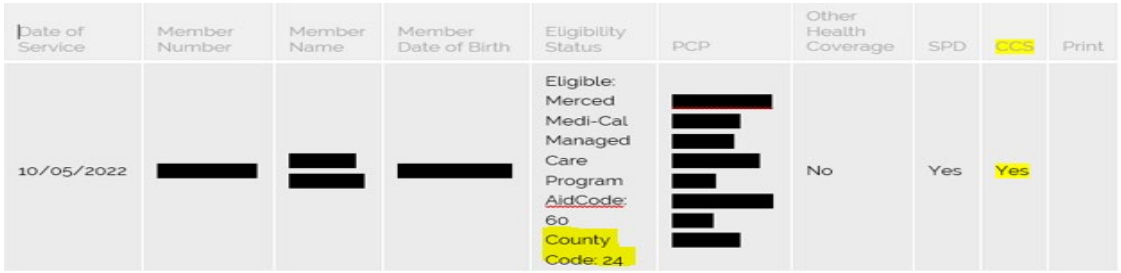
Providers who are interested in participating in the CCS program must fulfill CCS requirements by provider type, as shown on the DHCS website.

The process to become CCS-paneled is relatively simple. To get started, fill out the online application on the DHCS CCS provider paneling website. Provider paneling training and support materials are also available on the site.

For more information regarding provider paneling please contact Provider Services at (800) 430-5504

California Children's Services (CCS) Whole Child Model Program
How to Identify Member's County

Provider Portal Eligibility Verification



Date of Service	Member Number	Member Name	Member Date of Birth	Eligibility Status	PCP	Other Health Coverage	SPD	CCS	Print
10/05/2022	[redacted]	[redacted]	[redacted]	Eligible: Merced Medi-Cal Managed Care Program AidCode: 60 County Code: 24	[redacted]	No	Yes	Yes	

County	County Code
Mariposa	22
Merced	24
Monterey	27
San Benito	35
Santa Cruz	44

Provider Disputes Instructions

- Inquiries and disputes must be filed with the Alliance within 365 days of the action or decision being disputed or, in a case where the dispute addresses the Alliance's inaction, within 365 days of the expiration of the Alliance's time to act.
- Providers must file Inquiries and Disputes in writing, either by mail or fax for a hard copy, or by email for electronic.
- Information about the resolution process and the Provider Inquiry Form (PIF) are available on the Alliance website and in the Alliance's Provider Manual (the Provider Inquiry form contains all contact information)
- Enter all Provider contact information on the PIF to ensure the resolution is received by the provider timely.
- Ensure there is a clear explanation of the issue in question and the result the provider is expecting when filing a Provider Inquiry.
- The Alliance will acknowledge inquiries and disputes within ten (10) business days of receipt for hard copy cases, or within two (2) business days of receipt for requests received electronically.
- The Alliance will send a written resolution to inquiries and disputes within thirty (30) business days of the request received date for contracted providers and forty five (45) business days for non contracted providers.

Electronic Data Interchange FAQs

Q: How do we sign up for Electronic Claims submission with CCAH?
A: You will need to complete this form to sign up for Electronic Claims submission with CCAH: https://www.ccah-alliance.org/aspnetforms/ProviderECSForm.aspx

Q: How do I know whether I am signed up for Electronic Claims submission?
A: Upon receipt of your completed Electronic Claim submission form, you will receive confirmation of your setup from the CCAH EDI team in approximately 2-5 business days.

Q: How long does the Electronic Claims submission process take?
A: The setup process takes approximately 2-5 Business days.

Q: How do I change Clearing Houses?
A: If you are currently setup to send Electronic Claims with CCAH, and need to change Clearing Houses, please submit a new setup form. The EDI team will review and respond within 2-5 business days.

Q: I'm already signed up with another Clearing House, do I need to sign up again to connect to CCAH?
A: Yes, a new setup will be required to ensure your setup can successfully pass through the Clearing House to reach CCAH. You will need to complete this form to sign up for Electronic Claims submission with CCAH: https://www.ccah-alliance.org/aspnetforms/ProviderECSForm.aspx.

Electronic Data Interchange FAQs Continued

Q: How do we sign up to receive an Electronic Remittance Advice (ERA)?
A: To enroll in ERA, contact our partner ECHO Health at https://enrollments.echohealthinc.com/EFTERAInvitation.aspx?ReturnUrl=%2f or call (888) 834-3511.

Q: What is the CCAH Payer ID?
A: The two Clearing Houses used most often by the Alliance are Office Ally and Change Healthcare.
•The Payer ID for Office Ally is CCA01 (Professional and Institutional)
•The Payer IDs for Change Healthcare are SX169 (Professional); 12K82 (Institutional)

Q: Can I connect to CCAH using my own Clearing House (Clearing House that is not Office Ally)?
A: CCAH connects to many Clearing Houses. Upon enrollment setup, CCAH will verify if the provided Clearing House can be connected to. If a Clearing House is unavailable, a provider can still have the option to connect with EDI from your Clearing House via Office Ally or you may contact edisupport@ccah-alliance.org if interested in submitting directly to us.

Q: Is there a contact for EDI assistance at CCAH?
A: edisupport@ccah-alliance.org

Referral Process for ECM/ CS

1. The member or representative:
   - **Can complete a Referral Form** either using a web-based form
   - **Can call** and a member of the ECM team will walk through form
2. The provider completes:
   - **A Referral Form** using a web-based form

   Enhanced Care Management (ECM) and Community Supports Provider Referrals - Central California Alliance for Health (thealliance.health)
   - **A TAR Form** (fax or email return)
   - **Authorization through the provider portal**
   - **Can call** and a member of the ECM team will review above processes
3. The Alliance will **fax authorization correspondence** to both the servicing and requesting provider.
   - Approval
   - Denial
   - Void
   - Status Change