Newly Contracted Non-PCP Orientation

AGENDA:

1. Introduction
2. Member Benefits
3. Referrals & Authorizations
4. FAQs

NEWLY
CONTRACTED
NON-PCP
ORIENTATION

Welcome to the Alliance!

Who are we?

- Central California Alliance for Health (the Alliance)
- County Organized Health System
- Serve over 440,000 members in Mariposa, Monterey, Merced, San Benito and Santa Cruz Counties
- Operate using the Managed Care Model

What programs do we cover?

- Medi-Cal
- Alliance Care IHSS (Monterey)

Alliance Mission

- Ensure appropriate access to care.
- Improve medical outcomes, minimizing unnecessary suffering and cost.

- Promote self-care and wellness among health plan members.
- Increase health care providers' satisfaction and participation with the plan.
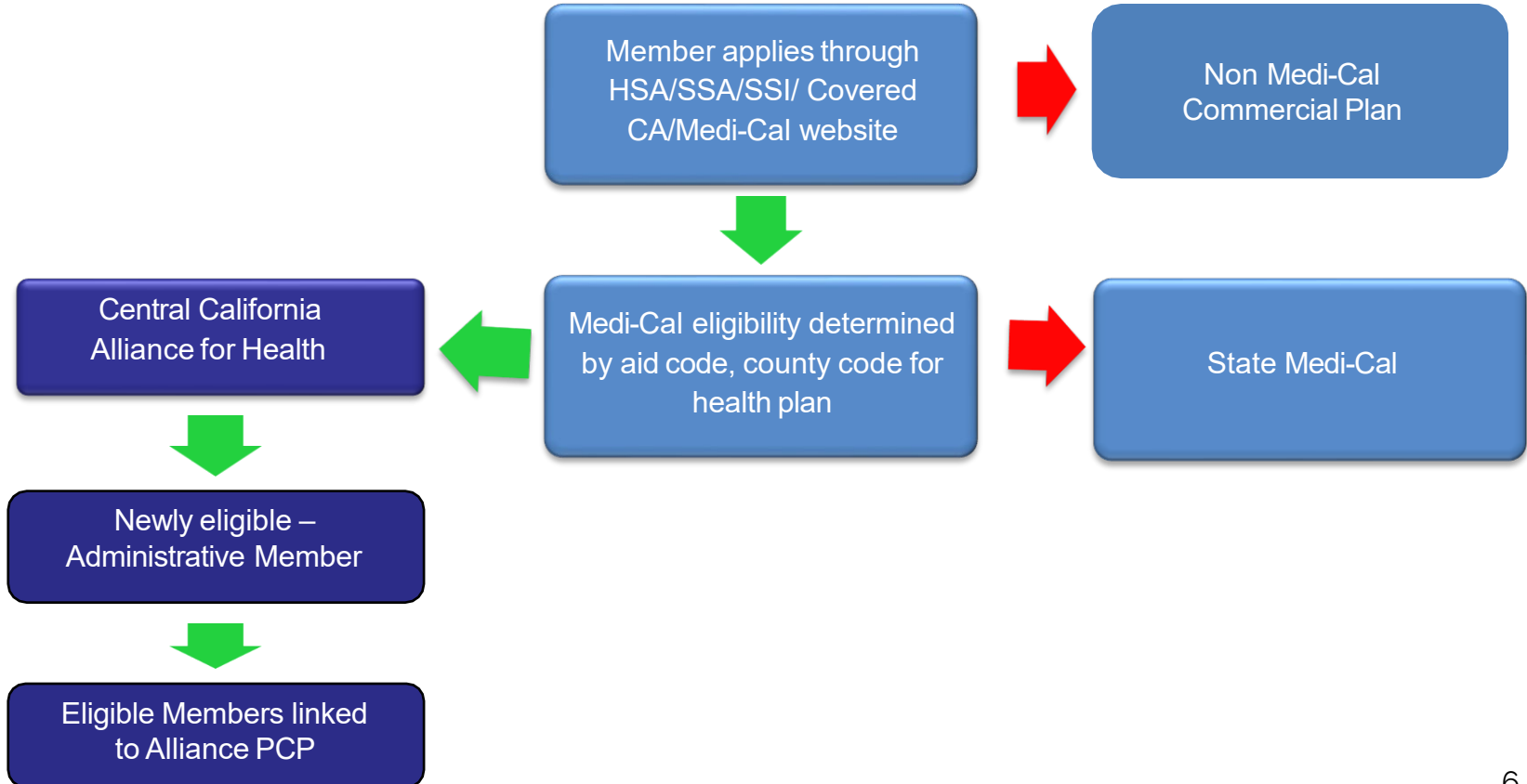
The Managed Care Model

- Members select a Primary Care Provider (PCP) who provides a patient-centered medical home.

- PCP is responsible for members' primary and preventive care, and arranging and coordinating all other aspects of their health care.

- PCPs are family practice, internal medicine, pediatrics or OB/GYNs.

- Eligible members assigned ("linked") to a PCP or clinic may only see a specialist (e.g., cardiologist, dermatologist, rheumatologist) if referred by their PCP.
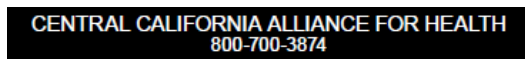
How Members Join the Alliance

Member applies through HSA/SSA/SSI/ Covered CA/Medi-Cal website → Non Medi-Cal Commercial Plan

Medi-Cal eligibility determined by aid code, county code for health plan → State Medi-Cal

Medi-Cal eligibility determined by aid code, county code for health plan ← Central California Alliance for Health

Central California Alliance for Health → Newly eligible – Administrative Member → Eligible Members linked to Alliance PCP

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Membership Cards

Alliance Cards

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
800-700-3874

Member:
Member ID:
Birth Date:
PCP:
Effective Date:
Program:

24/7 Nurse Advice Line/Línea de Consejos de Enfermeras: 844-971-8907
Dental/Cuidado dental: Medi-Cal Dental Program 800-322-6384
Mental health/Salud mental: Carelon Behavioral Health 855-765-9700
Prescription drugs/Medicamentos recetados: Medi-Cal Rx 800-977-2273
Vision/Visión: Vision Service Plan (VSP) 800-877-7195
TTY Line/Línea TTY: 877-548-0857
www.thealliance.health

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
ALLIANCE CARE IHSS HEALTH PLAN 800-700-3874

Member:
Member ID:
Birth Date:
PCP:
Effective Date:

Copayments: Office Visit: $10   Rx Generic: $5   Rx Brand Name: $15   ER: $25
24/7 Nurse Advice Line/Línea de Consejos de Enfermeras: 844-971-8907
Mental health & substance abuse/Salud mental y abuso de substancias:
Carelon Behavioral Health 800-808-5796
TTY Line/Línea TTY: 877-548-0857
www.thealliance.health

State Medi-Cal Card

STATE OF CALIFORNIA
BENEFITS IDENTIFICATION CARD
ID No. 01234567A96144
JOHN Q RECIPIENT
M 05 20 1991 Issue Date 05 24 16

Eligibility

Prior to patient visit:

1. Verify eligibility at every visit.

2. Eligible?

3. Are they linked to the PCP who referred to your practice?

4. If yes, go ahead and see the patient.

Reasons why a member may not be eligible:

Share of cost

Lost eligibility

Reasons why a member may not be linked to a practice:

Administrative member

State Medi-Cal

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

Accessibility

Category	Timely Access Standard
Urgent care appointment for which no prior authorization is required	48 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-physicians mental health provider *	10 business days
Non-urgent, Specialist care	15 business days
Non-urgent, Ancillary services	15 business days
Mental Health Care	Refer to Carelon Behavioral Health for screening. Mild to moderate levels of care will be referred to a Carelon provider. Severe levels of care referred to county mental health.

Training Agenda

····> Member Benefits

····> Referrals & Authorizations

····> Frequently Asked Questions (FAQs)

Member Benefits

- Primary care

- Specialty care

- Allied services

- Durable Medical Equipment

- Self-referred services

- Pharmacy

- Emergency care

- Inpatient and outpatient hospital care

- Diagnostic services (lab, x-ray, imaging)

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

Subcontracted Member Benefits

- Vision
  - Covered through Vision Services Plan (VSP).

- Medi-Cal Mental Health
  - Carelon Behavioral Health is subcontracted to provide outpatient mental health services for Alliance members.

- IHSS Mental Health (Monterey)
  - Carelon Behavioral Health manages outpatient and inpatient mental health. There is no referral to county.

Benefits Not Covered by the Alliance

- Dental Services (Denti-Cal)

- Inpatient Mental Health Services   (State Medi-Cal)

- Substance Abuse Treatment Services (State Medi-Cal)

- Local Education Authority Services (Regional Centers)

Referrals

Specialists should render services when:

- Referral is on file for the member.
- Member is eligible on the date of service.

In-Area Referrals

- The member's Primary Care Provider (PCP) initiates the referral process.

- The PCP completes the Referral Consultation Request (RCR) form via the Provider Portal.

- The number of visits, services and/or period of service to be rendered must appear on the (RCR) form.

- The PCP sends the (RCR) to the Alliance. Copies are sent to the specialist.

- The PCP files his/her copy and the respective reports in the patient's medical record.

Out-of-Area Referrals

- Made to providers outside of Mariposa, Merced, Monterey, San Benito and Santa Cruz Counties and non-contracted, in-network providers for all other lines of business.

- The member's (PCP) initiates the referral process.

- The (PCP) completes **and signs** the out-of-area referral either by using a State 50-1 TAR form or via the Provider Portal.

- Include: explanation of medical necessity, failed treatment attempts prior to referral, supporting medical documentation, reasons why care can not be accessed locally.

Referral Forms

In Area Referral

Out of Area Referral

These forms are also available to be completed electronically on the Provider Portal at

https://thealliance.health/for-providers/provider-portal/

Authorizations

- A Treatment Authorization Request / "authorization" or "TAR" is issued by the **servicing** provider to request authorization from the Alliance.

- Ensures elective procedures, hospital admissions, services & supplies are medically necessary and covered as required by state law.

- Must be completed on the State 50-1 TAR form or submitted through the Provider Portal.

Authorization must include:
- Medical Justification.
- Documentation of recent history. & physical to justify procedure.
- Copies of relevant lab & appropriate consultation report.
- Must be signed and dated by MD.

The Treatment Authorization Request must be submitted prior to a provision of a service unless emergent. Otherwise, it must be received within 30 calendar days of initiation of services with an explanation as to why it could not be submitted prior to service being rendered.

Authorizations

[Treatment Authorization Form](#)

This form is also available to be completed electronically on the Provider Portal at https://thealliance.health/for-providers/provider-portal/

FAQs

How do I find out if a CPT code requires a Treatment Authorization Request? If you have questions about which procedures require a TAR, please have the CPT code ready.

Check the Treatment Authorization Request User Guide:
eTAR User Guide Basics 2022 (etar_basics_2024)

Call your Provider Services Representative at: 831-430-5514.
Fax an "Treatment Authorization Request Form" to the Health Services Department at 831-430-5859.

How do I submit a Treatment Authorization Request to the Alliance?
You can submit a Treatment Authorization Request to the Alliance the following ways:

Submit through the Provider Portal
Fax to: 831-430-5850
Mail to: Central California Alliance for Health
ATTN: Authorizations
PO Box 660012
Scotts Valley, CA 95067

FAQs

How do I know which medication is covered by the Alliance?
Please refer to the Alliance formulary online at https://thealliance.health/for-providers/manage-care/pharmacy-services/pharmacy-formulary/ to find out if a particular medication is listed. If a patient requires a non-formulary medication, or the prescription exceeds the limit of days or quantity allowed per the formulary, a TAR may be submitted by FAX 831-430-5851 to the Alliance or can be mailed to the attention of the Pharmacy Department. Once the prescribing physician or filling pharmacist fills out and submits a TAR for a prescription, the Alliance will issue the pharmacy a Pre-Authorization number. You will need this number to process prescriptions that require a TAR.

For Healthy Kids, IHSS and Medi-Cal Access Program members, prior authorization requests for medications must be submitted on the "Prescription Drug Prior Authorization Request Form" If you need to speak to Alliance pharmacy personnel, please contact the Alliance Pharmacy at: 831-430-5500, ext. 5577.

Does the Alliance offer support for seniors and persons with disabilities? Yes! The Alliance offers an extensive amount of information on our Seniors and Disabilities (SPD) page. These resources are available to providers and their staff in order to better communicate and care for our diverse populations.

FAQs

What is an administrative member?
Some Alliance Medi-Cal patients are not assigned to a PCP. They are "administrative members" and can access care from any willing Medi-Cal provider without a referral. Administrative patients include those who:

- Are in an out of area placement situation
- Reside in a Skilled Nursing Facility
- Are in Hospice Care
- Have primary insurance including Medicare Part B
- Have Medi-Cal with a Share of Cost

How does share of cost apply to an Alliance member?
A share of cost is the amount that the individual or family is required to pay out of pocket for medical expenses before becoming eligible for Medi-Cal during that month.

Where can I find Alliance forms?
Alliance forms can be found in the Forms repository on the Provider website.

How do I find other providers who will see Alliance members?
You can look in our online Provider Directory to find providers who are contracted with the Alliance.

FAQs

How do I submit claims to the Alliance?

The Alliance accepts three types of claim forms: PM 160; CMS1500 and UB04. Providers may submit hard copy claims by mail or claims may be submitted electronically through a clearing hours (i.e. OfficeAlly).   Medi-Medi claims are sent to Medicare and can be crossed-over to the Alliance or you can elect to have the cross-over claims turned off in order to submit Medi-Medi claims via hard copy.   Please see the [Provider Manual](#) (page 107) for more information.

What coding reference should I use to bill the Alliance?

The Alliance uses the current year AMA CPT, ICD-10, the Healthcare Common Procedure Coding System (HCPCS) and the Medi-Cal Manual found at: www.medi-cal.ca.gov.

What is the fastest way to get payments from the Alliance?

With electronic funds transfer (EFT) you will receive payments up to seven days faster than paper checks. Replacing checks with EFTs is also the single best way to combat fraud. To sign up to [receive funds from the Alliance electronically, please go to Claims - Central California Alliance for Health](#) [(thealliance.health).](#)

FAQs

What happens when a member does not show for an appointment?
Providers can submit a "Member No Show" form to document missed appointments. The forms are located on the Provider page of the Alliance Website under "Department Forms".

How can I file a dispute?
Providers may file disputes regarding administrative, contract, and payment issues. Provider 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 our time to act. Providers must exhaust this dispute resolution process before pursuing other available legal remedies. The Provider Dispute Form is located on the Provider page of the Alliance Website under "Department Forms".

Can a member file a complaint about me or my practice?
Alliance members have the right to file complaints about their experiences with us or with our providers. While most providers have their own internal mechanisms for resolving patient complaints, we provide Grievance forms (in English, Spanish and Hmong).

Where can I get additional information and resources?

www.thealliance.health

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Where can I get additional information and resources?

Sign up or log in at the following link:
https://thealliance.health/for-providers/provider-portal/

Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (EPSDT)

- On a biannual basis, all Network Providers must complete the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Training.

- Network Providers can access the training on the Alliance Provider Training webpage by clicking **Medi-Cal for Kids & Teens** under Resources.

Medi-Cal for Kids & Teens Provider Training

DHCS

Gender Affirming Care
Senate Bill 923

Compliance with **Senate Bill 923-Gender-Affirming Care**

APL **APL24-018**

This APL formally adopts the **Transgender, Gender Divers, or Intersex (TGI) Working Group recommendations** regarding the topics in the training curriculum for health care service plan staff.

This APL requires a plan to ensure all health care service staff complete evidence-based cultural competence training when providing trans-inclusive health care for individuals who identify as TGI. For more information refer to pages 7-10 of the APL

The Alliance is required to include which in-network providers offer gender-affirming services in provider directories and call centers no later than Feb 14, 2025.

Please fill out this form to let us know if you offer gender-affirming services.

For more information, please refer to DMHC APL 24-018.

Confirm Review

After reviewing the information in this file, please click the link below to acknowledge that you have completed the training. Please note that the review must be completed prior to the 10th business day of the month.

Provider Attestation Form

Questions?