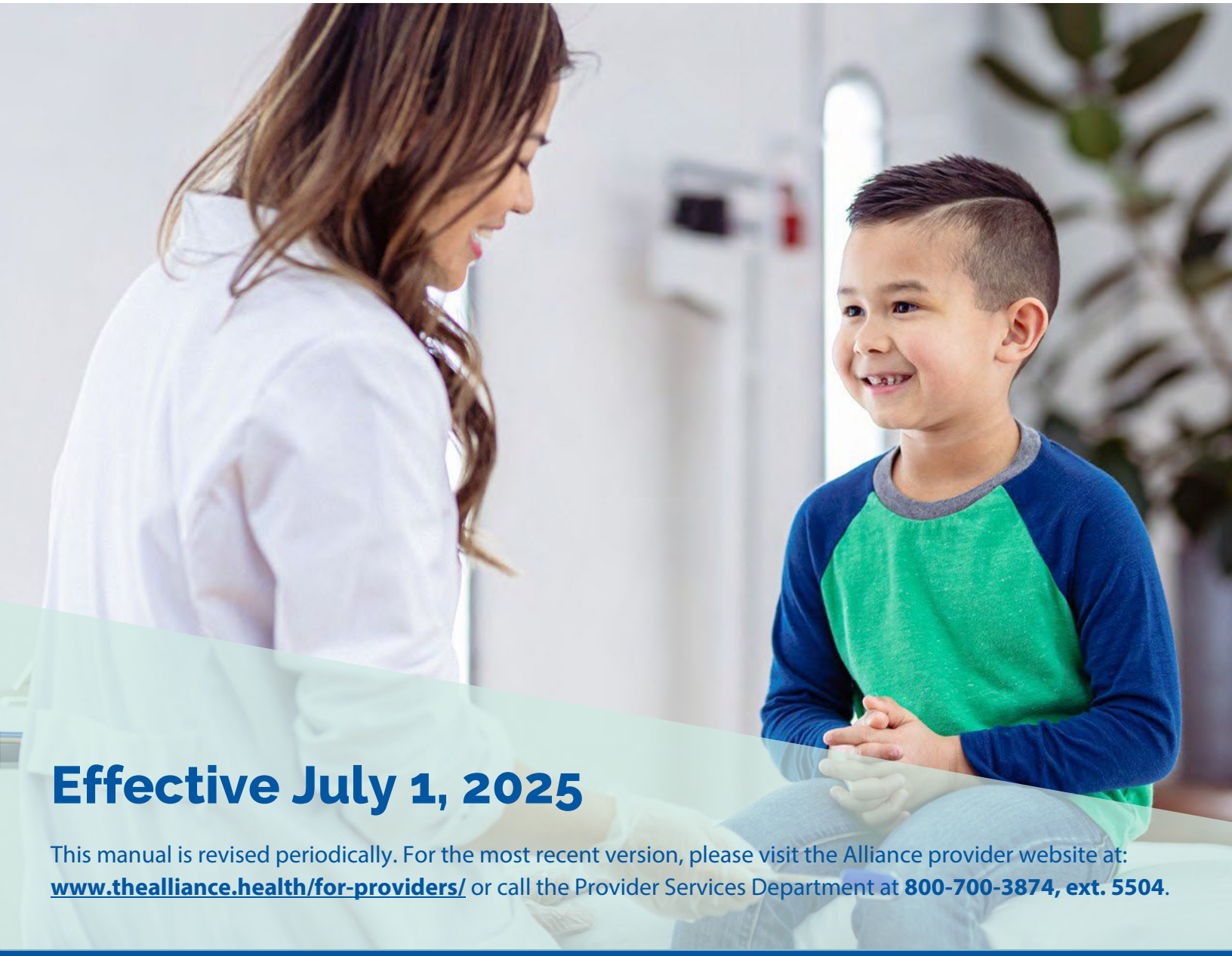
2025 Provider Manual



Effective July 1, 2025

This manual is revised periodically. For the most recent version, please visit the Alliance provider website at: **www.thealliance.health/for-providers/** or call the Provider Services Department at **800-700-3874, ext. 5504**.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

www.thealliance.health

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Section 1
Introduction

Organization of the Provider Manual

The Provider Manual (Manual) describes operational policies and procedures of Central California Alliance for Health (the Alliance). Topics covered in this Manual include, but are not limited to: member eligibility, authorizations, referrals, covered services, services covered by other agencies, care management, cultural and linguistic services, utilization management, billing, quality assurance and improvement, health assessment and screening, member grievances, coordination of benefits, reporting, credentialing, and dispute resolution.

For further information, or to suggest additions or improvements to the Manual, please call the Provider Relations Representatives in your area.

Mariposa County
Central California Alliance for Health
5362 Lemee Lane
Mariposa, CA 95338-9556
209-966-2000

Merced County
Central California Alliance for Health
530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

Monterey County
Central California Alliance for Health
950 East Blanco Road, Suite 101
Salinas, CA 93901-4419
831-755-6000

San Benito County
Central California Alliance for Health
1111 San Felipe Road, Suite 109
Hollister, CA 95023-2814
831-636-4180

Santa Cruz County
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

The Manual will be revised annually and/or periodically as needed. Providers will be notified when an updated version is effective, and the online version is available on the Alliance provider website. Providers may also request a hard copy version by contacting their Provider Relations Representative.

Accessing Provider Information

Alliance Main Website: www.thealliance.health

Provider Website: www.thealliance.health/for-providers

The current version of the Manual is always available on the Alliance provider website and is a comprehensive resource for information, resources and tools. You can easily access information in the Manual through the Table of Contents. For the PDF version, click on any heading or page number in the Table of Contents to go directly to the section you need. You may also search the Manual by keyword using your PDF reader's find/search function (often CTRL + F).

Additional helpful links found on our provider website include the following:

Provider Directory — Search by specific line of business, specialty, provider name, or city.

Provider News — Access the latest Alliance provider news updates.

Health Education and Disease Management Programs — Learn about Alliance's health education and disease management programs and download health education materials.

Cultural and Linguistic Services — Learn about how to access the Alliance's Language Assistance Services (Interpreter services) and cultural competency and health literacy tools.

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

Contracted providers may use the Provider Portal to check the eligibility status of Alliance members, verify if a member has other primary health insurance, review a member's prescription history, and search for claims. Primary care providers (PCPs) can view information for their linked members.

To utilize this service, visit the Provider Portal and click on the "Provider Portal Login" button and select "New User." You will need to provide basic registration information, after which a Provider Portal Representative will contact you to help you to set up an account.

Provider Forms Library: https://thealliance.health/tag/provider-forms/

The Provider Forms Library contains a list of forms you may require as an Alliance provider. This information can also be found in this manual in Section 19: Forms.

Alliance Mission, Vision and Values

Our Mission: Accessible, quality health care guided by local innovation.

Our Vision: Healthy people. Healthy communities.

Our Values:

Collaboration — Working together toward solutions and results.

Equity — Eliminating disparity through inclusion and justice.

Improvement — Continuous pursuit of quality through learning and growth.

Integrity — Telling the truth and doing what we say we will do.

We achieve the goals set by our mission, vision and values by improving local provider satisfaction; ensuring quality care guided by cultural humility; and expanding our network of local doctors and specialists so that members get access to the right care, at the right time.

The Alliance is governed by the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (also referred to as "the Commission" or the "Alliance Board"), which is composed of members representing physicians, clinics, hospitals, allied health providers, service agencies and the public.

Two groups provide advice to the Commission: The Physicians Advisory Group (PAG) and the Member Services Advisory Group (MSAG). The Commission meets monthly to review local concerns about health care issues, receive advisory input and revise policy for the Alliance as appropriate. The Alliance is responsive to local input via our regional governance, and we align our operations and policies based on industry best practices.

Overview of Alliance Programs

Medi-Cal

Types of Medi-Cal: Levels of Benefits

Medi-Cal is California's version of the federal Medicaid program. With a combination of federal and state funding, Medi-Cal provides health care coverage to qualifying residents who make less than a certain percentage of the Federal Poverty Level (FPL) or qualifying residents who are eligible for Supplemental Security Income (SSI). Medi-Cal offers three basic levels of benefits — full scope, limited scope and special programs.

Full-Scope Medi-Cal

Alliance Medi-Cal beneficiaries are eligible for full-scope Medi-Cal, which provides coverage for the full range of Medi-Cal covered services. However, there are some full-scope aid codes that are under the fee-for-service Medi-Cal system, such as Share of Cost (SOC) aid codes.

Limited-Scope or Restricted Medi-Cal

Limited-scope, or restricted Medi-Cal, provides coverage only for a limited set of benefits. It does not cover medicine or primary care. There is another set of limited-scope aid codes that cover services relating to long term care and/or treatment for breast or cervical cancer. The Alliance provides coverage for the full range of Medi-Cal covered services for members with limited-scope aid-codes. Most other limited-scope aid-codes are covered under the fee-for-service Medi-Cal program.

Special Programs

Medi-Cal also has aid codes that provide coverage under special programs. These special-program aid codes include tuberculosis services and minor-consent services. Individuals in these aid codes are covered under the fee-for-service Medi-Cal program and not through the Alliance.

Categories of Medi-Cal Eligibility: Aid Codes

Medi-Cal has more than 300 categories of eligibility, also known as aid codes. The Medi-Cal aid code is the two-digit number or combination of alpha and numeric characters that indicates the specific Medi-Cal program category under which the individual qualifies. DHCS establishes aid codes, not the Alliance. Medi-Cal aid codes are assigned by county Medi-Cal eligibility staff, or by the state, based on federal and state guidelines for eligibility. Aid codes are added or removed and revised periodically.

California Children Services – Whole Child Model Program

California Children's Services (CCS) is a state program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children (ages 0 until the day before 21st birthday) who have CCS-eligible medical conditions. CCS-eligible medical conditions include -- but are not limited to -- chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, infectious diseases producing major sequelae, those that limit or interfere with physical function but can be cured, improved or stabilized (e.g., birth defects, handicaps present at birth or developing later, and injuries from accidents or violence).

These conditions tend to be relatively uncommon, chronic rather than acute, and costly. They generally require the care of more than one health care specialist. A comprehensive overview of CCS Medical Eligibility can be found on the DHCS website.

Alliance Responsibility	County CCS Program Responsibility	DHCS Responsibility
Reimburses providers for CCS services for Alliance members	Enrollment, disenrollment, eligibility determination and inter-county eligibility transfers for all CCS members (including Alliance members)	Panels providers, reviews and certifies CCS facilities and specialty care centers
Coordinates, reviews, and authorizes services for Alliance members	Manages appeals/grievances for disputes related to member eligibility for all CCS members (including Alliance members)	
Case Management and Care coordination for Alliance members	Administers the Medical Therapy Program and the Pediatric Palliative Care Waiver	Reimburses providers for CCS services that are carved out from the Alliance (see Section 7 in this manual) or CCS services that are provided to non-Alliance members
Manages appeals/grievances for discontinuation or denial of services for Alliance members	Authorization, case management and care coordination for non-Alliance members	

Alliance Care In-Home Supportive Services

The Alliance Care In-Home Supportive Services (IHSS) program provides health care coverage for Monterey County IHSS providers who work a specified number of hours per month. Eligibility is processed by the Monterey County IHSS Public Authority. Enrollees pay monthly premiums to the Public Authority and pay copayments for some services.

All Alliance Care IHSS members are linked to a PCP from their first day of eligibility.

Key Contact Numbers for Alliance Providers

Topic	Department/Contact	Phone #
Referral Forms		
Questions about Referral Forms	Health Services	800-700-3874, ext. 5506
Ordering Referral Forms	Provider Relations	800-700-3874, ext. 5504
Authorization Status	Health Services	800-700-3874, ext. 5511
Special Services		
Non-emergency Transportation	Access Coordinator All Counties	800-700-3874, ext. 5577
Interpreter Services	Health Programs All Counties	800-700-3874, ext. 5580
Case Management	Health Services All Counties	800-700-3874, ext. 5512
Claims Inquiries (8:30 a.m.–4:30 p.m.)	Claims	800-700-3874, ext. 5503

Contract Questions	Provider Relations	800-700-3874, ext. 5504
Eligibility for Medi-Cal	Social Services San Benito County Santa Cruz County Mariposa County Monterey County Merced County	 831-630-5180 888-421-8080 209-966-2000 877-410-8823 209-385-3000
Vision Service Plan	VSP	800-877-7195
Medi-Cal Dental Program	State Office	800-322-6384
Medi-Cal Dental Program Provider Service Center	State Office	800-423-0507
DME Issues	Health Services All Counties	800-700-3874, ext. 5506
Pharmacy	Health Services	800-700-3874, ext. 5507
Concerns about 1099s	Change Healthcare/ ECHO Health Inc.	888-983-5574
Health Education	Health Programs All Counties	800-700-3874, ext. 5580
Chief Medical Officer/ Medical Director	All Counties	800-700-3874, ext. 5588
Eligibility Assistance		
Member Services	Member Services	800-700-3874, ext. 5505
Automated Eligibility System		800-700-3874, ext. 5501
State Automated Eligibility Verification System (AEVS) Eligibility and SOC		800-541-5555
Inquiries about Members or Member Services		
Reassignment of Member (PCP Only)	Provider Relations	800-700-3874, ext. 5504
Request for Administrative Member Status Due to Medical Condition	All Counties	831-430-5512
Missed Appointment/No-show Calls	Provider Relations	800-700-3874, ext. 5504
Member Services Representatives (verification of eligibility and PCP linkage)	Member Services	800-700-3874, ext. 5505
Provider Complaints and Grievances	Provider Relations	800-700-3874, ext. 5816
Recoveries or Other Insurance Recoveries	Claims	800-700-3874, ext. 2505
Behavioral Health		
Mariposa County • Specialty Mental Health Services • Substance Use Disorders	County Behavioral Health and Recovery	800-549-6741 209-966-7000

Merced County • Specialty Mental Health Services • Substance Use Disorders	County Behavioral Health	888-334-0163 209-381-6800
Monterey County • Specialty Mental Health Services • Substance Use Disorders	County Behavioral Health	888-258-6029 831-755-5505
San Benito County • Specialty Mental Health Services • Substance Use Disorders	County Behavioral Health	888-636-4020 831-636-4020
Santa Cruz County • Specialty Mental Health Services • Substance Use Disorders	County Behavioral Health	800-952-2335 831-454-4170
• Mental Health Services for Medi-Cal members, including CCS: Non-specialty Mental Health Services (formerly known as mild to moderate) • Behavioral Health Treatment Services for Development Disorders	Provider Relations	800-700-3874, ext. 5504
The Alliance Nurse Advice Line		
Nurse Advice Line (NAL), available 24 hours a day, 7 days a week	Hearing or speech impaired members can contact the Nurse Advice Line through the Telecommunications Relay Service at 800-735-2929 (TTY)/ 800-855-3000 (Spanish TTY) or 800-854-7784 (Speech-to-Speech) or Dial 7-1-1.	844-971-8907

Participating in the Alliance Network

To participate in the Alliance network, a provider must sign a Provider Services Agreement, and the Alliance's Medical Director or Peer Review and Credentialing Committee (PRCC) must approve the provider's credentials. The PRCC is composed of Alliance-contracted network physicians from major disciplines, including primary care and specialty practices. Providers are re-credentialed within 36 months after the initial credentialing date or the last re-credentialing approval date.

Pursuant to Article II of the Provider Services Agreement, all new providers and those eligible for re-credentialing must return a signed California Participating Physician Application (CPPA) to the Alliance, along with all required attachments, including, but not limited to, copies of the following documents:

- Current Medical License or Business License.
- Current Clinical Laboratory Improvement Amendments (CLIA) or Waiver, if applicable.
- Current Drug Enforcement Agency (DEA) License, if applicable.
- Documentation for National Provider Identifier (NPI) and Taxonomy Code.
- Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).
- Signed Taxpayer Identification Form (W-9 new providers only).
- Signed Declaration of Confidentiality form (new providers only).
- Curriculum vitae (with dates in MM/YYYY format)
- Hospital Privileges Status or Admitting Agreement
- Language Verification Form (new providers only).
- New Provider Orientation Attestation (new providers only)

If a provider is a supervising physician for a non-physician medical practitioner (NPMP), all new NPMPs and those eligible for re-credentialing must return a signed CPPA, along with all required attachments and copies of the following documentation:

- Current completed NPMP/Physician Assistant (PA) Delegation of Services Agreement(s), if applicable.
- Current NPMP staff licenses.
- Current NPMP staff Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).
- Signed Declaration of Confidentiality form (new providers only).

Medi-Cal Certification is Required – Screening and Enrollment

In addition to the Alliance's credentialing process, providers are required to complete screening and enrollment pursuant to the Department of Health Care Services (DHCS) guidelines. For more information, please see Alliance Policy 300-4025 – Provider Screening and Enrollment Process.

PCP Site Review

Before the verification process is finalized, a nurse from the Alliance will visit each Medi-Cal PCP site to conduct a site review. After the site review and verification of the credentialing information, the provider's initial credentialing and re-credentialing files are submitted to the Medical Director or the PRCC for review and approval.

New Provider Training

The new provider training materials will be included with the credentialing application for PCPs, Specialists, Allied or other providers, and providers will attest to completing the new provider training when completing the credentialing application. Providers are advised that training must be completed within 10 business days of their Active Status Date. For more information, please see Policy 300-6030 – New Provider Training.

Providers as HIV/AIDS Specialists

To qualify as an HIV/AIDS Specialist, a provider must have a valid license to practice medicine in the state of California and meet *at least one* of the following criteria:

- Credentialed as an HIV Specialist by the American Academy of HIV Medicine.
- Board certified, or has earned a Certificate of Forms Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties; or
- Board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties; and
- In the immediately preceding 12 months, has clinically managed medical care to a minimum of 25 patients who are infected with HIV and has successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients: or
- In the immediately preceding 24 months, has clinically managed medical care to a minimum of 20 patients who are infected with HIV and has completed any one of the following:
- In the immediately preceding 12 months, has obtained Board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties.
- In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients; or
- In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment,

or both, of HIV-infected patients, and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

If properly certified, a provider has the option to be listed in the Provider Directory as an HIV/AIDS Specialist.

For additional information about the Alliance's credentialing policies and procedures, please visit the Credentialing Policies section on the Alliance provider website.

Notification about Actions Taken Against Provider or Staff

Federal and state laws require that you notify us immediately by phone (with a follow-up in writing) of the following actions taken towards you or any practitioner on your staff:

- Revocation, suspension, restriction, non-renewal of license, certification, or clinical privileges.
- A peer review action, inquiry or formal corrective action.
- A malpractice action or a government action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the state licensing board or similar organization or the National Practitioner Data Bank of adverse credentialing or peer review action.
- Any material changes in any of the credentialing information.
- Sanctions under the Medicare or Medicaid programs.
- Placement on the Medi-Cal Suspended and Ineligible Provider list.
- Any incident that may affect any license or certification, or that may materially affect performance of the obligations under the agreement.

Appealing Adverse Decisions by the Peer Review and Credentialing Committee

If the PRCC should make a decision that alters the condition of a provider's participation with the Alliance based on issues related to quality of care, the provider may appeal the adverse decision. For more information on the Alliance fair hearing process for adverse decisions, please see Policy 300-4103 – Fair Hearing Process for Adverse Decisions. If a provider fails to meet the credentialing standards or if their license, certification or privileges are revoked, suspended, expired or not renewed, the Alliance must ensure that the provider does not provide any services to Alliance members. Additionally, any conduct that could adversely affect the health or welfare of a member will result in written notification instructing the provider not to provide services to Alliance members until the matter is resolved to our satisfaction.

Review Procedure for Decisions Concerning Provider Network Participation

If the Alliance should make a decision that alters the condition of a provider's participation with the Alliance for reasons not related to quality of care, a provider's failure to meet the licensing, certification or authority

requirements of the Provider Services Agreement, or a provider being either excluded from participating in, or sanctioned by, the Medicare or Medicaid programs, the provider may be heard through the Alliance review procedure. This review procedure is a provider right as described in the Provider Services Agreement. For more information on the provider review procedure, please see Policy 300-9010 – Review Procedure for Decisions Concerning Provider Network Participation.

Please note that in no event would a provider have access to both the Fair Hearing Process for Adverse Decisions and the Review Procedure for Decisions Concerning Provider Network Participation with respect to the same decision.

Changes in Ownership

Generally, Alliance provider agreements require that the provider obtain prior written consent from the Alliance when a change of ownership is planned. Depending upon the circumstances of the change in ownership, it is also possible that a provider's eligibility for incentives may be impacted.

If you anticipate a change in ownership of your organization, please complete the Notice of Change in Ownership form and return it to the Alliance as soon as possible to help ensure that your contract with the Alliance remains in force and accurate.

Debarment, Suspension, Ineligibility or Voluntary Exclusion

In accordance with the Code of Federal Regulations, Title 45, Part 76 (45CFR76), the Alliance receives federal funding and therefore must certify that it has not been debarred or otherwise excluded from receiving these funds. Under this rule, because the Alliance receives this federal funding, the Alliance is considered a "lower tier participant." As subcontractors, our providers, who essentially receive federal funding by nature of their Agreement with the Alliance, are also considered "lower tier participants" and thus must also attest to the fact that, by signing the form specified below, they have not been debarred or otherwise excluded by the federal government from receiving federal funding.

When providers apply to become part of the Alliance network, they receive a form titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion." This form must be signed by the provider and returned with a signed agreement, certifying, as stated above, that the provider is eligible to participate in the Alliance program and receive funds provided by the federal government. Pursuant to this certification and provider agreement with the Alliance, should the provider, or any other subcontracted provider, become suspended or ineligible to receive federal funds, the provider is required to notify the Alliance immediately.

Debarment, Suspension, Ineligibility of Prescribing Providers

In accordance with California Civil Code, Section 51303(k), the Alliance cannot reimburse providers for services ordered, prescribed, or rendered by a provider who is debarred, suspended, or otherwise ineligible from participation in the Medi-Cal program or included on federal debarment and suspension lists. Accordingly, should the Alliance receive a claim for payment, or retrospectively identify payment of a claim, resultant from

the order or prescription of a debarred, suspended, or otherwise ineligible provider, such a claim would be unallowable and subject to denial or recoupment, respectively.

For more information, please see Policy 105-3003 – Suspended, Excluded, and Ineligible Providers.

Program Integrity: Anti-Fraud, Waste and Abuse

Alliance anti-fraud, waste and abuse (FWA) efforts encompass two primary activities: FWA *prevention* and *investigation*, collectively known as Program Integrity.

Definitions

Abuse: Activity that is inconsistent with sound fiscal, business, or medical practice standards and results in unnecessary cost or reimbursement. It also includes any act that constitutes abuse under applicable federal law (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person (as defined in Title 42, Code of Federal Regulations Section 455.2). It includes any act that constitutes fraud under applicable federal or state law.

Waste: The overutilization, underutilization, or misuse of services and misuse of resources, and typically is not a criminal or intentional act.

Laws and Regulations

False Claims Act (Federal – *31 U.S.C. § 3729-3733;* California – *C.G.C. § 12650-12656)*: The California and Federal False Claim Acts (FCAs) make it illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the program's loss plus $27,894 per claim. Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States and entitles whistleblowers to a percentage of any recoveries. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines.

For additional anti-FWA laws and regulations that inform the Alliance's Program Integrity efforts, please review Policy 105-3001 – Program Integrity: Fraud, Waste and Abuse Prevention Program and 105-3001 Attachment A – Anti-FWA Laws and Regulations.

Fraud, Waste and Abuse Prevention

Alliance FWA prevention (FWAP) activities are facilitated by the Alliance FWAP Program. The FWAP Program ensures:

- Written policies, procedures and standards for all employees (including management), Subcontractors, Downstream Subcontractors, and Network Providers, that: articulate the Alliance's commitment to comply with all applicable federal and state anti-FWA standards; outline the

procedures for preventing and detecting potential/actual FWA; and, provide detailed information about the FCA, administrative remedies for false claims, state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA.

- Employee handbook inclusion of information about the FCA and related laws, the rights of employees to be protected as whistleblowers and Alliance policies and procedures for detecting and preventing FWA.
- The establishment of an anti-FWA program with a central point of contact for all suspected/actual FWA concerns.
- Provision for internal monitoring and auditing.
- Alliance Chief Compliance Officer and employees receive and complete effective training on FWA prevention, detection and reporting, including applicable laws and regulations.
- The Alliance does not employ or contract with individuals debarred, proposed for debarment, suspended, declared ineligible or voluntarily excluded by any federal department or agency.
- The Alliance's appropriate use of non-monetary incentives to promote good member health practices.
- No Alliance officer or employee receives compensation or has financial interest in any activity or enterprise funded by any state agency, unless required as a condition of regular state employment.

The FWAP Program promotes:

- Board member, employee, Subcontractor, Downstream Subcontractor, and Network Provider compliance with Alliance FWAP-related policy, and regulatory, contractual and legislative requirements governing the health plan, including the Alliance Code of Conduct and Oath of Confidentiality, where applicable.
- Member protection in the receipt of health care services through timely detection of potential/actual FWA.
- The protection, security and confidentiality of protected health information (PHI).
- Subcontractor development and maintenance of internal FWAP program and policy.
- Alliance board, subcontractor/provider and member understanding and awareness of FWA practices through education and information sharing.
- Prompt reporting by Alliance board members, employees and Subcontractors of suspected/actual violations of any FWA-related statute, regulation or guideline applicable to federal and/or state health care programs or Alliance policies.
- Alliance employees maintain awareness and protection of the legal rights of all parties involved in any case of potential/actual FWA.

- A system of internal assessment is organized and maintained to identify and analyze significant opportunities for FWAP program improvement.
- Recognition of Alliance board members, employees, providers, subcontractors, members, local law enforcement and the state as important partners in this effort.

The Alliance's FWAP program integrates the activities of all Alliance departments in meeting our FWAP objectives. The FWAP program is one of the many ways the Alliance ensures: appropriate service provision to our members; partnerships with reputable subcontractors; and proper administration of our health plan, including correct use of public funds. The Alliance takes the position that FWA at any level are impermissible and intolerable. When a practice is deemed not consistent with Alliance standards and requirements, an investigation may be performed and an action plan developed, as needed.

Fraud, Waste and Abuse Investigations

Investigations into suspected/actual FWA are facilitated by the Alliance Special Investigations Unit (SIU). The SIU will only investigate FWA concerns relating/potentially relating to Alliance members, health care providers, non-health care contractors, employees, or Board members. Should the Alliance become aware of potential/actual FWA not related to Alliance entities, the Alliance may facilitate referral to appropriate agencies. The SIU is obligated to investigate State, Federal, and Other Medi-Cal Managed Care Plans' referrals of FWA made directly to the Alliance. Any overpayment recovery or resolution of a disputed matter involving potential FWA between the Alliance and a provider or subcontractor is not binding on the California Department of Healthcare Services (DHCS), Division of Medi-Cal Fraud & Elder Abuse (DMFEA), or the United States Department of Justice (DOJ) and does not preclude these agencies from taking further action.

The SIU ensures:

- Prompt and complete investigation of suspected/actual FWA. The SIU undertakes research and data analysis, internally and potentially externally, when necessary.
- Reporting of investigative findings to the state and/or law enforcement, as appropriate, when there is reason to believe fraud and/or abuse has occurred by subcontractors, members, providers, or employees. For the Alliance's Medi-Cal program, potential/actual fraud or abuse concerns and identified or recovered overpayments due to potential FWA will be reported to California Department of Health Care Services (DHCS) within 10 business days; provider-related concerns may also be reported to the California DOJ Bureau of Medi-Cal Fraud and Elder Abuse, and/or other applicable law enforcement agencies.
- Development of corrective action plans, including the recoupment of identified overpayments, when indicated by investigative findings.

For additional information, please view Policy 105-3002 – Program Integrity: Special Investigations Unit Operations.

If you have any concerns about practice standards or general questions about Alliance Program Integrity efforts, please contact your Provider Relations Representative.

Medical Records

Each provider office is responsible for maintaining adequate medical records of patient care. Records must be maintained in accordance with applicable federal and state privacy laws. All medical records must be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for ten years after termination of agreement with the Alliance, including the period required by the Knox-Keene Act and Regulations, and Medicare and Medi-Cal programs.

To ensure compliance with medical record keeping requirements, the Alliance periodically performs audits of network providers for billed services. For additional information about this process, see Policy 105-3004 – Verification of Billed Services by Network Providers.

Confidentiality of Information

Providers are obligated to remain compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and any other relevant federal and/or state laws related to data sharing. Providers are responsible for ensuring and maintaining the confidentiality of information about members and their medical records, in accordance with applicable federal and state laws. The names of any member receiving public social services must be kept confidential and protected from unauthorized disclosure. This includes all information, records, and data collected and maintained for the operation of the Agreement including information accessed through the Alliance Provider Portal. Providers may not use any such information for any purpose other than carrying out the terms of their agreement. Furthermore, Providers are Covered Entities under Title 45 Code of Federal Regulations (CFR), Section 160.103 and shall use appropriate safeguards that reasonably and appropriately protects the confidentiality of Protected Health Information (as defined under 45 CFR Section 160.103). Therefore, occurrences of breach or disclosure of member PHI shall be handled in compliance with the privacy and security requirements established by HIPAA. Medical Record Keeping

The Alliance's provider agreements require medical records be maintained in a manner that is current and demonstrates the Medical Necessity of Covered Services for which a claim for payment is submitted. As a minimum standard, practitioners billing the Alliance for Covered Services must document the provision of such services in the member's medical record prior to submitting a claim for payment. The Alliance may recoup payments where it identifies that no documentation of the service exists in the member's medical record.

Access to and Copies of Records

Providers are required to have records readily retrievable for all billed services regardless of rendering location. Our Health Services and/or Compliance staff may request records from provider offices for one or more Alliance covered members for several reasons, including but not limited to:

- Quality improvement studies mandated by the Medi-Cal Managed Care Division.
- Authorization requests.
- Claims' payments issues.
- Assistance with case coordination.

- Determination of "requests for administrative member" status.
- Possible California Children's Services (CCS) referrals.
- Follow-up to a member complaint or quality of care issue.
- Evaluation of potential fraud/abuse concerns.
- Verification that medically necessary goods/services were received by Alliance members.
- Assistance facilitating a medical record review audit.

For complete details on provider responsibilities relative to medical records, please see Policy 401-1510 – Medical Record Review and Requirements.

Accessibility Standards

The provision of care within regulatory timely access standards will be assessed through a monitoring process, as described in relevant policies noted below. Standards are described in Policy 404-1202 – After-Hours Availability of Plan and Contract Physician. Additional access standards and monitoring procedures can be found in Policy 300-1509 – Timely Access to Care and Policy 300-8030 – Monitoring Network Compliance with Accessibility Standards.

Data Exchange Framework

Network providers are required to sign the California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF) Data Sharing Agreement (DSA) as outlined in California Health and Safety Code § 130290. Sign the Data Sharing Agreement today!

Background

The DSA ensures that Californians, as well as the health and human service and governmental entities who serve them, can access information needed to provide safe and effective care regardless of their location in the state.

The CalAIM Data Sharing Authorization Guidance published by DHCS supports data sharing between:

- Managed care plans (MCPs)
- Health care providers
- Community-based social and human service providers
- Local health jurisdictions
- County and other public agencies that provide services and manage care under CalAIM

Read the full guidance on the DHCS website.

The DxF advances health equity for all Californians by facilitating the secure and appropriate exchange of health and social services information. The DxF will address areas including but not limited to:

- Health information creation, including the use of national standards in clinical documentation, health plan records and social services data.
- Translation, mapping, controlled vocabularies, coding and data classification.
- Storage, maintenance and management of health information.
- Linking, sharing, exchanging and providing access to health information.

For more background information, refer to APL 23-013 on the APL page of the Alliance provider website. You can also review information shared previously with Alliance providers on this topic in Provider Digest Issue 31 (August 2023).

Unlawful Harassment

The provider as well as its agents and employees, shall not unlawfully harass or allow harassment against any Alliance Member or their representative. For the purpose of this provision, Harassment means conduct that has the purpose or effect of unreasonably interfering in a substantial manner with an individual's welfare, or creates an intimidating, hostile, offensive, or demeaning environment. Harassment includes, but is not limited to, the following examples of behavior:

- Physical harassment: assault, touching, impeding or blocking movement, grabbing, patting, leering, making express or implied job-related threats in return for submission to physical acts, mimicking, taunting, or any physical interference with normal movement.
- Verbal harassment, such as epithets (nicknames and slang terms), derogatory or suggestive comments, propositioning, jokes or slurs, intimidation, threats, gestures, flirtations, or graphic verbal commentaries about an individual's body or appearance. Verbal harassment includes patronizing or ridiculing statements that are disparaging and bullying.
- Visual forms of harassment, such as derogatory posters, notices, photographs, bulletins, cartoons, drawings, sexually suggestive objects, or inappropriate electronic communications such as email or texts.
- Sexual Harassment: harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), gender, gender identity, gender expression or sexual orientation. It may include all of the actions described above as harassment, as well as other unwelcome sex-based conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities, or other verbal or physical conduct of a sexual nature.

Section 3
The Role of the Primary Care Provider

Primary care providers (PCPs) are responsible for providing the full scope of primary care services to their Alliance members. As a PCP, your role is vital in the overall coordination of health care for each member in your practice, and in providing health care services. As a PCP, you are responsible for:

- Ensuring or facilitating members' access to the health care system, preventive care, and appropriate treatment interventions.
- Assessing each member's health status, including an Initial Health Appointment (IHA) for each new member within 120 days after their enrollment (see below).
- Providing quality primary care health services.
- Initiating and coordinating referrals to specialists or other participating providers as needed.
    - Coordination of transitional care with the hospital and Alliance teams and, following hospital or facility discharge, provision of post-discharge appointments within seven to fourteen days.
- Assuring that members in your practice are not discriminated against in the delivery of services based on race, ethnicity, national origin, spoken language, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, and/or source of payment.
- Assuring that no unnecessary or duplicate medical services are being provided. For additional information about unnecessary or duplicate medical services, see Policy 404-1108 – Monitoring of Over/Under Utilization of Services.
- Establishing a good medical records system for tracking, recalling, and identifying any clinical problems unique to your patient population.
- Determining the number of Alliance members your practice can accept. The number of members linked to your practice will be monitored by the Alliance to ensure that members have timely access to care through credentialed providers. For more additional information on capacity and capacity monitoring see Policy 300-8040 – Monitoring PCP Capacity.

Facility Site Review and Medical Record Review

The Alliance conducts Facility Site Reviews (FSRs) for new Medi-Cal PCPs at the time of initial credentialing, at least every three years thereafter per California Department of Health Care Services (DHCS) guidelines, and as part of the re-credentialing process, regardless of the status of other accreditation and/or certifications. PCPs must notify the Alliance at least 30 days prior to a physical move or expansion of their clinic so an FSR may be

conducted at the site, as specified in Managed Care Quality and Monitoring Division (MCQMD) All Plan Letter (APL) 22-017. There are three components to the FSR process:

1. The Facility Site Review survey
2. The Medical Record Review (MRR) survey
3. The Physical Accessibility Review Survey (PARS)

The FSR and MRR are scored reviews. The FSR reviews the physical aspects of the site for basic regulatory requirements in areas such as: access, safety, personnel, office management, infection control, and pharmaceutical/lab/x-ray/preventive services. The MRR is conducted 90 calendar days up to 180 calendar days after initial member linkage and focuses entirely on the medical record for format, documentation, evidence of coordination and continuity of care and provision of appropriate preventive health care services. The PARS is not a scored review and focuses entirely on the physical accessibility of the clinic for all Alliance members, including Seniors and Persons with Disabilities (SPDs).

Any Corrective Action Plans (CAPs) that result from the scored reviews must be addressed within the established CAP timelines. The Alliance assists sites with their CAPs by providing education, answering questions, and offering resources whenever possible. PCPs that fail an audit or do not meet CAP timelines, as specified in MCQMD APL 22-017 timelines, may be removed from the network.

PCPs that score 79% and below in either FSR or MRR for two consecutive reviews must score a minimum of 80% in the next review. Sites that do not score a minimum of 80% for the third consecutive review are required to be removed from the network. Additionally, new members cannot be assigned to PCPs that score 79% or below in either FSR or MRR until the Alliance has verified that the PCP has corrected the deficiencies and the CAP is closed.

For more information on Facility Site Reviews, please see Policy 401-1508 – Facility Site Review Process and Policy 401-1521 – Physical Accessibility Review.

The scoring tool and guidelines for FSR and MRR can be found on the Site Reviews page of the Alliance provider website.

More information and the survey for PARS can be found on the Physical Accessibility Review page of the Alliance provider website.

Primary Care Provider Selection

Every new Alliance Medi-Cal member will be provided with an opportunity to select a PCP within the first 30 calendar days of enrollment. The member may communicate their PCP selection to the Alliance by phone, mail, fax, or through the Alliance website. If the member does not choose a PCP by the end of that period, they will be auto-assigned to a PCP. The auto-assignment logic looks at the following factors when doing PCP assignment: ZIP Code, age, gender, family linkage and provider status. Alliance Care IHSS members are assigned to a PCP as of their effective date.

Initial Health Appointment

The Medi-Cal Managed Care Division of the California Department of Health Care Services (DHCS) requires that each PCP complete an Initial Health Appointment (IHA) for all their linked Medi-Cal members within 120

days of the member's enrollment. At a minimum, an IHA must include the following: comprehensive history, preventive services, comprehensive physical with risk assessment, mental status exam and diagnoses plan of care. For related instructions and information on the IHA codes please visit the CBI IHA Tip Sheet. Refer to MMCD All Plan Letter 22-030 for requirements on IHA components. It is the providers' responsibility to code appropriately.

For more information on IHA criteria, please see Policy 401-1511 – Initial Health Appointment.

Early and Periodic Screen, Diagnosis and Treatment (EPSDT)

PCPs are required to ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. EPSDT includes the provision of medically necessary comprehensive and preventive health care services provided to Members less than 21 years of age.

For more information on coordinating EPSDT services, please see Policy 404-1313 – Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.

Preventive Care

PCPs are required to provide preventive health care according to nationally recognized criteria. Please visit the provider website for assistance with preventive care guidelines for either children or adult patients. Alliance prevention guidelines for healthy, asymptomatic adults are based on the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF). All preventive services identified as USPSTF "A" and "B" recommendation must be provided. For more information on Adult Preventive Care, please see Policy 401-1502 – Adult Preventive Care.

Alliance prevention guidelines for children are based on recommendations of the American Academy of Pediatrics (AAP) Bright Futures Guidelines and Child Health and Disability Prevention (CHDP) standards. Alliance immunization guidelines for adults and children are based upon recommendations of Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (CDC-ACIP). For the CDC recommended immunization schedule for adults and children, please visit the Vaccine Schedules page on the CDC website. For more information on immunization services, please see Policy 401-1505 – Childhood Preventive Care and Policy 401-1506 – Immunization Services and Reimbursement.

Providers should note that lead screening for children less than 6 years is a particular priority and state legal mandate. It is important that every encounter is coded with the correct CPT code, (83655 – Blood lead test) and submitted in a complete manner using the CMS 1500/UB 04 or 837 P/837 I to report confidential screening/billing to DHCS for point of care testing. Finally, providers are required to submit all blood lead screening test results to the Childhood Lead Poisoning Prevention Branch (CLPPB). State law also requires laboratories analyzing human blood drawn in California for lead to report all blood lead test results, on persons of any age, to the CLPPB. Analyzing laboratories must also report specific information on the person tested, the ordering physician, the analyzing laboratory, and the test performed. Information must be reported electronically.

For more information on lead screening, see Policy 401-1505 – Childhood Preventive Care.

Adverse Childhood Experiences (ACEs) Screening

Adverse childhood experiences (ACEs) and toxic stress are linked to serious and costly health conditions. The California Department of Health Care Services (DHCS) has a goal to reduce ACEs and toxic stress by half in one generation. As a result, they have implemented a state-wide effort to train providers, provide clinical protocols, and resources for establishing a trauma informed care network via the ACEs Aware website (www.acesaware.org). DHCS encourages all primary care providers (PCPs) to be trained and complete ACE screenings. An ACE screening will better determine the likelihood of a member's increased health risk due to a toxic stress response, which can inform patient treatment and encourage the use of trauma-informed care.

Primary care providers, including mid-level providers, are required to complete the Becoming ACEs Aware in California training (formerly known as ACEs Aware Core Training), and complete the DHCS training attestation form in the evaluation of the course. Providers must complete the DHCS training attestation form by including their National Provider Identifier (NPI) for the Alliance to identify if they have completed the training. Mid-level provider's supervising physician also needs to complete the required training and attestation. Providers must complete this training and attestation form before billing the Alliance and administering screenings. The Alliance receives a monthly list from DHCS of providers who have completed their training and attestations in the following month of when the training was completed. If the provider's NPI is not on the DHCS attestation list, the claim will be denied.

Once providers complete their training and attestation, the Alliance will reimburse per screening using the billing codes below. Federally qualified Health Centers are eligible for payment in addition to their existing Prospective Payment System payment but need to bill on a separate claim. ACE screenings completed via telehealth visits also qualify for payment.

Screening frequency:

- Children ages 1–20 should be screened annually.
- Adults ages 21–65 should be screened once in a lifetime.

HCPCS Code	Description
G9919	Score 4 or greater (high risk), results are positive
G9920	Score between 0–3 (low risk), results are negative

For more information on training and payment for Adverse Childhood Experiences Screening (ACES), see Policy 300-4180 – Provider Training and Payment for Adverse Childhood Experiences Screenings. Contact your Provider Relations Representative if you have questions about this screening or if you **need assistance in verifying providers on the DHCS attestation list**.

Cognitive Health Assessment

Alliance members 65 years of age or older, who do not have Medicare coverage, should receive an annual cognitive health assessment, per All Plan Letter 22-025. This assessment is intended to identify whether the

member has symptoms of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment by the American Academy of Neurology (AAN)*.

All licensed health care professionals who are enrolled as a Medi-Cal Provider must complete training specified by DHCS and use screening tools validated by DHCS. Provider payment is based on the completion of the training, and DHCS will maintain a list of providers of who completed their training that will be shared with the Alliance. Dementia Care Aware training is available on the Dementia Care Aware website at https://www.dementiacareaware.org

Providers must use a Cognitive assessment tool to determine if a full dementia evaluation is needed. Examples of approved DHCS assessment tools are list below, but are limited to:

- **Patient assessment tools**
    - General Practitioner assessment of Cognition (GPCOG)

      https://www.alz.org/getmedia/fb6a8416-8d51-4132-b41c-96caf39f9e6a/jalz-1528.pdf
    - Mini-Cog

      https://mini-cog.com/download-the-mini-cog-instrument/
- **Informant tools (family members and close friends)**
    - Eight-item Informant Interview to Differentiate Aging and Dementia

      https://www.alz.org/getmedia/6e7291bf-4ac8-40ed-a148-824d4591ed7e/ad8-dementia-screening.pdf
    - GPCOG

      https://www.alz.org/getmedia/a195e9f7-5dea-407a-83a9-2bc80e4c4796/gpcog-screening-test-english.pdf
    - Short Informant Questionnaire on Cognitive Decline in the Elderly

      https://www.alz.org/getmedia/77436b38-a073-4eca-8298-46552ab94c17/short-form-informant-questionnaire-decline.pdf

Alliance network providers may be requested to provide medical record documentation to ensure that the necessary follow-up services based on the assessment scores are being completed, and the appropriate screening tools are being used.

Alliance licensed health care professional who are enrolled as a Medi-Cal Provider, acting within their scope of practice, and are eligible to bill Evaluation and Management (E&M) codes are eligible to conduct and bill for cognitive health assessments for members, if they have completed the required training.

* AAN Guidelines on dementia and mild cognitive impairment: https://n.neurology.org/content/56/9/1143 and https://n.neurology.org/content/90/3/126

Billing Code	Description
CPT Code 1494F	Only applicable for members 65 years of age and older without Medicare coverage.
CPT Code 99483	Comprehensive diagnostic evaluation and management (E&M) of a patient who exhibits signs and/or symptoms of cognitive impairment to establish or confirm a diagnosis, etiology, or severity of the condition.
CPT Code 96125	Time spent administering standardized cognitive performance tests to the patient and time spent interpreting the results and preparing the formal medical report.

Note: *99483 and 96125 cannot be billed in conjunction with 1494F*.

Documentation Requirements:

- Providers must document the following in the member's medical records and have such records available upon request:
    - The screening tool or tools that were used
    - Verification that screening results were reviewed by a Provider
    - The results of the screening
    - The interpretation of results
    - Details discussed with the member and/or authorized representative, as well as any appropriate actions taken regarding screening results

If you have any questions regarding cognitive health training and/or screenings, please contact your Provider Relations Representative at 800-700-3874, ext. 5504.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

PCPs are required to offer Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services to all members under 21 years of age, including pregnant women, with a validated screening starting at 11 years of age, related to alcohol and drug misuse as recommended by the American Academy of Pediatrics (AAP), Bright Futures, and USPSTF Grade A and B recommendations). SABIRT should be provided to members who respond affirmatively to an alcohol pre-screen question or those who the PCP otherwise identifies as having risky or hazardous alcohol use. Each member is eligible for three screenings annually, as well as additional screenings if considered medically necessary. Brief intervention(s) typically include one to three sessions, and may be offered in-person, by telephone, or via telehealth. These sessions may be combined into one or two visits or administered as three separate visits and may be provided on the same date of service as the screening or on subsequent days. For those members who respond affirmatively to pre-screening, the Alcohol Use Disorder Identification Test – Consumption (AUDIT-C), for drug misuse, DAST-10, or other validated alcohol or drug screening questionnaires should be administered, PCPs are required to offer alcohol or drug use brief interventions (up to three 15-minute sessions in person or by phone) or refer members identified with possible alcohol use disorders to Substance Use Disorder Services in the county where the member resides for further evaluation and treatment.

County Contact	Phone
Mariposa County Behavioral Health Access	800-549-6741
Merced County Behavioral Health Access	888-334-0163 or 209-381-6800
Monterey County Behavioral Health Access	888-258-6029 or 831-755-5505
San Benito County Behavioral Health Access	888-636-4020
Santa Cruz County Behavioral Health Access	800-952-2335 or 831-454-4170

More information regarding screening and brief intervention is available on the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website and the Alliance Health Assessments page. For more information, also see the following Alliance policies:

404-1313 – Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home

401-1502 – Adult Preventive Care

401-1505 – Childhood Preventive Care

405-1318 – Pediatric Complex Case Management

Enhanced Primary Care Pain Management Program

The Enhanced Primary Care Pain Management Program has been developed to increase access to pain management and substance use management services from Primary Care Providers for their linked Medi-Cal members. Such services are for the purpose of supporting primary care providers in offering Medication Assisted Treatment (MAT) for members on high doses of opioid medications for chronic non-cancer pain as well as for members with opioid use disorder or substance use disorder.

Eligible Members

Members eligible for the program include a provider's linked Medi-Cal members with an ICD-10 diagnosis of F11 through F11.99.

Eligible Providers

To be eligible to provide services under the program, rendering physicians must 1) be credentialed under a Primary Care Physician Services Agreement, and 2) have DEA X-licensure (DATA Waiver). In addition to meeting these requirements (credentialed and DEA X-licensure), rendering physician assistants and nurse practitioners must also be supervised by a physician that has DEA X-licensure.

Eligible Services

Eligible services under the program include initial and follow-up consultative evaluation and management services for the treatment of concerns related to opioid use, while meeting the additional requirements described below.

Initial Visit

1. History and physical exam;
2. Assessment of cause of pain, current treatment regimen and/or any co-occurring substance use disorder;
3. Development of a plan of care regarding MAT;
4. Communications and follow-up with the Alliance regarding the member's condition; and
5. Must be billable under CPT codes 99204 or 99205.

Follow-Up Visits

1. MAT management;
2. Services vary in duration and content depending on circumstances; and
3. Must be billable under CPT codes 99212 through 99215.

Services for each member entering the program must receive prior authorization from the Alliance, and otherwise be considered covered services under the provider's Primary Care Physician Services Agreement to be considered payable under the program. Authorization requests for services provided by physician assistants and nurse practitioners must be submitted under the provider's supervising physician and billed under their supervising physician as well. Authorization under the program will not exceed one year in duration. Services rendered after the one-year expiration date will require a new authorization to remain in the program. There is no limit to the number of sequential authorizations requested.

To receive reimbursement for program services, the provider must include the authorization number on the claim form.

Compensation

Eligible program services provided by program eligible providers to program eligible members as described above are not considered Primary Care Physician Services subject to case management and will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement as applicable. For more information, please see Policy 404-1731 – Medication Assisted Treatment.

Seniors and Persons with Disabilities

DHCS has requirements for providers treating the Seniors and Persons with Disabilities (SPD) population. These requirements are part of the Medi-Cal 2020 Waiver.

Health Risk Assessments

All newly enrolled SPD members will receive a Health Risk Assessment (HRA) within 44 days of enrollment with the plan. The Alliance will administer the HRA either telephonically or by mail. All HRAs will be conducted in the member's preferred language. Members will be stratified into low, medium/rising, and high-risk stratifications, and members in the medium/rising risk stratification will be offered Alliance Care Management Services for complex case management. Members stratified as being high risk will be offered Enhanced Care Management services through community-based providers. Complex Care Management and Enhanced Care Management are programs that are optional for members. Administering the HRA and coordinating follow-up care is not the responsibility of the PCP, but you will be notified when members are enrolled in Alliance case management services. The HRA does not take the place of the Initial Health Appointment (IHA). The IHA is required for all new members and must be conducted within 120 days after the member's enrollment with the Alliance.

Specialists as PCPs

Specialists are eligible to act as PCPs for SPD members and members who are eligible for CCS. Members are linked to the provider's panel. To become an SPD or CCS PCP, providers need to meet the needs of the member within the scope of their practice, have a contract, and be credentialed. Provider offices will also have to undergo and pass a Facility Site Review as part of the credentialing process.

Sensitivity Training

All providers must receive sensitivity training to better meet the needs of the SPD population. In addition to periodic workshops, sensitivity training materials may be found on the Alliance provider website.

Physical Accessibility Review

All PCPs, high volume specialists, and ancillary providers will be surveyed for physical accessibility. The Physical Accessibility Review (PAR) is an informational survey that will evaluate accessibility in the following categories: parking, building exterior, building interior, restroom, exam room and medical equipment (height adjustable exam tables, patient accessible weight scales, equipment used for diagnosis and treatment). Results of the survey will be made available to providers and are published in the Provider Directory. Your practice site will be listed as either having Basic Access or Limited Access. The first PAR will take place as part of the initial credentialing process, or as soon as practical for existing PCPs and identified high volume specialists. Subsequent PARs will occur every three years, unless significant physical changes are made to the provider's site. For more information about the PAR, please visit the Physical Accessibility Review Survey page on the Alliance website, as well as see Policy 401-1521 – Physical Accessibility Review.

For additional information regarding SPDs, see Policy 405-1112 – Care Management of Seniors and Persons with Disabilities for Medi-Cal.

For additional information regarding complex case management, see Policy 405-1313 – Adult Complex Case Management and Policy 405-1318 – Pediatric Complex Case Management

Comprehensive Tobacco Cessation Services

PCPs are responsible for screening for smoking and tobacco use among patients of all ages, providing counseling, and making appropriate referrals. Smoking and tobacco cessation counseling must be provided by a physician or other qualified health professional face-to-face. Supporting documentation is required for any office audit for codes 99406 (smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes). Please note: 99407 is not to be billed in conjunction with 99406. Documentation must include the total time spent with the patient and what was discussed, including cessation techniques, resources offered, and follow-up. Counseling lasting less than three minutes is considered part of an Evaluation and Management (E&M) service (e.g., 99202-99215), not paid separately and not covered by 99406 and 99407. For additional information about this benefit and the Alliance Tobacco Cessation Support Program (TCSP), please see Policy 401-3109 – Comprehensive Tobacco Cessation Services or refer to Section 13: Health and Wellness Programs.

Utilization Management Program

PCPs are accountable for aspects of the Alliance Utilization Management program within their scope of practice. For information on the program, please see Policy 404-1101 – Utilization Management Program.

Case Management

Primary Care Physician Services

The services listed below are the Primary Care Physician Services to be provided by PCPs in accordance with the Case Management of a linked member. Providers shall administer these Primary Care Physician Services as medically necessary, unless this service is outside the scope of the medical services rendered by the provider. If the provider is paid on a capitation basis for Primary Care Physician Services, and an on-call or covering PCP sees a member linked to another provider, the Alliance will not pay the on-call or covering provider in addition to the capitation payment for the services listed below.

CPT CODE	DESCRIPTION
Office Visit	**New Patient**
99202	Expanded problem focus; 20 minutes
99203	Detailed history, low complexity; 30 minutes
99204	Comprehensive history and exam; moderate complexity; 45 minutes
99205	Comprehensive history and exam; high complexity; 60 minutes
Office Visit	**Established Patient**
99211	Minimal problem; physician supervised services; 5 minutes
99212	Problem focus history and exam; 10 minutes
99213	Expanded problem focus history and exam; 15 minutes

99214	Detailed history and exam, moderate complexity; 25 minutes
99215	Comprehensive history and exam; high complexity; 40 minutes
Prevention	**New Patient**
99381	New patient, infant evaluation
99382	Early childhood, age 1 to 4 years old
99383	Late childhood, age 5 to 11 years old
99384	Adolescent, age 12 to 17 years old
99385	18 to 39 years
99386	40 to 64 years
99387	65 years and older
Prevention	**Established Patient**
99391	Established patient, infant, periodic reevaluation
99392	Early childhood, age 1 to 4 years old
99393	Late childhood, age 5 to 11 years old
99394	Adolescent, age 12 to 17 years old
99395	18 to 39 years
99396	40 to 64 years
99397	65 years and older
Other Evaluation and Management	
99417	Prolonged Physician Service; Office or Outpatient setting; each additional 15 minutes
99354	Prolonged Physician Service; Office or Outpatient setting; first hour
99355	Prolonged Physician Service; Office or Outpatient setting; each additional 30 minutes
Emergency Room	
99281	ER Level 1
99282	ER Level 2
99283	ER Level 3
99284	ER Level 4
99285	ER Level 5
Minor Surgical Procedures	
11900	Injection; intralesional up to 7 lesions
11901	More than 7 lesions

16000	Initial treatment for 1st degree burns
16020	Dressing and/or debridement of burns; small
16025	Dressing and/or debridement of burns; medium
16030	Dressing and/or debridement of burns; large
46600	Diagnostic Anoscopy
51701	Insertion of non-indwelling bladder catheter (e.g., straight catheterization for residual urine)
51703	Insertion of temporary indwelling bladder catheter, complicated (e.g., altered anatomy, fractured catheter/balloon)
54055	Electrodesiccation
69200	Clear outer ear canal
69210	Removal impacted cerumen

Injections

20550	Injection; single tendon sheath or ligament
20610	Arthrocentesis, aspiration or injection, major joint or bursa only

Collection/Handling Blood

36400	Venipuncture, age 3 or under
36405	Scalp vein
36410	Venipuncture, over age 3
36420	Venipuncture, under age 1
36425	Age 1 and over
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory

Vision and Hearing

92081	Visual field exam
92551	Screening test, pure tone
92552	Pure tone audiometry
92553	Air and bone
92555	Speech audiometry
92556	Threshold and discrimination
92557	Basic comprehensive audiometry
92567	Tympanometry (impedance testing)

Allergy Immunotherapy

95115	Single injection
95117	Multiple use allergy injections
95199	Unlisted allergy immunology services

ECG, Other Miscellaneous Test, Supplies

93000	Electrocardiogram
93005	Tracing only, without interpretation or report
93010	Interpretation and report only
93040	Rhythm ECG with report
93041	Rhythm ECG, tracing
93042	Rhythm ECG, report
94150	Vital capacity
94640	Inhalation treatment
95017	Allergy testing, with venoms
95018	Allergy testing, with drugs or biological
95052	Photo patch tests
95070	Bronchial allergy tests
97799	Unlisted physical medicine
99070	Special supplies

Notes

California Children Services (CCS) program services are provided by CCS approved or paneled physicians, for the treatment of an Alliance Medi-Cal member's CCS eligible condition, are not considered Primary Care Physician Services subject to case management. These services will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement, as applicable, subject to authorization requirements.

Children's Health and Disability Prevention (CHDP) services provided by CHDP enrolled providers to Medi-Cal members are not considered Primary Care Physician Services subject to Case Management. Providers shall bill the Alliance separately for these services and will be paid fee-for-service rates as set forth in the Primary Care Physician Services Agreement, as applicable, subject to any referral and authorization requirements.

Comprehensive Perinatal Services Program (CPSP) services provided to Medi-Cal members are not considered Primary Care Physician Services subject to Case Management and will be paid fee-for-service rates by the Plan as set forth in the Primary Care Physician Services Agreement, as applicable, subject to any authorization requirements.

Enhanced Primary Care Pain Management Program services provided to members eligible under the program, by providers who are eligible to participate in the program are not considered Primary Care Physician Services subject to Case Management. These services will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement as applicable, subject to authorization requirements.

Palliative Care services provided to Medi-Cal members are not considered Case Managed Primary Care Physician Services and will be paid fee-for-service rates by Plan as set forth in the Primary Care Physician Services Agreement, as applicable, subject to any authorization requirements. Providers must include a U1 modifier in the first position for every code submitted for Palliative Care services on the claim.

Capitation Payment

For providers who are paid on a capitation basis for Primary Care Physician Services subject to case management, capitation rates are outlined in the Primary Care Physician Services Agreement. Below is a table that links Medi-Cal aid code to the corresponding Medi-Cal Member Type referenced in the Primary Care Physician Services Agreement. Please note, the Medi-Cal Member Type categories are not equivalent to DHCS aid code categories.

Aid Code	Aid Code Name	Medi-Cal Member Type
01	Refugee Coverage	Public Assistance: Family\Child\Family
02	Refugee Coverage	Public Assistance: Family\Child\Family
03	Adoption	Medically Indigent: Child
04	Adoption	Medically Indigent: Child
06	Adoption	Public Assistance: Family\Child\Family
07	Extended Adoption	Medically Indigent: Child
08	Entrant Coverage	Public Assistance: Family\Child\Family
10	SSI -- Social Security	Public Assistance: Aged
13	LTC	Medically Needy: Aged
14	Aged, Medically Needy	Medically Needy: Aged
16	Aged, Pickle Eligibles	Public Assistance: Aged
20	SSI -- Social Security	Public Assistance: Disabled
23	LTC	Medically Needy: Disabled
24	Disabled, Medically Needy	Medically Needy: Disabled
26	Disabled, Pickle Eligibles	Public Assistance: Disabled
30	Aid to Families	Public Assistance: Family\Child\Family
32	Aid to Families	Public Assistance: Family\Child\Family
33	Aid to Families	Public Assistance: Family\Child\Family
34	Aid to Families	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult

Aid Code	Aid Code Name	Medi-Cal Member Type
35	Aid to Families	Public Assistance: Family\Child\Family
36	Aid to Disabled	Public Assistance: Aged
38	Continued Eligibility	Public Assistance: Family\Child\Family
39	Continued Eligibility	Public Assistance: Family\Child\Family
40	Foster Care	Public Assistance: Family\Child\Family
42	Foster Care	Public Assistance: Family\Child\Family
43	Foster Care	Public Assistance: Family\Child\Family
45	Foster Care	Medically Indigent: Child
46	Aid to Families	Public Assistance: Family\Child\Family
47	Medically Needy	% Poverty
49	Foster Care	Public Assistance: Family\Child\Family
53	LTC – No Acute Care	Medically Needy: Disabled
54	Continued Eligibility	Public Assistance: Family\Child\Family
59	Continued Eligibility	Public Assistance: Family\Child\Family
60	SSI -- Social Security	Public Assistance: Disabled
63	LTC	Medically Needy: Disabled
64	Disabled, Medically Needy	Medically Needy: Disabled
66	Disabled, Pickle Eligibles	Public Assistance: Disabled
72	Aid to Child	% Poverty
76	Adult & Family/OTLIC	Medi-Cal Postpartum Care Extension under the Provisions of ARPA
81	Medically Indigent	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
82	Medically Indigent	Medically Indigent: Child
86	Medically Indigent	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
87	Medically Indigent	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0A	Refugee Coverage	Public Assistance: Family\Child\Family
0E	Medi-Cal Access Program (MCAP)	Public Assistance: Family\Child\Family
0M	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0N	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult

Aid Code	Aid Code Name	Medi-Cal Member Type
0P	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0R	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0T	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0U	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0W	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
1E	Aged, Continued Eligibility	Medically Needy: Aged
1H	Aged, Medically Needy	Medically Needy: Aged
1X	Aged, Medically Needy	Medically Needy: Aged
2E	Disabled, Continued Eligibility	Medically Needy: Disabled
2H	Disabled, Medically Needy	Public Assistance: Disabled
2P	ARC Program	Public Assistance: Family\Child\Family
2R	ARC Program	Public Assistance: Family\Child\Family
2S	ARC Program	Public Assistance: Family\Child\Family
2T	ARC Program	Public Assistance: Family\Child\Family
2U	ARC Program	Public Assistance: Family\Child\Family
2V	Adult & Family/OTLIC	Trafficking and Crime Victims Assistance Program (TCVAP). Refugee Medical Assistance (RMA)
3A	Aid to Families	Public Assistance: Family\Child\Family
3C	Aid to Families	Public Assistance: Family\Child\Family
3E	Aid to Families	Public Assistance: Family\Child\Family
3F	Aid to Families	Public Assistance: Family\Child\Family
3G	Aid to Families	Public Assistance: Family\Child\Family
3H	Aid to Families	Public Assistance: Family\Child\Family
3L	Aid to Families	Public Assistance: Family\Child\Family
3M	Aid to Families	Public Assistance: Family\Child\Family
3N	Aid to Families	Public Assistance: Family\Child\Family
3P	Aid to Families	Public Assistance: Family\Child\Family
3R	Aid to Families	Public Assistance: Family\Child\Family
3U	Aid to Families	Public Assistance: Family\Child\Family

Aid Code	Aid Code Name	Medi-Cal Member Type
3W	Aid to Families	Public Assistance: Family\Child\Family
4A	Adoption	Medically Indigent: Child
4F	Aid to Child	Public Assistance: Family\Child\Family
4G	Aid to Child	Public Assistance: Family\Child\Family
4H	Foster Care	Public Assistance: Family\Child\Family
4K	Foster Care	Medically Indigent: Child
4L	Foster Care	Public Assistance: Family\Child\Family
4M	Former Foster Care	Medically Indigent: Child
4N	Foster Care	Public Assistance: Family\Child\Family
4S	Former Foster Care	Public Assistance: Family\Child\Family
4T	Foster Care	Public Assistance: Family\Child\Family
4U	Former Foster Care	Public Assistance: Family\Child\Family
4W	Aid to Families	Public Assistance: Family\Child\Family
5C	HFP Transition	Public Assistance: Family\Child\Family
5D	HFP Transition	Public Assistance: Family\Child\Family
5K	Foster Care	Medically Indigent: Child
5L	Foster Care	Medically Indigent: Child
5V	Adult & Family/OTLIC	TCVAP. Covers non-citizen victims of human trafficking, domestic violence and other serious crimes
6A	Disabled, Adult/Child	Public Assistance: Disabled
6C	Disabled, Adult/Child	Public Assistance: Disabled
6E	Disabled, Continued Eligibility	Medically Needy: Disabled
6G	Working Disabled	Medically Needy: Disabled
6H	Disabled, Medically Needy	Medically Needy: Disabled
6J	Disabled, Medically Needy	Medically Needy: Disabled
6N	Disabled, Continued Eligibility	Medically Needy: Disabled
6P	Disabled, Continued Eligibility	Medically Needy: Disabled
6V	Disabled, Medically Needy	Medically Needy: Disabled
6X	Disabled, Medically Needy	Medically Indigent: Child
7J	Aid to Child	Medically Indigent: Child
7L	Adult Expansion	CalFresh eligible disabled/blind adults aged 19-65, who are citizens or lawfully present, who are not enrolled in Medicare and whose MAGI is at or below 128 percent FPL

Aid Code	Aid Code Name	Medi-Cal Member Type
7S	Express Enrollment, Adult	Public Assistance: Family\Child\Family
7U	Express Enrollment, Adult	Adult Expansion
7W	Express Enrollment, Child	Public Assistance: Family\Child\Family
8E	Adult & Family/OTLIC	Accelerated Enrollment. Provides immediate, temporary, fee-for-service, full-scope Medi-Cal benefits
8P	Medically Needy	% Poverty
8R	Medically Needy	% Poverty
8U	ACA, Infant	Public Assistance: Family\Child\Family
E6	MAP, Infant	Public Assistance: Family\Child\Family
E7	MCAP, Infant	Public Assistance: Family\Child\Family
E8	Adult & Family/OTLIC	Newborn Gateway Linked Infant MCAIP – Medi-Cal Access Infant Program (Title XXI)
H1	HFP Transition	Public Assistance: Family\Child\Family
H2	HFP Transition	Public Assistance: Family\Child\Family
H3	HFP Transition	Public Assistance: Family\Child\Family
H4	HFP Transition	Public Assistance: Family\Child\Family
H5	HFP Transition	Public Assistance: Family\Child\Family
K1	Aid to Families	Public Assistance: Family\Child\Family
L1	LIHP Transition	Adult Expansion
L6	ACA, Disabled Adult	Adult Expansion
M1	ACA, Adult	Adult Expansion
M3	ACA, Adult	Public Assistance: Family\Child\Family
M5	ACA, Child	Public Assistance: Family\Child\Family
M7	ACA, Pregnant Women	Public Assistance: Family\Child\Family
M9	Adult & Family /OTLIC	ACA Pregnant Women, 139%-213% FPL – Citizen. Pregnant women. Provides family planning and pregnancy related services
P5	ACA, Child	Public Assistance: Family\Child\Family
P7	ACA, Child	Public Assistance: Family\Child\Family
P9	ACA, Infant	Public Assistance: Family\Child\Family
R1	Aid to Families	Public Assistance: Family\Child\Family
T1	ACA, OTLIC – Premium	Public Assistance: Family\Child\Family
T2	ACA, OTLIC – No Premium	Public Assistance: Family\Child\Family
T3	ACA, OTLIC – Premium	Public Assistance: Family\Child\Family

Aid Code	Aid Code Name	Medi-Cal Member Type
T4	ACA, OTLIC – No Premium	Public Assistance: Family\Child\Family
T5	ACA, OTLIC – No Premium	Public Assistance: Family\Child\Family

For more information on physician case management responsibilities, see Policy 405-1312 – Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.

Medi-Cal

Individuals and families apply for Medi-Cal through their county Human Services/Social Services Department or through Covered California. Applications may be done in person, online, through the mail or over the phone. Individuals who receive Supplemental Security Income (SSI) automatically receive Medi-Cal along with their SSI benefit.

Eligibility for Medi-Cal is month to month. Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Eligibility for Medi-Cal can also be effective retroactively in some cases. Please note that a member's eligibility must be verified before delivery of services and that the Alliance identification card alone is not a guarantee of eligibility.

Eligibility for CCS is determined by the County CCS program in the county in which the member resides, CCS eligibility information is available in the State Children's Medical Services Network (CMS Net) Provider Electronic Data Interchange (PEDI) and is visible in the Alliance portal.

Timing of Eligibility through Fee-For-Service Medi-Cal and the Alliance

Not all Medi-Cal beneficiaries in Santa Cruz, Monterey, Merced, San Benito, and Mariposa counties are Alliance members. Those that are not Alliance members are eligible under the Medi-Cal Fee-For-Service system (FFS Medi-Cal). Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Affiliated Computer Services, the state Medi-Cal fiscal intermediary. Any necessary prior authorization for elective services (referred to as an "Authorized Referral Request," formerly known as "Treatment Authorization Request" or "TAR") for Medi-Cal beneficiaries not covered by the Alliance should be submitted to the Medi-Cal field office, not to the Alliance. *The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.*

FFS Medi-Cal beneficiaries with CCS eligible conditions are not Alliance members. Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Electronic Data Systems (EDS). Any necessary authorization for CCS services (referred to as a "Service Authorization Request") for FFS Medi-Cal beneficiaries with CCS eligible conditions should be submitted to the local county CCS Program.

Newly eligible Medi-Cal beneficiaries are covered through FFS Medi-Cal for at least their initial month of eligibility and, depending on when during the month they became eligible, could be covered under FFS for the following month as well. If they requested and received eligibility for any prior months, known as retroactive eligibility, those months would also be covered through FFS Medi-Cal. Newly eligible Medi-Cal beneficiaries will not become Alliance members until the first of the month following their enrollment as long as their eligibility is processed in time to be transmitted to the Alliance by the state in a month end eligibility file. For example:

A Medi-Cal applicant is determined eligible on June 3: Once eligibility is determined, eligibility will be effective as of June 1. The beneficiary will be covered through FFS Medi-Cal for the month of June. Alliance enrollment will begin on July 1.

A Medi-Cal applicant is determined eligible on June 26: Once eligibility is determined, eligibility will be effective as of June 1. The beneficiary will be covered through FFS Medi-Cal for the months of June and July. Alliance enrollment will begin on August 1.

In addition, the Alliance may be responsible for services provided to an Alliance Medi-Cal member whose annual eligibility redetermination occurs within 60-days after the member's annual eligibility redetermination date. If the member completes the redetermination process within 60 days after their eligibility redetermination date, their eligibility will be made retroactive to that date and the member will be covered by the Alliance for the entire period. If the member allows their benefits to lapse for more than 60 days from their annual renewal date, any period of retroactive eligibility will be covered by FFS Medi-Cal and Alliance enrollment will begin the first of the following month.

Providers should always verify eligibility prior to rendering services, to ensure eligibility and find out if coverage is through FFS Medi-Cal or the Alliance.

How to Verify Eligibility with the Alliance

Member eligibility verification is available online through the Provider Portal. If you have not used this feature in the past, you should complete the Provider Portal Account Request Form to register to use the Provider Portal. A link to the state Medi-Cal website is also accessible on our website in case you need to verify FFS Medi-Cal status.

The online and automated eligibility systems provide you with the following information:

- Eligibility status for the date(s) of service requested
- Name of the member's PCP or notification that the member is an administrative member
- Other health coverage the member may have (if applicable and if the Alliance is aware of coverage)
- The member's eligibility for CCS (if applicable)
- A confirmation number

Other ways to verify eligibility are:

- Call 800-700-3874, ext.5501 for the 24-hour interactive voice-response eligibility verification line.
- Call the Alliance Member Services department at 800-700-3874, ext. 5505, Monday–Friday, 8 a.m.–5:30 p.m. Eligibility can be verified for a *maximum of three members* at a time.

When you telephone, please provide *all* of the following:

- The member's full name.
- The member's Alliance Member ID number or Social Security Number. If you do not have either of these, you must provide the member's date of birth.
- Date(s) of service for which you want to check eligibility.

Please note that eligibility information is available for the current month and the preceding 11 months; we cannot check eligibility for dates of service past one year, nor can we verify eligibility for future dates of service. Remember that not all Medi-Cal beneficiaries are Alliance members. If you cannot verify eligibility for a Medi-Cal member through the Alliance, swipe the Benefits Identification Card (BIC) or check the DHCS website; results should tell you if your patient is eligible for Medi-Cal but not covered under the Alliance. **The Alliance is not able to verify eligibility for Medi-Cal beneficiaries who are not Alliance members.**

If you are a PCP, you may also check your Alliance Member List through your Provider Portal account.

Administrative vs. Linked Member

A "linked" member of the Alliance is an individual who has selected or been assigned to a PCP. An "Administrative Member" is a member who is not assigned to a specific physician or clinic and, therefore, may see any willing Medi-Cal provider within the Alliance's Service Area. Administrative members have "Administrative Member" listed on their Alliance ID cards in the PCP section, rather than the name of a doctor or clinic. Newly eligible Alliance members have "Administrative Member – Newly Eligible" on their ID cards in the PCP section. Categories of administrative members include:

- **Long Term Care** — A member who is residing in a skilled or intermediate-care nursing facility for more than 30 days after the month of admission.
- **Out of Area** — A member who resides outside of the Alliance's service area but whose Medi-Cal case remains in Santa Cruz, Monterey, Merced, San Benito or Mariposa counties. These may include out-of-area foster-care or adoption-assistance placements and long-term care placements. They would also include members who have moved out of the area and are in the process of having their Medi-Cal case transferred to their new county.
- **Newly Eligible** — A member in the first month of eligibility as an Alliance member who may see any willing Medi-Cal provider within the Alliance's service area until they have chosen or been assigned to a PCP.
- **Other Health Coverage (OHC)** — A member who has other health insurance that is primary to their Medi-Cal; this includes members with both Medi-Cal and Medicare, as well as members with both Medi-Cal and commercial insurance. Alliance members with other health coverage must access care through their primary insurance.

The change of a member's status from linked to administrative is not automatic — the provider or the member must notify the Alliance of the member's circumstances in order for the Alliance to change the status. If you feel a member's status should be changed to administrative for medical reasons you may submit a Request for Administrative Member Status form. You may also contact our Health Services Department at 800-700-3874, ext. 5512.

If you have information that an Alliance member has other health coverage (OHC) not reflected in the Alliance's system, please provide the information on the OHC using the Other Health Coverage (OHC) Referral Form in the Provider Forms Library on the Alliance provider website. You may also submit the Explanation of Benefits from the primary payer along with your claim when you bill the Alliance as secondary.

For other non-medical reasons for a change in member status, please contact the Member Services Department at 800-700-3874.

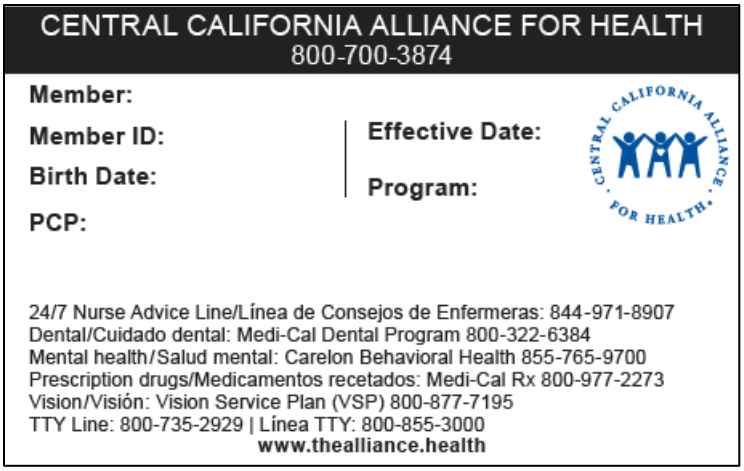
Claims for services rendered to administrative members must be sent to the Alliance. If the member has other health coverage, in addition to Medi-Cal, the claim should be sent first to the primary payer. All covered services that the Alliance is responsible for that are provided to administrative members are reimbursed by the Alliance on a fee-for-service basis.

For more information about administrative members, please see Policy 200-5000 – Administrative Member Status – Medi-Cal Members.

Member ID Card

The state of California issues a plastic Medi-Cal ID card known as the Benefits Identification Card, or BIC. The BIC shows the member's name, date of birth, 14-digit identification number and the card issue date. Use this information to verify eligibility with the state or with the Alliance (the Alliance uses the first nine digits of the Medi-Cal ID number as the Alliance Member ID number). The county Social Services Department may issue a temporary, emergency "paper card" when the member cannot wait for the state to issue the BIC.

The Alliance also issues a printed ID card to members, an example of which is shown below. Alliance members may also request a digital copy of their ID card by calling Alliance Member Services.



The Alliance ID card is a black and white card that identifies Medi-Cal recipients as Alliance members; however, this ID card is not a guarantee of eligibility or payment for services. It is the responsibility of the provider to verify eligibility before providing services. Both eligibility and PCP linkage are subject to change. The provider is responsible for verifying eligibility for each date of service in which services are rendered. The Alliance member ID number has nine digits, starting with the number "9" and ending with a letter. Use this number to verify eligibility with the Alliance.

Out-of-Area Medi-Cal Beneficiaries

Medi-Cal beneficiaries who become eligible in counties other than Santa Cruz, Monterey, Merced, San Benito or Mariposa are not the responsibility of the Alliance. However, any Medi-Cal provider may render services to these members and bill Affiliated Computer Services or the appropriate Medi-Cal Managed Health Care Plan.

When an Alliance member moves, the member must notify their County Medi-Cal benefits representative or, for those receiving Supplemental Security Income (SSI), notification is required to the Social Security Administration. Depending on when the move is reported, the member may be dropped from your case-management list by the first of the following month.

If the Alliance member is CCS eligible, the Alliance will work with the County CCS program to transfer the CCS case to the new county of residence and coordinate appropriate care.

The majority of Alliance members who leave the service area will eventually become the financial responsibility of the new county of residence and cease to be Alliance members. The timeframe in which to effect this change depends on several factors and can take from 1–3 months. During this time, the member is covered by the Alliance only for emergency or urgent care services while outside of the Alliance service area.

Circumstances in which a member moves or relocates out of our services area(s) that may not result in a change of the responsible county, this might include: placement of foster care, adoption assistance for children out of our service area(s) or other out-of-area placement of children or residents who reside in long-term care facilities when there is a local conservator or guardian involved.

Alliance Care In-Home Supportive Services Program – Monterey County

Eligibility is determined by the Monterey County In-Home Supportive Services Program (IHSS) Public Authority and the Public Authority handles enrollment and premium collection. To be eligible for enrollment, a person must meet all of the following requirements:

- Work at least the minimum number of months and hours per month as established by the In-Home Supportive Services Public Authority of Monterey County, also referred to as the Public Authority;
- Live or work in Monterey County;
- Not have previously been terminated by the Alliance for fraud, deception or failing to provide complete information;
- Have submitted the required enrollment information to the Public Authority; and
- Applied at the time the Public Authority has openings to add subscribers to the Alliance Care IHSS Health Plan.

The Public Authority informs individuals when they are eligible to enroll in the Alliance Care IHSS Health Plan. After notification of eligibility, individuals may enroll themselves by submitting an enrollment application to the Public Authority at 730 La Guardia Street, Salinas, CA 93905 within 30 days of notification of eligibility.

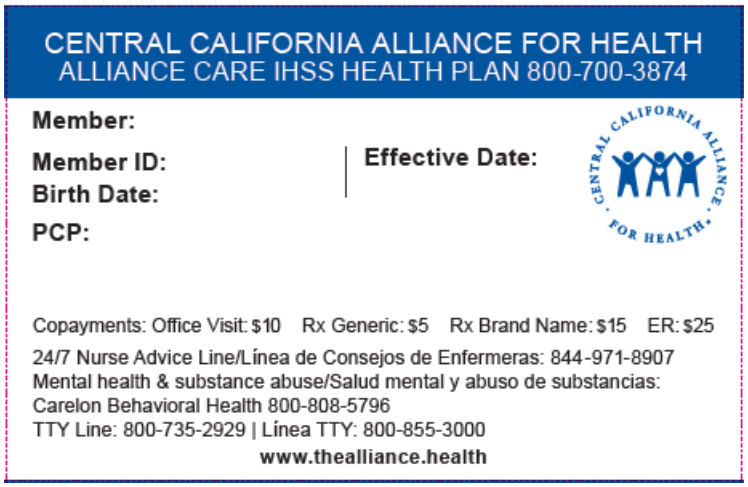
Please contact the Public Authority at 831-755-4466 for more information about eligibility, enrollment, premiums and the start of coverage.

Provider Linkage

All Alliance Care IHSS members are linked to a PCP from their first day of eligibility. They select their PCP during the enrollment process. Members may change their PCP by contacting Member Services at 800-700-3874. The change will be effective the first of the following month.

Alliance Care IHSS Member ID Card

The member ID card for our IHSS program has a strip of blue across the top and the Alliance logo on the top right-hand corner. Alliance members may also request a digital copy of their ID card by calling Alliance Member Services.



Medi-Cal and Alliance Care IHSS

To ensure that medically necessary, in-progress, covered medical services are not interrupted due to the termination of a provider's contract; we assure continuity of care for our members, as well as for those newly enrolled individuals who have been receiving covered services from a non-participating provider.

When a provider's contract is terminated or discontinued for reasons other than a medical disciplinary cause, fraud or other unethical activity, a member may be able to receive continued care with the provider after the contract ends. Continuity of care is permitted for the following conditions:

- An acute condition.
- A serious chronic condition and/or a terminal illness.
- A pregnancy and care of a newborn child from birth to 36 months.
- Surgery or other procedure that has been authorized and documented by the provider to occur within 180 days of the contract termination.
- Any other covered service dictated by good professional practice.
- The practitioner must continue to treat the member and must accept the payment and/or other terms.
- For an acute or terminal condition, the services shall be covered for the duration of the illness.
- For CCS eligible conditions under the Whole Child Model.
- For members receiving covered outpatient Behavioral Health and Behavioral Health Treatment Services.

For further details on continuity of care, please see Policy 404-1114 – Continuity of Care.

Section 6
Alliance Covered Benefits and Services

Covered Benefits

Medi-Cal

To view a summary of benefits for Alliance Medi-Cal members, please visit the Alliance member website.

Alliance Care IHSS Benefits

All health care services under the Alliance Care IHSS plan must be obtained from a participating Alliance provider, and all benefits are subject to the guidelines and procedures of our Utilization Management Department. The benefit year for Alliance Care IHSS is July 1 to June 30. There is a $3,000 copayment maximum per member per benefit year. To view a summary of benefits and copayments for Alliance Care IHSS members, please visit the Alliance member website.

Covered Services

Community Based Adult Services (Formerly Adult Day Health Care)

CBAS is an outpatient facility-based program that delivers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.

There are licensed CBAS centers providing effective coverage in our service areas. For counties without licensed CBAS centers, the Alliance will facilitate unbundled CBAS services to those members who meet the eligibility criteria. The Alliance will provide care coordination (person-centered planning) to ensure continuity of care.

Common services that CBAS centers offer to qualifying members are: professional nursing care, personal care services, social services, behavioral health services, speech therapy, therapeutic activities, and registered dietician-nutrition counseling.

CBAS centers can now provide Emergency Remote Services (ERS) when needed. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings such as the community, in or at the doorstep of the participant's home, or via telehealth The purpose of ERS is to allow for immediate response to address the continuity of care needs of members participating in CBAS when an emergency restricts or prevents them from receiving services at their center. ERS services are available to CBAS participants as needed, under unique circumstances. The provision of ERS supports and services is temporary and time limited, and specifically either:

1. Short Term: Members may receive ERS for an emergency occurrence for up to three consecutive months; or,
2. Beyond Three Consecutive Months: ERS for an emergency occurrence may not exceed three consecutive

months, either within or crossing over an authorized period, without assessment and review for possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan. Instances that go beyond three months must be authorized by the Alliance.

3. The Alliance coordinates with CBAS providers to ensure duration of ERS is appropriate during the member's current authorized period and, as necessary, for reauthorization into a new period. Members must be assessed for continued need for remote/telehealth delivery of CBAS services. Referrals for CBAS services may be made by a physician, community service agency, member, caregiver, hospital or health care provider, or a CBAS center.

Prior authorization through the Alliance is required to obtain CBAS services. A face-to-face assessment (or telephonically during PHE by Governor Health Order) by an Alliance registered nurse will be done prior to an assessment being started at the CBAS center. The authorization process entails eligibility screening, a multidisciplinary assessment at the CBAS center, completion of an Individualized Plan of Care (IPC) by the CBAS center, and decision-making by the Alliance. If approved after the Alliance assessment, the members may receive CBAS services from one to five days per week, depending upon the member's acuity and unique needs. Reauthorization is required every six months by submitting an Authorization Request to the Utilization Management Department, along with any necessary medical documentation for review.

To qualify for CBAS services, members must be over the age of 18 and meet one of the following specific medical criteria of any one or more of the following categories:

Category 1: Nursing Facility-A (NF-A) level of care or above:

- Has been determined by DHCS to meet the NF-A level of care or above, and
- Meets eligibility and medical necessity criteria contained in Sections 14525(a), (c), (d) and (e); 14526.1(d)(1), (3), (4) and (5); and 14526(e) of the W&I Code (summarized below):
    - The individual is 18 years of age or older and has one or more chronic or post-acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner or other health care provider has, within their scope of practice, requested CBAS services for the person.
    - The individual requires ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health or mental health professional to improve, stabilize, maintain or minimize deterioration of the medical, cognitive or mental health condition.
    - The individual requires CBAS services, as defined in W&I Code, Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the CBAS program to support the individual and their family or caregiver in the living arrangement of their choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing nursing or continuous nursing care.
    - Any individual who is a resident of an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) shall be eligible for CBAS services if that resident has

disabilities and a level of functioning that are of such a nature that, without supplemental intervention through CBAS, placement to a more costly institutional level of care would be likely to occur.

Except for individuals residing in an ICF/DD-H, the individual must meet all of the following:

- The individual has one or more chronic or post-acute medical, cognitive or mental health conditions that are identified by the individual's personal health care provider as requiring one or more of the following: monitoring, treatment or intervention, without which the individual's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization.
- The individual's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
- The individual lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
- The individual resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the individual.
- The individual has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the individual.
- A high potential exists for the deterioration of the individual's medical, cognitive or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization or other institutionalization if CBAS services are not provided.
- The individual's condition or conditions require CBAS services, on each day of attendance that are individualized and designed to maintain the ability of the individual to remain in the community and avoid emergency department visits, hospitalizations or other **institutionalization**.

Category 2: Organic, acquired or traumatic brain injury and/or chronic mental disorder:

- Has been diagnosed by a physician as having an organic, acquired or traumatic brain injury, and/or has a chronic mental disorder; AND
- Meets CBAS eligibility and medical necessity criteria specified above in A.2.; And
- Demonstrates a need for assistance or supervision with at least:
- Two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene; or
- One ADL/IADL listed above, and one of the following: money management, accessing resources, meal preparation, or transportation.

Category 3: Alzheimer's disease or other dementias:

- Individuals who have moderate to severe Alzheimer's disease or other dementia, characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's disease (see guide to stages below):

- Stage 5: Moderately severe cognitive decline. Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential.
- Stage 6: Severe cognitive decline. Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with daily activities.
- Stage 7: Very severe cognitive decline. This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement; AND
- Meets CBAS eligibility and medical necessity criteria specified above in A.2.

Category 4: Mild cognitive impairment including Alzheimer's disease or other dementias:

- Individuals have mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease, characterized by one or more of the following:
- Decreased knowledge of recent events
- Impaired ability to perform challenging mental arithmetic
- Decreased capacity to perform complex tasks
- Reduced memory of personal history
- The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations; AND
- Meets CBAS eligibility and medical necessity criteria specified above in A.2.; AND
- The individual must demonstrate a need for assistance or supervision with two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.

Category 5: Developmental disabilities:

- Meets the criteria for regional center eligibility; AND
- Meets CBAS eligibility and medical necessity criteria specified above in A.2.

For more information on CBAS and Emergency Remote CBAS Services, please see Policy 405-1111 – Community Based Adult Services.

Community Health Worker (CHW) Benefit

Central California Alliance for Health (the Alliance) covers Community Health Worker Services to members that meet criteria in accordance with Alliance Policy and DHCS requirements. CHW care must be overseen by a Supervising Provider which must be a licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization. Supervising Provider Responsibilities are as follows:

- Ensure that CHWs are approved through Alliance Peer Review and Credentialing.
- Oversee the CHWs and CHW Services delivered to members.

- Appropriate claim submission of all CHW Services.
- Ensure the provision of CHW services complies with all applicable requirements and provide direct or indirect oversight to CHWs.

Supervising Providers do not need to be physically present at the location when the CHW Services are provided to the members. Supervision of the CHWs as employees may be delegated as determined by the Supervising Provider.

CHW Services require a written recommendation by a physician or other licensed practitioner. The recommending Provider must determine whether a member meets eligibility criteria for CHW services based on the presence of one or more of the following and verify the eligibility criteria:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental health or substance use disorder condition that has not been diagnosed.
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via the Adverse Childhood Events screening.
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
- Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
- One or more visits to a hospital emergency department (ED) within the previous six months.
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months or being at risk of institutionalization.
- One or more stays at a detox facility within the previous year.
- Two or more missed medical appointments within the previous six months.
- Member expressed need for support in health system navigation or resource coordination services.
- Need for recommended preventative services, including updated immunizations, annual dental visit, and well childcare visits for children.
- Violence prevention services

Prior authorization is not required for the first 12 units of CHW services.

A member is not eligible for CHW services at the same time they are receiving services from ECM. For members who need multiple ongoing CHW services, or continued CHW services after the first 12 units of services, a recommendation must be submitted to the Alliance initially and every 6 months that includes attestation that a written care plan is in place that has been updated annually.

A written care plan must be written by one or more individual licensed providers, which may include the recommending provider and other licensed providers affiliated with the CHW Supervising Provider. The provider ordering the plan of care does not need to be the same Provider who initially recommended CHW

services or the Supervising Provider for CHW services. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team and/or other Providers. The Plan of care may not exceed a period of one year. The plan of care must:

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Include a list of other health care professionals providing treatment for the condition or barrier;
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health;
- List the specific services required for meeting the written objectives; and
- Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

A licensed provider must review the member's plan of care at least every six months from the effective date of the initial plan of care. If there is a significant change in the recipient's condition, the plan may be amended.

For more information, please see Policy 300-4035 – Community Health Workers Requirements and Policy 404-1738 – Community Health Worker Services.

Diabetes Prevention Program (DPP)

Diabetes Prevention Program (DPP) is a Medi-Cal covered benefit. The Alliance covers a minimum of 22 hours of DPP sessions for the first 12 months of the DPP benefit (Core Sessions and/or Core Maintenance Sessions) per the full CDC curriculum and a second year comprising eight (8) hour sessions (ongoing maintenance sessions) to promote maintenance, which is reserved for those individuals who have successfully completed the first year and have achieved and maintained their weight loss goal. These services are provided through Alliance-approved DPP education providers who can bill for these services. Members can be referred by their PCP or other Alliance case management staff or can self-refer. The DPP is an evidence-based lifestyle change program, taught by peer coaches, designed to prevent or delay the onset of type 2 diabetes among individuals (ages 18 and older) diagnosed with prediabetes. Alliance-approved DPP providers must meet the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) and be enrolled in the Medi-Cal Program with DHCS.

DPP education providers who are interested in joining the Alliance network must adhere to the following requirements prior to contracting with the Alliance:

- DPP education providers must comply with guidelines issued by the CDC DPRP and obtain pending, preliminary, or full recognition by the CDC. As a CDC-recognized organization, DPP providers are required to use the National DPP CDC-approved lifestyle change curriculum.
- DPP education providers who are CDC-recognized organizations must also be Medi-Cal enrolled providers and comply with Medi-Cal program integrity rules such as confidentiality, screening, and disclosure standards in order to become a Medi-Cal DPP Supplier. This applies to both currently enrolled and newly enrolled providers; DPP suppliers must have DHCS approval prior to rendering DPP services to Medi-Cal members. Please visit the DHCS website for important information, including required Medi-Cal program components.

- DPP education providers must hold a National Provider Identifier (NPI), cannot be debarred, and must maintain at least one administrative location in California. An "administrative location" is defined as the physical location associated with the DPP's operations, and where DPP services may or may not be furnished.
- DPP education can be delivered by non-medical personnel such as peer coaches, lifestyle coaches, community outreach workers, and/or promoters. The DPP may be delivered through an online, virtual, or in-person format.
- DPP education providers must be contracted with the Alliance and abide by all requirements outlined in DHCS APL 18-018 and Alliance policies related to provider credentialing guidelines.

For additional information about the Alliance's credentialing policies and procedures, please visit the Credentialing Policies section of the Provider Credentialing Applications and Policies page on the Alliance provider website.

eConsult Program

The Alliance offers contracted primary care physicians (PCPs), Physician Assistants (PAs) and Nurse Practitioners (NPs) providing primary care access to specialist networks via eConsult services. eConsult utilizes a HIPAA-secure, web-based platform to enable communication between a provider and a specialist. Through eConsult, eligible primary care providers typically present a brief question regarding a patient's symptom management or diagnosis which may include medical records and images. Like email, communication occurs asynchronously but includes follow up questions and clarifications.

Requirements of Participating Providers

All participating providers must agree to vendors' terms of service and utilize eConsult services for Alliance members without other health care coverage. Supervising PCPs will oversee all cases submitted by PAs or NPs.

Note that the PCP remains solely responsible for the diagnosis and treatment of their patients. If a PCP is unsure of the course of action following use of eConsult, they are still obligated to deliver the appropriate standard of care through the established referral process.

eConsult Partners

The Alliance contracts with two vendors that offer eConsult services. Interested providers should contact the vendors directly to determine which organization best meets their needs. The vendors will provide training on how to use their platform and obtain eConsults with specialists.

Alliance approved eConsult vendors' information is listed below:

AristaMD
www.aristamd.com

Direct Dermatology
www.directderm.com

To become an eConsult referral specialist, physicians can contact Alliance eConsult vendors directly.

Urgent Visit Access

Urgent Visit Access offers an alternative access site for an urgent visit if the member's PCP is not able to accommodate an acute visit.

Participating Urgent Visits Access Site Requirements

Many Alliance PCPs are open evenings and weekends. In order to participate as an Urgent Visit Access participating provider, PCPs should:

- Provide urgent visits to non-linked Alliance members; and
- Be open for an extended hour each weekday, beyond the typical Monday–Friday, 8 a.m.–5 p.m.; or
- Be open for a minimum of four (4) hours on the weekends.

The Alliance may make exceptions to these criteria on a case-by-case basis.

Member Steps

If a member needs care after regular office hours, they can take the following steps:

1. Call their PCP and ask if an appointment is available.
2. Call the Nurse Advice Line (NAL) for an over-the-phone assessment and guidance of what to do next.
3. If the member's PCP is unable to accommodate an urgent visit or by the recommendation of the NAL, the member may seek care at a participating Urgent Visit Access site. No referral is required.

Documentation

Urgent Visit Access sites have been asked to fax information to the member's PCP with details of the visit. This may be an after-visit summary or a full clinic note (preferred).

Referrals

Referrals required subsequent to the urgent visit will be directed to the PCP. If an urgent specialist referral is needed, a call should be made from the participating urgent visit site to the PCP to facilitate an immediate referral.

For more information on how to become a participating Urgent Visit Access site, please contact your Provider Relations Representative at: 800-700-3874, ext. 5504.

Emergency Services

Emergency services are covered inpatient and outpatient services that are necessary to enable stabilization or evaluation of an emergency medical condition and are provided by a health care professional qualified to furnish emergency services.

An emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the individual or, in case of a pregnant woman, the health of the woman or her unborn child.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

No prior authorization is required for emergency/urgent services and emergency hospital admissions. All inpatient hospital stays require an authorization after admission. Authorization can be obtained by faxing a Hospital Admission Face Sheet and clinical documentation to the Utilization Management Department to 831-430-5850.

For emergency hospital admissions and emergency room outpatient services, the hospital should verify the member's eligibility and assigned PCP by telephoning our Eligibility Verification System or Eligibility Clerk. Contracting facilities are obligated to notify the Alliance within one business day of service and to forward a copy of the ED report/face sheet to the PCP within the same timeframe.

When a member presents an emergency condition at a hospital or other provider facility and is admitted for inpatient services, the hospital/treating physician should notify the PCP and the Alliance within one working day of admission.

For more information on hospital services, see the section below.

Providers may direct their Alliance Medi-Cal patients to any outpatient clinical laboratory that services Alliance Medi-Cal members. Alliance Care IHSS and Medi-Cal Access Program members should be directed to any contracted outpatient clinical laboratory. An updated list of contracted laboratories is available in the Alliance Provider Directory.

Hospital Services

NICU Services for CCS-Eligible Members

The Alliance will authorize CCS-eligible NICU stays based on the CCS policy for Medical Eligibility for Care in a CCS Approved Neonatal Intensive Care Unit. Authorization will be provided only for the level of services for which a NICU has been approved by DHCS. If the NICU is not CCS-approved, or if the level of care that is required by the member is above the NICU level of approval, the hospital must follow CCS guidelines for Stabilization, Transfer and Transport of a CCS-Eligible NICU Patient.

Medical Records

Each hospital is responsible for maintaining adequate medical records of patient care. Records should be maintained in accordance with applicable state and federal privacy laws. The Alliance has the right to review records for claims authorization and service authorization. All medical records should be maintained in a manner consistent with professional practices and prevailing community standards as well as all federal, state

and accrediting body regulations. For more information, see Policy 401-1510 – Medical Record Review and Requirements.

Discharge Planning

Discharge planning is initiated upon admission to facilitate the transition of beneficiaries to the next phase of care. The discharge planning team is multi-disciplinary and consists of treating physicians and hospital discharge planners. Physician responsibility includes participation in coordinating member discharge planning and referrals to appropriate post-discharge settings. Alliance staff will work with the hospital's discharge planning staff, as needed, in determining the most appropriate post-discharge setting.

Acute Administrative Days – Medi-Cal Only

Acute administrative days are those days approved in an acute care inpatient facility which provides a higher level of medical care than that currently needed by the patient. These days may be authorized for patients awaiting placement in skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). For more information on how hospitals may qualify for reimbursement of acute administrative days, please see Policy 404-1520 – Administrative Day Criteria.

Identification and Referral of CCS Cases

Admitting physicians, hospital discharge planners, neonatologists, hospital pediatricians and other hospital staff, as appropriate, shall work with the Alliance to ensure that children with potentially CCS-eligible conditions are identified and referred to the local county CCS program for CCS eligibility determination. For more information on CCS referral procedures, please see Policy 408-1305 Behavioral Health Services. For more information on CCS identification and referrals, please refer to the California Children's Services (CCS) page on the Alliance provider website. For more information regarding the CCS program, please refer to the CCS page on the California Department of Health Care Services (DHCS) website.

Authorizations

For more detailed information about the hospital authorization process, please see the following policies:

404-1102 – Inpatient Review

404-1201 – Authorization Request Process

404-1521 – Hospital Stays Where Discharge, Death or Transfer Occurs on the Day of Admission

404-1524 – Long-Term Care for Medi-Cal Members

404-1525 – Skilled Nursing Program Policy for Medi-Cal

Utilization Management

For detailed information on the Alliance Utilization Management Program, please see Policy 404-1101 – Utilization Management Program..

Credit Balance Report

The Alliance requires all participating contracted Hospital Providers to complete a Credit Balance Report on a quarterly basis. The report is used to monitor, identify, and recover "credit balances" owed to the Alliance for improper or excess payments made to the provider resulting from claims processing errors. For detailed information on completing and submitting the Credit Balance Report, please see Policy 702-1300 – Credit Balance Report.

Laboratory Services

The Alliance reimburses contracted physicians for certain Clinical Laboratory Improvement Amendments (CLIA) waived lab tests that are performed in a physician's office, if the physician meets the requirements of 42 USC Section 263a (CLIA) and provides the Alliance with a current CLIA Certificate of Waiver. Effective in 2015, the Alliance has expanded the list of approved CLIA waived labs to include those allowed by Medi-Cal. More information on the codes can be found in the Pathology: Billing and Modifiers section of the Medi-Cal Provider Manuals. Providers should review the Medi-Cal Provider Manuals to confirm the code is allowed by Medi-Cal as a CLIA waived lab.

Upon request for information, following Policy 404-1714 – Technology Assessment, the Alliance will evaluate new technologies such as medical and behavioral health procedures, pharmaceuticals and devices, and will evaluate changes in the application of existing technologies to determine whether a new technology should be an added benefit.

Skilled Nursing Facilities and, Long Term Care, and Private Duty Nursing Medi-Cal

Long Term Care (LTC) is defined as care in a facility for longer than one full month. LTC facilities may include a Skilled Nursing Facility (SNF), sub-acute facilities (pediatric and adult) or intermediate care facilities.

Determination of the most appropriate level of care for the member, and the best facility to provide such care, is made by collaborative efforts between the PCP, the hospital Discharge Planning/Care Management departments, and the Alliance Utilization Management and Case Management teams. Prior authorization is required for approval of admission to a long-term care facility of any kind.

The criteria for receiving skilled-nursing services must meet the level-of-care standards set by Medi-Cal (Title 22, Section 51215).

- The patient must require the continuous availability of procedures, including but not limited to: Administration of IV, IM or SC injections and IV or SC infusions.
- Gastric tube or gastronomy feedings.
- Nasopharyngeal aspiration.
- Insertion or replacement of catheters.
- Application of dressings involving prescribed medications and aseptic techniques.
- Treatments that require observation by licensed health care staff to evaluate the patient's progress.
- Administration of medical gases under a prescribed therapeutic regimen.

- Restorative nursing procedures that require the presence of a licensed nurse. Medically necessary long-term care will be authorized by the Alliance at the time of admission for members who meet the criteria. If the member does not meet the criteria for long term care, if no AR was submitted, or if the facility is unable to meet the member's nursing needs, a denial notice will be sent to the member, the PCP and the admitting physician. The notification will include the process to appeal the denial decision.

Unless otherwise determined, the PCP and member relationship continues during the limited long term care stay.

For more information on LTC and SNF benefits for Alliance Medi-Cal members, please see the following policies:

404-1524 – Long-Term Care for Medi-Cal Members

404-1525 – Skilled Nursing Program Policy for Medi-Cal

Medi-Cal Long-Term Care Facility Admission and Discharge Notification (MC171) Form

Medi-Cal LTC Facilities are required to complete the Medi-Cal Long-Term Care Facility Admission and Discharge Notification Form (MC171) on the day of admission or discharge of the patient. The MC171 form is located on the DHCS website.

On admission to an LTC facility, a Medi-Cal recipient or the recipient's representative must complete the

Medi-Cal Long Term Care Facility Admission and Discharge Notification (MC171) form, Parts I and II.

When a Supplemental Security Income (SSI) recipient enters a LTC facility, providers must notify the Social Security Administration (SSA) field office of the recipient's name, Social Security Number (SSN) and date of entry. SSI recipients are required to report their status to the provider when entering a nursing facility.

- The LTC facility must retain a copy of the MC171 form for its files and send either the original or a copy to the proper government agencies depending on whether the patient receives Supplemental Security Income/State Supplemental Payment (SSI/SSP).

  or

- The patient receives aid under any program other than SSI/SSP.
- If the patient receives SSI/SSP, the original MC171 should be sent to the local Social Security Office. The aid code for these recipients is 10, 20, or 60. A copy of the MC 171 should also be forwarded to the local county welfare department.
- If the patient receives aid under a program other than SSI/SSP; the original MC171 should be sent to the local county welfare department. The aid code for these recipients will be other than 10, 20, or 60.
- The LTC facility is not required to submit a copy of the MC171 form to the California Department of Health Care Services, Medi-Cal Eligibility Division. The Medi-Cal field office will use the recipient's initial Treatment Authorization Request (TAR) as notification of the patient's admission.
- When the patient is discharged (or expires), the facility must complete Part III of the MC171 form and submit the original copy to the county welfare department. For additional information, please see *Long Term Care (LTC) Manual*, Section: *Admissions and Discharges* of the Medi-Cal Provider Manuals.

Private Duty Nursing is an EPSDT supplemental services benefit (for individuals under age 21). For additional information, please see Policy 404 – 1720 Private Duty Nursing EPSDT Benefit.

Alliance Care IHSS

For Alliance Care IHSS members, prior authorization is required for approval of admission to a SNF of any kind. Determination of the most appropriate level of care for the member, and the best facility to provide such care, is made by collaborative efforts between the PCP, the hospital Discharge Planning/Care Management departments, and the Alliance Utilization Management and Case Management teams.

To qualify for skilled-nursing care, the patient must require the continuous availability of procedures, including but not limited to:

- Administration of IV, IM or SC injections and IV or SC infusions.
- Gastric tube or gastronomy feedings.
- Nasopharyngeal aspiration.
- Insertion or replacement of catheters.
- Application of dressings involving prescribed medications and aseptic techniques.
- Treatments that require observation by licensed health care staff to evaluate the patient's progress.
- Administration of medical gases under a prescribed therapeutic regimen.
- Restorative nursing procedures that require the presence of a licensed nurse.

Medically necessary skilled-nursing care will be authorized by the Alliance at the time of admission for members who meet the criteria. If the member does not meet the criteria for a SNF, if no AR was submitted or if the SNF is unable to meet the member's skilled nursing needs, a denial notice will be sent to the member, the PCP and the admitting physician. The notification will include the process to appeal the denial decision.

Telehealth

Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. (Section 2290.5(a)(6) of the Business and Professions Code).

Telehealth Coverage

In keeping with current California law (AB 415 passed in 2011), the Alliance provides coverage for telehealth services, as defined above. Services may be delivered as asynchronous store and forward or synchronous interaction.

Synchronous Telehealth Services and Settings

Synchronous telehealth is real-time interaction between a member and a health care provider located at a distant site. The member's provider may be present at the originating site during synchronous interaction if

deemed necessary. Synchronous telehealth services can be provided to Alliance members by any Alliance credentialed health care provider with the member's verbal consent, as documented in the patient's medical record.

Asynchronous Telehealth Services and Settings

Asynchronous telehealth is the transmission of a member's medical information, including photographs, x-rays, or other forms of data, from an originating site to the health care provider at a distant site without the presence of the member. Asynchronous store and forward telehealth services provide for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time. The following health care providers may provide store and forward services:

- Ophthalmologists
- Dermatologists
- Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code)

The Alliance will pay for services in teledermatology, teleoptometry and teleophthalmology, as long as they meet federal and state guidelines for medical necessity and are covered benefits according to the Alliance member's Evidence of Coverage (EOC). Services provided by telehealth may require a referral from the PCP. Providers should follow the procedures outlined in Policy 404-1201 Authorization Request Process.

Patients receiving teledermatology, teleophthalmology or teleoptometry services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the patient's notification of the results of the consultation.

Telehealth services are also available for mild to moderate mental health services. For more information, see "Telehealth Services: Behavioral Health" on page 72.

Telehealth services can be provided in a number of settings: physician office, clinic, hospital, skilled nursing facility, or a member's home. These would each be considered originating sites. A licensed provider must be present if the provider fee for the visit is to be reimbursable. If a licensed provider is not present at the originating site, a site facility fee may be billed in lieu of the provider fee for the visit. In addition, transmission cost fees may be billed. For lines of business that require a copay for services, the payment will be collected at the time of the member's visit to the originating site.

At the distant site expert providers would serve as consultants or offer ongoing care for specific conditions. That provider may bill for an office or inpatient consultation as well as transmission cost fees. For those lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

The health care provider at the originating site must inform the member that telehealth services will be used and obtain the member's verbal or written consent, which will be documented in the member's medical record. In situations when the asynchronous store and forward system is used, members must be notified of their right to have interactive communication with the distant specialist at the time of the consultation or within 30 days of the patient's notification of the results of the consultation. In all circumstances, providers will

abide by HIPAA laws, including not disclosing a member's personal health information to any third party without written consent.

The audio-video telemedicine system used, must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT-code billed.

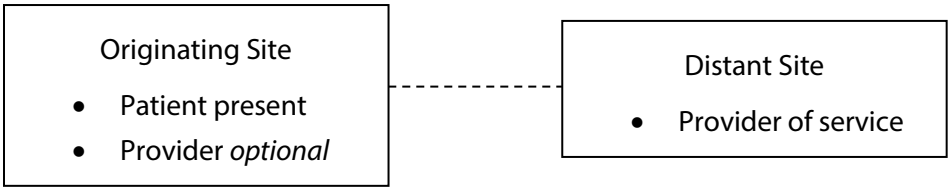
Billing Guidelines

Below are guidelines for providers using telehealth services to enable providers to accurately bill for such services. The Alliance will reimburse contracted providers for telehealth services as described in Alliance Policy 404-1727 – Provision of Telehealth Services to Alliance Members.

Reimbursement for Telehealth Services

The three main models of telehealth services available to Alliance members are explained on the following pages.

Reimbursement for Traditional Synchronous Telehealth Services



Billing guidelines for originating site providers:

Originating Site	
Service	**Code**
Site Facility Fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed Provider Fee (*if present*)	E&M codes 99202–99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.
Required Place of Service	Place of Service code "02" (not required for FQHCs, RHCs or HIS-MOA clinics)

If a licensed provider also is present at the telehealth originating site with the patient present and a progress note is generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating provider should be documented in the progress note that are distinct from those provided by the distant site and will be the basis of the E&M and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed. No modifier is needed at the originating site. For lines of business requiring a copay for services, the payment will be collected at the originating site.

Billing guidelines for distant site providers:

Distant Site	
Service	**Code**
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Initial hospital care or subsequent hospital care (new or established patient)	99221–99233
Licensed Provider Fee	99202–99215
Consultations: Office or other outpatient (Initial or follow-up), Inpatient, and confirmatory	99242–99255
E-Consultations	99451
Required Modifier	95 modifier required for all CPT-Codes except Transmission Cost codes
Required Place of Service	Place of Service code "02" (not required for FQHCs, RHCs or HIS-MOA clinics)

For IHSS members, the copay will be waived for services provided at the distant site.

Reimbursement for Asynchronous Telehealth Services (Store and Forward) for Teleophthamology, Teleoptometry and Teledermatology Services:

Originating Site	Information stored and forwarded to Distant Site	Distant Site
Patient present Provider optional		Provider of service

Billing guidelines for originating site providers:

Originating Site	
Service	**Code**
Site facility fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (*If present*)	E&M codes 99202–99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.
Required Place of Service	Place of Service code "02" (not required for FQHCs, RHCs or HIS-MOA clinics)

If a licensed provider also is present at the telehealth-originating site, with the patient present and a progress note generated by the originating provider, the telehealth service is reimbursable as a visit. The scope of the interaction with the originating provider should be documented in the progress note and will be the basis of the CPT code(s) used. If a CPT code is included, the originating site fee and the transmission cost fees may still be billed. No modifier is needed. For lines of business requiring a copay for services, the payment will be collected at the originating site.

Billing guidelines for distant store and forward site providers:

Distant Store and Forward Site	
Service	**CPT Codes**
Licensed Provider Fee	92002, 92004, 92012, 92014, 99202–99215
Office consultation, new or established patient	99242–99255
E-Consultations	99451
Retinal photography with interpretation for services provided by optometrists or ophthalmologists	92250
Required Modifier	All asynchronous, store-and-forward services are billed with a "GQ" modifier
Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)

For lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

Reimbursement for Synchronous: Provider to Patient Telehealth Services

The Telehealth Advancement Act of 2011 allows for telehealth services to be provided between a qualified provider and patient at a distant location. The location may be a health facility, residential home, patient's home or other location. For lines of business requiring a copay, the payment will be collected at the originating site.

Originating Site – Patient Location

1. Health facility
2. Residential home
3. Patient home
4. Other location

Distant Site

- Provider Site
- Patient NOT present

Billing guidelines for the distant site:

Distant Site	
Service	**Code**
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (*if present*)	E&M codes 99202–99215
Required Modifier	95 modifier required for all CPT-Codes except Transmission Cost codes
Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)

For IHSS members, the copay will be waived for services provided at the distant site.

A licensed provider who provides E&M services for a patient utilizing telehealth technology to access the provider's office may submit claims for the service using the E&M code, without the modifier. The contracted arrangements for primary care providers and specialty providers continue to apply. T1014 Transmission Cost fee may also be billed.

Exclusions

Telehealth does not include email, text, inadequate resolution video or written communication between providers or between patients and providers, unless such exceptions have been granted under California or applicable Federal law or regulations.

Palliative Care Services

The Palliative Care benefit is designed to help members with advanced disease states to understand and receive supportive and specialized healthcare before hospice care is indicated. In its full capacity, the Palliative Care benefit will connect members with clinicians who are trained to focus on symptom management and who understand advance care planning and end of life complexities.

Eligible Members

Members eligible for the benefit are expected to have one (1) year or less life expectancy, be in the advanced stage of illness, have received appropriate patient-desired medical therapy, or for whom patient-desired medical therapy is no longer effective, and have started to access the hospital or emergency department as a means to manage late stage illness. Members should also have one or more of the following disease-specific eligibility criteria:

- Congestive heart failure (CHF): hospitalized due to CHF as primary diagnosis (no further invasive interventions planned) OR NYHA III or higher AND EF <30% or significant comorbidities
- Chronic obstructive pulmonary disease (COPD): FEV1<35% predicted and 24 hour and O2 requirement less than 3L/min OR 24-hour O2 requirement >3L/min

- Advanced cancer: any stage III or IV solid organ cancer, leukemia or lymphoma and Karnofsky Performance Scale score < 70 OR treatment failure of 2 lines of chemotherapy
- Liver disease: evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND ascites, spontaneous bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices OR evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.
- Other advanced disease states will be considered on a case-by-case basis

Eligible Providers

Contracted rendering physician leaders of Palliative Care teams must 1) be credentialed under Primary Care Physician Services Agreement or a Referral Physician Services Agreement, and 2) meet the Palliative Care specific requirements set forth in Policy 404-1527 – Palliative and Hospice Care.

Eligible Services

Palliative Care services include advanced care planning, palliative assessment and consultation with a palliative care team, care coordination, and mental health and medical social services for counseling and support. Pastoral care may also be provided, though it is not reimbursed by the Alliance. Traditional Palliative Care provision includes curative and/or supportive treatment planning, pain and symptom management, medication side effects, emotional and social challenges, spiritual concerns, patient goal setting, and advance directives, including completion of physician order for life-sustaining treatment (POLST) form.

To receive palliative care services, a referral must be submitted. To receive reimbursement for Palliative Care services, the provider must include the authorization number on the claim form, as well as a U1 modifier as described below. Claims for Palliative Care services will be processed in accordance with Alliance policies and procedures. If Palliative Care services are provided to members with OHC or Medicare, the services rendered must be billed to the primary insurance first. The claim should be then sent to the Alliance with the primary insurer's explanation of benefits. All applicable coordination of benefit rules applies to claims for Palliative Care services.

The codes and frequency limits for Palliative Care services are listed below. Providers must include a U1 modifier in the first position for every code submitted for Palliative Care services on the claim.

Code	Description	Frequency Limitations
99202–99205	Office Or Other Outpatient Visit For The Evaluation And Management Of A New Patient	One time per 36 months per member
99212–99215	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99242–99245	Office Consultation For A New Or Established Patient	One time per day per member
99304–99310	Initial Nursing Facility Care, Per Day, For The Evaluation And Management Of A Patient	One time per day per member

99324–99328	Domiciliary Or Rest Home Visit For The Evaluation And Management Of A New Patient	One time per day per member
99334–99337	Domiciliary Or Rest Home Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99341–99345	Home Visit For The Evaluation And Management Of A New Patient	One time per day per member
99347–99350	Home Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99354	Prolonged Evaluation And Management Or Psychotherapy Service(s) (Beyond The Typical Service Time Of The Primary Procedure) In The Office Or Other Outpatient Setting Requiring Direct Patient Contact Beyond The Usual Service; First Hour	One time per day per member
99355	Prolonged Evaluation And Management Or Psychotherapy Service(s) (Beyond The Typical Service Time Of The Primary Procedure) In The Office Or Other Outpatient Setting Requiring Direct Patient Contact Beyond The Usual Service; Each Additional 30 Minutes	Four times per day per member
99356	Prolonged Service In The Inpatient Or Observation Setting, Requiring Unit/Floor Time Beyond The Usual Service; First Hour	One time per day per member
99357	Prolonged Service In The Inpatient Or Observation Setting, Requiring Unit/Floor Time Beyond The Usual Service; Each Additional 30 Minutes	Six times per day per member
99358–99359	Prolonged Evaluation And Management Service Before And/or After Direct Patient Care; First Hour	One time per day per member
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death	One time per day per member
99489	Complex Chronic Care Management Services, With The Following Required Elements: Multiple (Two Or More) Chronic Conditions Expected To Last At Least 12 Months, Or Until The Death Of The Patient; Chronic Conditions Place The Patient At Significant Risk	One time per day per member
99490	Chronic Care Management Services, At Least 20 Minutes Of Clinical Staff Time Directed By A Physician Or Other Qualified Health Care Professional, Per Calendar Month, With The Following Required Elements: Multiple (Two Or More) Chronic Conditions	No frequency limitation

99497	Advance Care Planning Including The Explanation And Discussion Of Advance Directives Such As Standard Forms (With Completion Of Such Forms, When Performed), By The Physician Or Other Qualified Health Care Professional; First 30 Minutes, Face-To-Face	One time per day up to two times per month per member
99498	Advance Care Planning Including The Explanation And Discussion Of Advance Directives Such As Standard Forms (With Completion Of Such Forms, When Performed), By The Physician Or Other Qualified Health Care Professional; Each Additional 30 Minutes	One time per day up to two times per month per member
G0506	Comprehensive Assessment Of And Care Planning For Patients Requiring Chronic Care Management Services (List Separately In Addition To Primary Monthly Care Management Service)	One time per member at onset of chronic care management services

For the purpose of calculating frequency limitations, a *new patient* shall be defined as someone who has not been seen in the preceding three years by a practitioner or provider in the same specialty as the practitioner or provider who is rendering care.

For more information, please see Policy 404-1527 – Palliative and Hospice Care.

Street Medicine

The Street Medicine benefit is a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. The fundamental approach of street medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate

barriers to care access and follow-through. Street medicine is provided to an individual experiencing unsheltered homelessness in their lived environment, places that are not intended for human habitation. Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified location do not qualify as street medicine, but are considered mobile medicine, as they require people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location. Mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") are considered street medicine.

The Place of Service (POS) code for Street Medicine services is listed below.

POS Code	Description
27 Outreach Site/Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals. (Effective October 1, 2023)

DHCS is clarifying that POS codes 04 (Homeless Shelter), 15 (Mobile Unit), and 16 (Temporary Lodging) should continue to be utilized for services provided in those respective settings, whether or not they are provided by a "street medicine provider." In the instance of street medicine, the POS code claimed should equate to the location of the service provided, rather than the provider type.

Street Medicine Provider as a Member's Assigned PCP

Street medicine Provider refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).

For a non-physician medical practitioner (PA, NP, and CNM), the Alliance will ensure compliance with state law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of street medicine, a supervising Physician must be a practicing street medicine Provider, with knowledge of and experience in street medicine clinical guidelines and protocols.

Contracted street medicine Providers may choose to serve as the Member's assigned PCP upon Member election, similar to how Obstetrician-Gynecologist (OB/GYN) Providers can elect to serve as PCPs. In order to serve as a PCP, the street medicine Provider must meet the Alliance's eligibility criteria for being a PCP, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice, and agree to serve in a PCP role. Street medicine Providers, when elected by Members to act as their assigned PCP, are responsible for providing the full array of Primary Care services, including but not limited to, preventive services, and the treatment of acute and chronic conditions. Thus, street medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:

- Basic Population Health Management;
- Care coordination and health promotion;
- Support for Members, their families, and their authorized representatives;
- Referral to Specialists, including behavioral health, community, and social support services, when needed;
- The use of Health Information Technology to link services, as feasible and appropriate; and
- Provision of primary and preventative services to assigned Members.

If the street medicine Provider does not have the capability to provide Primary Care services on the street, the street medicine Provider must be affiliated with a brick-and-mortar facility (e.g., primary care medical office, Federally Qualified Health Center (FQHC), clinic, etc.). In this case, the Alliance will assign Members to the affiliated brick-and-mortar facility to which the street medicine Provider is affiliated.

If the street medicine Provider is willing to serve in the Member's assigned PCP capacity and is not yet contracted and credentialed with the Alliance, the Alliance will enroll and credential the street medicine Provider, in accordance with APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.

Process for a Street Medicine Provider to Become a Member's Assigned PCP

If the street medicine Provider is willing to be the Member's assigned PCP, the street medicine Provider must initiate the request via telephone call to the Alliance Member Services Call Center with the Member on the line, and both parties must confirm to the Alliance the Member's choice in selecting the street medicine Provider to be their assigned PCP.

Member Services
Monday through Friday from 8 a.m. to 5:30 p.m.
Call toll free: 800-700-3874

Billing Guidelines

Street medicine Providers rendering services to Alliance eligible members should bill the Alliance for appropriate and applicable services within their scope of practice. Street medicine Providers must comply with the billing provisions for street medicine Providers as applicable in FFS, including but not limited to, the Medi-Cal Provider Manual. For managed care Members, street medicine Providers must comply with the billing provisions for street medicine Providers as applicable to plan policies and procedures.

If the street medicine Provider is an FQHC, they can still be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located. The FQHC will be paid their applicable PPS rate when the street medicine Provider is a billable clinic provider.

Access to Care

Street medicine Providers elected as a Member's assigned PCP are exempt from PCP time and distance standards as the Member does not have a permanent residential address and the street medicine Provider is meeting the Member at their lived environment. The Alliance is not expected to contract with street medicine Providers in order to meet time and distance standards as part of Annual Network Certification requirements.

The service Location requirement for PCPs is not applicable to street medicine Providers serving as PCPs, as these street medicine Providers are not rendering services at a brick-and-mortar location.

Access requirements of a street medicine Provider include, at a minimum:

1. A process for street medicine Providers to contract with the Alliance as a PCP, if desired, and not requiring contracted street medicine Providers to be PCPs;
2. A process to ensure timely access to traditional PCPs and Specialists in the Alliance's Network;
3. A method of providing transportation to a traditional PCP that is not limited by time or distance standards, upon the Member's request.

Authorizations

Prior authorization to see a street medicine provider would not be needed if the Member seeks services directly from a street medicine Provider related to the Member's primary care. This means that an Alliance-contracted street medicine Provider, that meets all Alliance-required administrative processes, could provide

services to an Alliance Member and be compensated for those services, even if the Member is assigned to a Subcontractor, such as a medical group or IPA.

Enhanced Care Management and Street Medicine

The Alliance may contract with street medicine Providers to become ECM Providers, and they may be contracted to provide both PCP and ECM services to a Member. Street medicine Providers that are also ECM Providers are required to fulfill all ECM requirements; have the capacity to provide culturally appropriate and timely in-person care management activities; and have formal agreements, data systems, and processes in place with entities across sectors to support care coordination and care management. The Alliance will ensure non-duplication of services provided through ECM and any other covered benefit, program, and/or delivery system.

Street Medicine Provider Serving Solely as Referring or Treating Contracted Provider

The contracted street medicine Provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted Provider working with individuals experiencing unsheltered homelessness. To provide care in this capacity, street medicine Providers must have processes in place to work with the Alliance, the Member's PCP, and ECM Care Manager to ensure the Member has referrals to primary care, Community Supports, behavioral health services, and other social services as needed.

Eligibility

Street medicine Providers are required to verify the Medi-Cal eligibility of individuals they encounter in the provision of health care services. Medi-Cal eligible individuals will be covered by either the Medi-Cal Fee-for-Service (FFS) or Medi-Cal managed care (with a corresponding MCP, such as the Alliance) delivery system. For those individuals without Medi-Cal coverage, the Hospital Presumptive Eligibility (HPE) program is one pathway for qualified HPE Providers to determine Medi-Cal eligibility. HPE provides qualified individuals immediate access to temporary Medi-Cal services while individuals apply for permanent Medi-Cal coverage.

DHCS allows qualified HPE Providers to determine presumptive eligibility under the HPE program off the premises of hospitals and clinics, such as in mobile clinics, street teams, or other locations. Street medicine Providers are not required to participate in the HPE program, but may do so if they meet and fulfill all qualifications and requirements of the HPE program.

Training

The Alliance will ensure that street medicine Providers are given the necessary provider training and manuals and have adequate systems in place to adhere to administration requirements, such as grievances and appeals, referrals, after-hours and timely access, prior authorizations, quality improvement, performance measures, and electronic health records. Street medicine Providers must comply with all applicable Alliance administration requirements in accordance with federal and state laws and the Alliance's Contract based on provider contracting type.

For more information please see Alliance Policy 300-4046 – Street Medicine Providers.

Transportation: Emergency and Non-Emergency

Emergency Transportation from PCP Office to Hospital

On occasion members require admission to acute-care facilities directly from the PCP's office; in such cases we reimburse the costs of this transportation to the hospital.

When a PCP determines that a member requires immediate hospitalization from their office, the PCP may determine at their own medical discretion which is the most appropriate and safe mode of transportation.

- Ambulance transportation can be accessed by dialing 911, or Taxicab service can be accessed by calling the cab company directly.
- If the PCP determines that cab service is more appropriate than ambulance service, the PCP office will notify the Alliance Transportation Coordinator at 800-700-3874, ext. 5640 after the taxicab has been called to ensure reimbursement to the cab company. The Transportation Coordinator will document in Essette the PCP's notification that a taxicab was called to transport the member to the hospital.
- Authorization is not required for Emergency Medical Transportation (EMT) for all emergency covered services, as to not delay member access, in alignment with Alliance Policy 404-1309 – Member Access to Self-Referred Services.

For more information about emergency transportation, please see Policy 404-1724 – Hospital Transportation from Primary Care Physician Office.

Non-Emergency Medical Transportation: Medi-Cal

The Alliance covers Non-Emergency Medical Transportation (NEMT) as specified in the California Code of Regulations, Title 22, Section 51323. Such transportation is approved when the member has a medical condition that prevents them from traveling by another form of conveyance without jeopardizing the member's health.

Transfer of a member from a hospital or facility to another hospital or facility through NEMT that is determined to be medically necessary by the treating practitioner, authorization is not required by the Alliance. NEMT for a member discharge to home or to any medical appointments requires authorization from the Alliance. When possible, we require advance notice of five days for all NEMT requests. Specifically, the following types of transport will be allowed:

- The member is being moved either to a higher or lower level of care.
- The member requires transportation from their home to a medically necessary medical appointment for services covered by the Alliance.

The Alliance does not cover public transportation such as airplane, passenger car, taxicab or other forms of public conveyance under NEMT. Selection of an appropriate transportation service will take the following into account:

- Member's medical and physical condition.
- Urgency of the need for transportation.
- Availability of transportation at the time of need.

If a member disputes a determination that they do not meet the criteria for coverage of NEMT, the Transportation Coordinator will review the transportation request for Non-Medical Transportation (NMT) criteria or for other options.

Please contact the Transportation Coordinator at 800-700-3874, ext.5640.

For more information on NEMT, please see Policy 404-1726 – Non-Emergency Medical Transportation.

Non-emergency Medical Transportation: Alliance Care IHSS

Non-emergency transportation will be authorized for the transfer of Alliance Care IHSS members from a hospital to another hospital or facility, and from a hospital or facility to the member's residence, provided that the transport is medically necessary.

Please contact the Transportation Coordinator at 800-700-3874, ext.5640.

For more information on non-emergency transportation, please see Policy 404-1726 – Non-Emergency Medical Transportation.

Non-Medical Transportation (NMT): Medi-Cal Only

Non-Medical Transportation (NMT) services are available for Alliance Medi-Cal members. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members; this is currently available under the NEMT benefit.

Physicians may authorize NMT for members currently using a wheelchair only if the member is able to ambulate without assistance from the driver. If assistance is required, the transportation would be arranged through NEMT. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

Eligibility Requirements

- Members must be eligible at the time of service.
- Members must attest (in-person, electronically, or over the phone) that all other transportation resources have been reasonably exhausted.
- Prior authorization is required.
    - Transportation must be requested 5–7 business days in advance of the trip to ensure time to process the authorization and coordinate transportation.

- Transportation must be for an Alliance covered service or Medi-Cal service that is not covered under the Central California Alliance Health Managed Care Plan contract. This includes doctor's appointments, pharmacy, or to pick up medical equipment or supplies.
- The transportation provided must be the least costly method of transportation that meets the member's needs.

NMT transportation may be by public transportation, passenger car, taxicab, or any other form of public or private conveyance. The type of transportation authorized to members will depend on their circumstances and the lowest cost type of transportation available.

Mileage reimbursement will be based on IRS Standard mileage rate for Medical Purposes.

- The driver must be compliant with all California driving requirements.
- The driver cannot be the member.
- Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available.

NMT services help must be requested **at least 5–7 business days in advance** for initial services or routine visits. More time may be necessary for more complex requests. Members can request NMT by contacting Call the Car at **800-700-3874, ext. 5577 (TTY: Dial 711), Monday–Saturday, 8 a.m.–7:00 p.m.**

For more information on Non-Medical Transportation, please see Policy 200-2010 Non-Medical Transportation For more information on the Meals, Transportation, and Lodging benefit for CCS-eligible members, please see Policy 404-1732 Maintenance and Transportation for Members with CCS Eligibility.

Behavioral Health Benefits: Medi-Cal

Outpatient non-specialty mental health services are a benefit covered by the Alliance. PCPs can refer to the Alliance Behavioral Health Care Management team who will conduct the standardized statewide Adult or Youth Screening Tool to guide mental health referrals to the appropriate Medi-Cal delivery system and ensure that Members receive timely coordinated care. You can also submit a referral request using the Behavioral Health PCP Referral form on the Behavioral Health page of the Alliance provider website. Referring providers should encourage mental health providers to ask members to sign a statement authorizing both providers to share clinical status information to the extent permitted by law. Members may elect to authorize or refuse to authorize release of any information except as necessary to comply with federal, state and local laws.

The behavioral health services covered by the Alliance include:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Family therapy focused on improving relationships and behaviors in the family and between family members.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for the purposes of monitoring drug therapy.

- Outpatient laboratory, drugs, supplies and supplements (excluding anti-psychotic drugs which are covered by Medi-Cal FFS).
- Psychiatric consultation.

The same behavioral health benefits available to Medi-Cal members are available to CCS members. Family therapy is also covered for CCS eligible members. Coverage of behavioral health services under the CCS benefit is available when the member is CCS eligible, and the rendering provider is a CCS paneled behavioral health provider. Access to these benefits follows the same process as Medi-Cal. Members may contact **Alliance Member Services at 800-700-3874** and PCPs may contact Provider Services at 800-700-3874, ext. 5504 for more information.

Behavioral Health Treatment (BHT) is an evidence-based behavioral intervention to promote, to the maximum extent practicable, the functioning of a member. These services are deemed medically necessary as determined by a qualified medical practitioner, such as a licensed physician, surgeon, or psychologist and it is a covered benefit for eligible Medi-Cal members. Prior authorization for Applied Behavioral Analysis (ABA)/ Behavioral Health Therapy (BHT) is required. This benefit is available for members under the age of 21. The role of the PCP is important to identify and refer children who are in need of behavioral health treatment, as well as to provide medical follow-up for commonly co-occurring medical disorders. BHT services include applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions. Providers can use the Behavioral Health Referral Forms on the Behavioral Health page of the Alliance provider website. Prior authorization is not required for psychotherapy and for Comprehensive Diagnostic Evaluations. PCPs also provide Dyadic behavioral health (DBH) well-child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development. DBH well-child visits are provided for the child and caregiver(s) or parent(s) at medical visits. At these PCP visits a child and caregiver(s) or parent(s) are screened for behavioral health problems, interpersonal safety, tobacco and substance misuse, and social drivers of health (SDOH), such as food insecurity and housing instability, as well as provided referrals for appropriate follow-up care.

The Alliance will continue to cover outpatient laboratory, supplies, supplements, and behavioral health services provided by PCPs.

For more information on the Alliance Medi-Cal behavioral health benefits, see Policy 408-1305 – Behavioral Health Services and Policy 405-1312 – Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.

Behavioral Health Services – Outpatient (Non-Specialty)

Alliance Medi-Cal minors aged 12 or older can consent to non-specialty outpatient Medi-Cal mental health treatment without parental consent if deemed mature enough by the professional. Parental involvement is required unless the professional determines it's inappropriate after consulting the minor, with safeguards in

place to protect confidentiality. The professional must document their decision on parent/guardian involvement in the minor's record, including any contact attempts or reasons for not contacting them.

Behavioral Health Services: Alliance Care IHSS Program

Behavioral Health Services – Inpatient

Behavioral health care services in a participating hospital will be provided to Alliance Care IHSS members when ordered and performed by a participating behavioral health professional. Prior authorization is required.

To access behavioral health services, the member can call Alliance Member Services at 800-700-3874. There is no copayment associated with inpatient behavioral health services.

Diagnosis and inpatient treatment of a behavioral health condition includes services for all mental health and substance use conditions in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Behavioral Health Services – Outpatient

Behavioral health care services will also be provided to Alliance Care IHSS members on an outpatient basis. You can refer a member or members can self-refer for outpatient services.

Copayment

The copayment for behavioral health services for Alliance Care IHSS members is $10 per visit.

Telehealth Services: Behavioral Health

Telehealth services are available for non-specialty mental health services for Medi-Cal and behavioral health services for IHSS members. Behavioral health services offered through telehealth are specific services for members who prefer to receive services via telehealth or are unable to receive outpatient psychopharmacology and/or psychotherapy treatment locally due to a lack of available resources in their geographic area. It is ideal for rural settings and other locations where professional services would not otherwise be readily available, interim coverage when a psychiatrist, psychologist and/or mental health clinician is unavailable, or other situations that would prevent or delay service delivery. The goal is to improve access to and delivery of psychopharmacology and/or psychotherapy services to ensure that all members receive the best possible care regardless of geographic location.

Enteral Nutrition Product Benefit

Enteral Nutrition Products that are billed as a pharmacy claim are transitioned from the Alliance pharmacy benefit to Medi-Cal Rx for Medi-Cal members. Enteral nutrition formulas, including nutrition support (tube feed) formulas, oral nutrition supplements and specialty infant formulas, can only be billed on a pharmacy claim. Refer to the list of *Covered Enteral Nutrition Products* on the Medi-Cal Rx website. Prior authorization requests for Enteral Nutrition Products that are billed as a pharmacy claim must be submitted to Medi-Cal Rx. For more details about Medi-Cal Rx, refer to "Outpatient Pharmacy Services" above.

For other Enteral Nutrition Products that are billed as a medical claim, a prior authorization is required to be submitted to the Alliance. Prior authorization requests can be submitted by the prescribing or servicing provider, and may be submitted via the Provider Portal or fax to 831-430-5850. A copy of the prescription and recent chart notes detailing the member's diagnosis and medical necessity of the product being prescribed must be submitted. The criteria the Alliance uses to review authorization requests for medical necessity can be found in Policy 403-1136 – Enteral Nutrition Products.

Medical Nutrition Therapy

Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) is a covered benefit for all lines of business for members that meet qualifying conditions or deemed at nutritional risk. A Treatment Authorization Request (TAR) must be submitted for authorization.

Providers offering MNT to Alliance members should use the following codes for authorization and claims payment:

- CPT Code 97802 – MNT, initial assessment and intervention, individual, face-to-face with patient, each 15 minutes
- CPT Code 97803 – MNT, re-assessment and intervention, individual, face-to-face with patient, each 15 minutes
- CPT Code 97804 – MNT, group (2 or more individual (s), each 30 minutes
- CPT-4 Code G0270 – MNT, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
- CPT-4 Code G0271 – MNT, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
- HCPCS Code S9470 – Nutritional Counseling, dietitian visit, each 15 minutes
- CPT Code T1014 – Telehealth if applicable

Annual MNT coverage is limited to 3 hours for the first calendar year and 2 hours per calendar year in subsequent years. For additional hours beyond these limitations a new TAR with clinical documentation must be submitted for review.

Conditions include but are not limited to;

- Pediatric obesity with a BMI >95th percentile
- Cancer with significant weight loss
- Pre-Post bariatric surgery
- Conditions impairing digestion and absorption
- Underweight status or unintended weight loss

For more information on MNT, please see Policy 403-1149 – Medical Nutrition Therapy.

Carved Out Services: Medi-Cal

Certain medical or allied-health services are not included in the Alliance's benefits package and thus we are not responsible for authorizing or providing those services; rather, they are covered directly by the state Medi-Cal program. These are referred to as "Carved-Out Benefits." The following is a list of these benefits with contact information.

Dental Services

Please call Medi-Cal Dental program at 800-322-6384 for assistance in locating a Medi-Cal dentist or to obtain prior authorization for service.

Behavioral Health Services

Short-Doyle/Medi-Cal County Behavioral Health services (inpatient or outpatient)

Specialty Mental Health Services

Providers are required to assist Medi-Cal members needing Specialty Mental Health services by calling the County Behavioral Health Access phone numbers in the table below.

The Alliance does not manage Specialty Mental Health services for Medi-Cal members but will assist members with accessing county behavioral health services, using a Statewide Screening Tool. Providers should coordinate services with the Medi-Cal member's behavioral health provider, as appropriate.

County Contact	Phone
Mariposa County Behavioral Health Access	800-549-6741
Merced County Behavioral Health Access	888-334-0163 or 209-381-6800
Monterey County Behavioral Health Access	888-258-6029 or 831-755-5505
San Benito County Behavioral Health Access	888-636-4020
Santa Cruz County Behavioral Health Access	800-952-2335 or 831-454-4170

Pharmacy Services

Please consult Section 16, Pharmacy Services, of this Provider Manual for detailed information regarding carved-out Medi-Cal RX pharmacy services.

Substance Use Disorder (SUD) Services

Program Services

PCPs are required to provide assistance to Medi-Cal members needing Alcohol and Drug Treatment services by referring them to the appropriate county or community agency. Services include Voluntary Inpatient Detoxification and outpatient opioid detoxification. PCPs may call Alliance Provider Services at 800-700-3874 for assistance in appropriately referring members with substance use disorders. In addition, County Behavioral Health has Substance Use Disorder Services and the access team phone numbers are in the table above.

- PCPs are required to provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) to members ages 11 years and older, including pregnant women.
- In the event that treatment slots are not available in the county alcohol and SUD treatment program within the Alliance's service area, the PCP can make a referral to the Alliance's Behavioral Health Case Management team to assist in pursuing placement outside the area.
- Appropriate referrals for additional evaluation and treatment, including medications for addiction treatment, must be offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:
    - Providing feedback to the patient regarding screening and assessment results.
    - Discussing negative consequences that have occurred and the overall severity of the problem.
    - Supporting the patient in making behavioral changes; and
    - Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Physicians credentialed under a Primary Care Physician Services Agreement and with a DEA X license may provide Medication Assisted Treatment (MAT) for substance use disorders and to prevent opioid overdose.

Laboratory Services

Laboratory services are provided under the state serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of DHCS.

Other Carved Out Services

Targeted Case Management Services as specified in Title 22 CCR Section 51351.

Certain home and community-based wavered services (e.g., In Home Operations, HIV/AIDS Home and Community Based Services Waiver, Multipurpose Senior Services Program) are available through Medi-Cal waiver programs administered by DHCS or community-based organizations. For more information on waiver services please see Policy 405-1107 – HIV/AIDS Home and Community Based Services Waiver Programs and Policy 405-1111 – Community Based Adult Services and Policy 405-1108 – Medi-Cal Home and Community Based Services (HCBS) Waiver Programs.

Prenatal Lab Tests

Fetal aneuploidy screening with cell free DNA and alfa-fetoprotein are covered through the CDPH California Prenatal Screening Program.

California Children's Services – Medical Therapy Program

The Medical Therapy Program (MTP) is a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

The MTP is administered by the County CCS program. For more information on how to initiate a referral to the MTP, please refer to the CCS page on the Alliance website.

Subcontracted Benefits

Vision Services: Medi-Cal

The Alliance sub-contracts with Vision Services Plan (VSP) to provide vision services to Alliance members. An eye exam and glasses are covered every 2 years. Members must go to a VSP Medi-Cal participating provider. Participating providers can be found in the VSP Provider Directory.

For information on how to become an approved optometrist, please reference Policy 300-4160 – Optometrists Reimbursement for Medical Services.

Vision Services: Alliance Care IHSS

Not a covered benefit.

Dental Services: Alliance Care IHSS

Not a covered benefit.

Child Health and Disability Prevention Program

The Child Health and Disability Prevention (CHDP) Program is a preventive program to ensure periodic health assessments and services for low-income children and youth in California. CHDP is funded by both federal and state governments to ensure the provision of a pre-specified maximum number of *preventive-care* visits for children under 21 years who are enrolled in Medi-Cal.

Health assessments are provided by CHDP-enrolled private physicians, local health departments, community clinics, managed care plans and some local school districts.

The services covered by CHDP include, but are not limited to:

- Developmental assessment
- Health and development history
- Immunizations
- Laboratory tests and procedures (including tests for serum levels of lead)
- Periodic comprehensive health examinations
- Psychosocial screening
- Speech screening
- Vision screening

Early Start Program for Developmentally Disabled Infants and Toddlers: Medi-Cal

The Early Start Program is California's response to federal legislation ensuring that early intervention and medically necessary diagnostic and therapeutic services are provided to infants and children with developmental delays or disabilities — and that such services are provided in a coordinated, family-centered network.

Alliance members eligible for early intervention services are infants and toddlers from birth to 36 months for whom documented evaluation and assessment confirms that they meet any ***one*** of the following criteria:

- Child has a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
- Child has an established risk condition(s) of known etiology, with a high probability of resulting in delayed development; or
- Child is at high risk of having a substantial developmental disability due to a combination of risk factors.

California state legislation requires that you refer children between 0–36 months to the Early Start Program at the local Regional Center for evaluation if they exhibit a significant developmental delay, have multiple risk factors, or have an established risk factor; this referral must take place within 48 hours of your assessment.

PCPs should collaborate in the development of a child's IFSP (the Regional Center's Individualized Family Service Plan) and monitor and coordinate all medical services with Regional Center staff, when applicable.

Section 8
Referrals and Authorizations

Authorized Referrals

Authorized Referrals: Referral of an Alliance member to a non-contracted Out of Service Area provider requires review and authorization by the Alliance prior to the services being rendered. Referral of an Alliance Care In-Home Supportive Services (IHSS) (Other Lines of Business) member to any non-contracted provider requires authorization by the Alliance. The Alliance reviews such referrals to ensure that medical criteria are met and that the member is referred to an appropriate provider, prior to providing Authorization for the referral. *The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.* For more information on referrals to out of service area, non-contracted providers, please see Policy 404-1310 – Authorization Process for Referrals to Out of Network, Non-Contracted Specialty Providers.

Alliance Service Area: The Alliance's Medi-Cal Service Area consists of Santa Cruz, Monterey, Merced, San Benito and Mariposa counties. The Alliance's Service Area for In-Home Supportive Services (IHSS) is Monterey County.

In Service Area Provider: Any provider based in the Alliance's Service Area, regardless of contract status.

Local Out of Service Area Provider: A specialist physician, hospital or allied provider based in an area adjacent to the Service Area, with whom the Alliance has contracted based on an existing referral pattern and claims payments, and the need for access to the provider's specialty type.

Out of Service Area Provider: A provider not based in the Alliance's Service area, regardless of contract status and not designated by the Alliance as a Local Out of Service Area Provider.

Members must obtain a referral from their PCP before scheduling an appointment with any non-contracted provider, except for a specialist-to-specialist referral for a CCS eligible condition or for the self-referred services described below under "Self-Referral."

PCPs should use an Authorized Referral form for any service provided by out of network provider. *The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.*

For authorization purposes, a requested service or medical equipment is approved if it is determined to be medically necessary. For more information on Medical Necessity see Policy 404-1112 – Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests.

Referral Requests for members under 21 years of age will be reviewed for potential CCS medical eligibility. For more information, please see Policy 404-1305 – Screening and Referral of Medically Eligible Children to California Children's Services (CCS) Program.

Referral Consultation Requests (RCR)

Consultation Requests: Referral of an Alliance member by Primary Care Provider (PCP) or In-Network Specialist to a health care provider within the Alliance Service Area or Local Out of Service Area. *The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.*

Prior authorization is required for any service provided by a non-contracted and/or non-credentialed provider. For more information on the Authorization Request process refer to Policy 404-1201 Authorization Request Process.

Direct referrals from specialist to out of network occupational and physical therapy providers require submission of a Treatment Authorization Request (TAR) to be reviewed by the Alliance.

For WCM CCS-eligible members, *the Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.*

Referral Consultation Requests (RCR) and Authorized Referrals are not required for administrative members. For more information on Administrative status, please see Policy 200-5000 – Administrative Member Status – Medi-Cal Members and Policy 404-1201 Authorization Request Process.

PCPs are required to maintain a referral tracking system for members sent to specialists for care and must follow up within a reasonable time frame to ensure that the member kept the appointment and obtain the specialist's report and recommendations.

Referrals are not required from PCPs in the following situations:

- Emergency care
- Sensitive Services
- Office visits related to Gender Dysphoria and/or Gender Affirming Care (GAC).
- Post Emergency Department (ED) follow up care for the treatment types referenced below.

When member is seen in the Emergency Department (ED), a referral is not needed for follow-up care with a specialist for treatment types listed below:

- Orthopedic surgeons: for documented or suspected fracture, sprains, and strains
- General surgeons: For chronic cholecystitis
- Ophthalmologists: For emergency retinal detachment; corneal abrasions; burns and retained foreign bodies; acute ocular infections; and glaucoma emergencies
- Pain management: For acute or acute onset chronic lumbar and/or cervical radiculopathy

Self-Referral: No Authorization or Referral Required for Medi-Cal

Alliance Medi-Cal members may access certain services without a referral from a PCP, as long as the provider they choose is a member of the Alliance network, as follows:

- Urgent Visit primary care services at Urgent Visit access sites.

- The limited allied health benefit allows members to self-refer for acupuncture, chiropractic, podiatry (note that some podiatric visits require authorization), speech and occupational therapy services. A maximum of two visits are allowed per month. Any additional visits or course of treatment will require authorization with approval from the Alliance and the number of treatments allowed is based on the member's medical condition and current Alliance and Medi-Cal guidelines and benefits. For WCM CCS-eligible members, an authorized referral is required for initial evaluation/consultation for Podiatry, Speech, and Occupational Therapy.
- Mental health services (except for psychological testing and BHT). For WCM CCS-eligible members, an authorized referral is required to ensure that the member is referred to a CCS paneled provider.
- Alliance Medi-Cal members also may self-refer to any willing Medi-Cal provider for family planning and sensitive services. Female Alliance members may self-refer to any willing Medi-Cal OB/GYN within the Alliance's service area for routine well woman care.
- Alliance Medi-Cal members may self-refer to any willing medical OB/GYN for pregnancy services, or self-refer, to a qualified certified nurse practitioner or certified nurse mid-wife, including use of alternative birth center facilities.
- Office visits related to gender dysphoria and/or gender affirming care.

No prior authorization is required for emergency/urgent services and emergency hospital admissions. For emergency inpatient admissions or emergency services, the hospital should contact the Alliance for verification of the member's eligibility. All inpatient hospital stays require authorization after admission. Authorization can be obtained by faxing a Hospital Admission Face Sheet and clinical documentation to the Utilization Management Department to 831-430-5850. Contracting facilities are obligated to notify the Alliance within one day of admission to obtain authorizations and confirm the length of stay and level of care needed by the patient.

For after-hours authorization of post-stabilization requests for non-contracted facilities, the provider should contact The Alliance Medical Director on-call at 831-423-5560. For more information, please see Alliance Policy 404-1202 – After-Hours Availability of Plan or Contract Physician.

Administrative members, i.e., those not linked to a PCP, may self-refer to a Medi-Cal provider within the Alliance's service area for covered benefits. In addition, authorization from the Alliance is not required for members with other health coverage including Medicare since the Alliance is not the primary payer.

No prior authorization is required for family planning and sensitive services. Family planning services include birth control and pregnancy testing and counseling. Sensitive services include pregnancy testing and counseling, birth control, AIDS/HIV testing, sexually transmitted infection (STI) testing and treatment and termination of pregnancy. These services are listed alphabetically below:

- Abortion/termination of pregnancy (legal, unspecified, failed).
- Contraception and contraceptive management, including provision of contraceptive pills/devices/supplies and tubal ligation and vasectomy.
- Diagnosis and treatment of STIs if medically indicated.

- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Health education and counseling are necessary to make informed choices and understand contraceptive methods.
- High-risk sexual behavior.
- Laboratory tests, if medically indicated as part of the decision-making process for choice of contraceptive methods.
- Limited history and physical examination.
- Observation following alleged rape or seduction.
- Pthirus pubis (pubic lice) and Pubic Scabies.
- Pregnancy exam or test, pregnancy unconfirmed.
- Rape examination.
- Screening, testing and counseling of at-risk individuals for HIV and other STIs and referral for treatment.

For more information about which services Medi-Cal members may access without a referral from a PCP, please see the following policies:

404-1309 – Member Access to Self-Referred Services

404-1702 – Provision of Family Planning Services to Members

404-1707 – Acupuncture Services for Alliance Members

404-1710 – Pediatric Therapies for Medi-Cal Recipients

300-4080 – Open Access to Care

Referral Guidelines

The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers. The PCP and/or other referring physician is responsible for verifying the list of contracted providers for all referrals to ensure that the referral is being made to an appropriate Alliance network provider. CCS-eligible members must be referred to CCS-paneled specialists, when applicable. Referrals to non-contracted and/or out-of-network providers will be authorized under compelling medical circumstances and/or when medically necessary services are not readily available within the Alliance network. Specialists need the medical information on the referral to be as specific as possible. Care should be taken by the PCP in completing authorized referral requests to non-contracted providers since what is authorized will determine the scope and duration of services and claims paid for these services.

The referral specialist is responsible for informing the PCP of the patient's status and proposed interventions throughout the course of treatment. The PCP is responsible for maintaining the referral tracking system.

You may submit referrals:

- Online by logging into your Alliance Provider Portal account.
- By fax to 831-430-5850.
- By mail to: Central California Alliance for Health
  P.O. Box 660015
  Scotts Valley, CA 95067-0015

View Policy 404-1201 – Authorization Request Process for instruction on how to complete the Authorization Request process. Some common examples of situations in which an authorization request is required include:

- Laboratory and diagnostic testing (non-routine, out-of-network)
- Specialty consultation/treatment for out-of-network providers

Serious and Complex Medical Conditions

Providers should develop a written treatment plan for members with serious and complex medical conditions. The plan must provide for a standing referral or extended referral to an out of network specialist, as appropriate. Regardless of the length of the standing referral, all specialist providers are required to send the PCP regular reports on the care and status of the patient.

The written treatment plan should indicate whether the patient will require:

- Continuing care from a specialist or specialty care center over a prolonged period of time.
- Standing referral visits to the out of network specialists.
- Extended access to a specialist because of a life threatening, degenerative or disabling condition involving coordination of care by a specialty care practitioner (for extended out of network specialty referrals, the requesting provider should indicate the specific health care services to be managed by the out of network specialist vs. the requesting physician).

For additional information on extended referral authorization, please see Policy 404-1306 – Extended and Standing Referral Authorizations.

Patients with HIV or AIDS are designated as administrative members and are deemed as having "a condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative, or disabling" — thus assuring that the member has a standing referral to a specialty HIV/AIDS provider.

Audiology, Podiatry, Occupational and Speech Therapy

The Alliance provides coverage for Audiology, Podiatry and Speech Therapy services, with referral requirements for out of network providers as noted below.

Audiology: *The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.*

Podiatry Services and Occupational and Speech Therapy: Alliance Medi-Cal members may have an initial visit (1 visit) with a podiatrist or speech or occupational health therapist without needing a referral from their PCP.

The purpose of this visit would be to evaluate whether there is a need for treatment. Any additional visits or further treatment would require authorization from the Alliance. If the provider wishes to submit an authorization request for treatment, the provider would submit the results of the initial evaluation/consultation along with the authorization request.

Out-of-Service-Area Referrals

When a member needs specialty care, the member's PCP should refer the member to a contracted provider within the Alliance's service area.

If there is no contracted provider available within the service area, the PCP may refer the member to a non-contracted provider within the service area. The process for making these referrals is for the PCP to complete an Authorization Request Form, sending one copy to the referral provider and one copy to the Alliance for out-of-network and/or non-contracted providers.

The Alliance must review and approve referrals to out-of-network providers before the service can be provided. This is called an Authorized Referral. The process for these referrals is for the PCP to complete and submit an Authorization Request form to the Alliance.

Members with a CCS-eligible condition must always be referred to a CCS paneled provider for their CCS-eligible condition. These requests must be authorized by the Alliance.

In the event of an urgent/emergent medical situation outside of the Alliance network, the facility providing the service is required to contact the Alliance within one business day to confirm eligibility and service authorization.

All services requested will be reviewed for clinical appropriateness by an Alliance nurse, with final decisions made by the Chief Medical Officer or Medical Director.

For more information on out-of-network referrals, please see Policy 404-1310 – Authorization Process for Referrals to Out of Network, Non-Contracted Specialty Providers.

Open Access to Care

It is the policy of the Alliance to allow and encourage Medi-Cal members to seek care from Network Providers. Referrals to specialty care for Medi-Cal members are approved without prior authorization for in service area, and Local Out of Service Area (LOOSA) Contracted and Credentialed Providers.

Prior authorization may be required for any service provided by a non-contracted or non-credentialed in-area provider.

A Medi-Cal member may seek care without referral for sensitive services from any provider who is enrolled in the Medi-Cal Program, regardless of their contracted status with the Alliance. Members may receive emergency services from any provider regardless of their contract status with the Alliance or Medi-Cal enrollment status. For more information, please see Policy 300-4080 – Open Access to Care.

Prior Authorizations

Authorization requests are reviewed by a Prior Authorization nurse or Pharmacist according to predetermined criteria, protocols and the medical information from the physician or other provider. In some cases, the nurse

may need to contact the provider directly to request additional information or one of the Alliance Medical Directors or Pharmacists may need to speak directly with the provider to discuss the request.

The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.

Authorizations for members under 21 years of age will be reviewed for potential CCS medical eligibility. For more information, please see Policy 404-1305 – Screening and Referral of Medically Eligible Children to California Children's Services (CCS) Program.

Only licensed medical professionals employed by the Alliance make decisions about authorizations. Only the Alliance Chief Medical Officer, Medical Directors or Pharmacists have the authority to modify or deny authorization requests. Authorization decisions are based upon evidence-based Alliance policies as well as nationally recognized standards including:

- Title 22 criteria
- Medi-Cal Medical Necessity Guidelines (when available)
- California Children's Services (CCS) Medical Necessity Guidelines (when available)

  Alliance Health Services & Pharmacy Guidelines and Policies & Procedures approved by the Continuous Quality Improvement Committee and the Pharmacy and Therapeutics Committee.
- Evidence-based guidelines, such as:
  - MCG (formerly Milliman Care Guidelines)
  - Medicare (CMS) Guidelines
  - Consensus statements and nationally recognized standards of practice.
- Guidelines developed by other health plans.
- Expert opinion:
  - Clinical advisors serving on Alliance Committees
  - Outside Independent Medical Review

For more information on Medical Necessity, see Policy 404-1112 – Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests.

For more information about timely submission of ARs, see Policy 404-1201 – Authorization Request Process.

Medical Services Requiring Prior Authorization

Common medical services or procedures that generally require prior authorization include:

1. Genetic Testing, please see Policy 404-1715 – Genetic Testing.
2. Home Health services.
3. MRIs and unlisted CT scans.
4. Physical, occupational and speech therapy.

5. Podiatric treatment. Prior authorization for podiatric services rendered by podiatrists is not required if a physician or surgeon rendering the same services would not be required to request prior authorization
6. Outpatient surgery.
7. Non-emergency hospitalizations, except for an obstetrical delivery.
8. Some medical supplies and Durable Medical Equipment (DME).
9. Requests for referral to an out-of-service-area provider/facility or a non-contracted provider/facility.
10. Non-Emergency Medical Transportation
11. Sleep studies, please see Policy 404-1711 – Sleep Study (Polysomnography/Sleep Disorder Testing) Authorizations.
12. Sclerotherapy procedure, please see Policy 404-1203 – Surgical Treatment of Varicose Veins.
13. Electromyography, Nerve Conduction Studies, please see Policy 404-1713 – Electromyography, Nerve Conduction Studies.
14. Physician-Administered Drugs and drugs not included in our Formulary (or if the quantity requested is more than a 90-day supply for maintenance drugs and a 30-day supply for all other agents).
15. Total Joint Replacement Surgery

Acupuncture Services – Medi-Cal

Acupuncture services are included in the Limited Allied Health Services benefit which allows the provision of two services per calendar month without primary care physician (PCP) referral (for out-of-network providers) or prior authorization. Members are eligible for up to two (2) visits per month under the Limited Allied Health Services and up to five (5) acupuncture visits per month. Prior authorization is required for more than five acupuncture treatments per month and is limited to 20 visits per authorization for treatment of pain. Note that members can self-refer for up to two visits per month. For more information, please see Policy 404-1707 – Acupuncture Services for Alliance Members.

Acupuncture and Chiropractic Services – IHSS

Prior authorization is required for acupuncture and chiropractic care, which are limited to 20 visits per benefit year.

Laparoscopic Cholecystectomy and Laparoscopic Cholecystectomy with Cholangiogram

Elective, emergent, or urgent laparoscopic cholecystectomy, or laparoscopic cholecystectomy with cholangiogram, do not require prior authorization. If inpatient admission is required, the admitting facility must notify the Alliance of admission within one business day. Please see Policy 404-1204 – Laparoscopy – Cholecystectomy Authorization Process for more information.

Medical Supplies and DME

Some medical supplies and DME require prior authorization. For more information about requests for Medical Supplies and DME, see Policy 404-1603 – Medical Supplies Authorizations or Policy 404-1601 – Durable Medical Equipment (DME) Authorization.

Physical Therapy

Authorization requests will be considered according to the criteria and procedures described in Policy 404-1706 – Physical Therapy Guidelines. For coding information see Section 10: Claims for designated codes that allow flexibility in providing a variety of physical therapy modalities.

Behavioral Health Services Requiring Prior Authorization

Behavioral health services that require prior authorization include:

- Behavioral Health Treatment (BHT)

These services require input from the PCP and information in the Diagnostic Evaluation Form (Medi-Cal).

Submitting Prior Authorization Requests

Prescribing physicians may request authorization by completing an Authorization Request Form and submitting it via:

- The Alliance Provider Portal
- Fax to 831-430-5850
- U.S. Mail to: Central California Alliance for Health, P.O. Box 660015, Scotts Valley, CA 95067-0012

The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers

For questions regarding Authorization Requests, please call 831-430-5506.

When a member requests a specific service, treatment, or referral to a specialist out of network, it is the PCP's responsibility to assess the medical need before providing or referring for treatment. If the service requested is not medically indicated, discuss an alternative treatment plan with the member or their representative.

Adherence to the following checklist for effective submission of an Authorization Request will ensure the timeliest decision:

1. Please complete the form — an illegible handwritten form may be returned to the provider.
2. Be sure to include your name, address and contact number — and fax number.
3. Be sure to include member's name, address, age, sex, date of birth, and identifying information such as the member's Alliance ID Number.
4. The Medi-Cal identification number must be correct. Refer to the Medi-Cal card if necessary.
5. Enter into the appropriate box the description of the diagnosis and ICD-10 or CPT code with appropriate modifiers that most closely describe the member's condition.
6. Use the correct ten-digit provider identification (NPI) number. If the patient is hospitalized, the hospital NPI must be used.
7. Attach documentation that supports the medical necessity of the request to the form (in addition to providing documentation required in the Medical Justification box).
8. Be sure to sign and date the form (must be signed by the referring provider).
9. Submit a separate AR for each service request per member; the AR will be given a unique number that is used to facilitate reimbursement.

Routine Pre-Service Requests

The prescribing provider must submit a prior Authorization Request before services are provided. For routine pre-service requests for procedures/services that can be pre-scheduled without danger of adverse outcome to the member, the Alliance strives to make a determination *within 5 business days, but no longer than 14 days* from receipt of the request and appropriate documentation of medical necessity.

In certain circumstances, a decision may be deferred for *an additional 14 days* when the member or provider requests an extension, or if the original Authorization Request did not contain sufficient information.

All decisions for Authorization Requests are communicated to the provider by fax *within one business day* of the decision; providers inform the member about the decision. Decisions to modify or deny Authorization Requests are communicated to the member in writing *within two business days* of the decision; a copy will be sent to the provider when an Authorization Request is concurrent with services being provided, the Alliance will ensure that medically necessary care is not interrupted or discontinued until the members treating physician has been notified of the decision and a care plan has been agreed upon by the treating provider/PCP that is appropriate for the medical needs of the patient.

Expedited/Urgent Requests

In medically urgent situations, you may request an expedited Authorization Request review by calling our Health Services Department at 800-700-3874, ext.5506 or faxing a request to 831-430-5850. Expedited Authorization Requests will be reviewed within 72-hours or as soon as possible after receipt of the request when the provider indicates that following a standard timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function.

Post-Service Authorization Requests

If it was not possible for the provider to obtain authorization before providing a medically necessary service, we will respond to a post-service Authorization Request if it is received within 30 calendar days of initiation of the service. The Alliance will inform the provider of the decision to approve, modify or deny the Authorization Request within 30 days.

While elective surgery requires prior authorization, under exceptional medical circumstances we may provide authorization after the fact.

If an Authorization Request is submitted for a member who has obtained retroactive eligibility, it must be received by the Alliance within 60 calendar days from the date on which the member obtained eligibility.

For more information about the authorization review process, please see Policy 404-1201 – Authorization Request Process.

Hospital Inpatient Services

Admissions to an acute-care facility or Ambulatory Surgery Center for scheduled surgery require prior authorization. All requests must be accompanied by the appropriate medical documentation including, but not limited to:

- Laboratory test results
- X-rays
- Medical records
- Other reports that have relevance to the planned admission (e.g., pre-operative history and physical)

Emergency and urgent admissions do not require prior authorization. However, the Alliance must be notified by the facility of emergency admissions within one business day.

Discharge planning is initiated upon admission to facilitate the transition of beneficiaries to the next phase of care. The discharge planning team is multi-disciplinary and consists of the treating physician and hospital discharge planners. Physician responsibility includes participation in coordinating member discharge planning and referrals to appropriate post-discharge settings. Alliance staff will work with the hospital's discharge planning staff, as needed, in determining the most appropriate post-discharge setting.

For more information about hospital services please see Section 6: Alliance Covered Benefits and Services.

Obtaining a Second Opinion

Members, members' parents, members' custodial parents, members' legal guardians, and other authorized representatives for the member may request a second opinion about a recommended procedure or service. The Alliance honors all requests for second opinions without the need for a prior authorization as long as the second provider is contracted with the Alliance and within the Alliance's service area. *The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.*

Referrals for CCS-eligible members require a prior authorization for out-of-network providers, including referrals for second opinions in Merced, Monterey, and Santa Cruz, Counties. Referrals for out-of-network providers in Mariposa and San Benito Counties should be routed to Co. CCS program or to DHCS.

Second opinions may be rendered only by an appropriately qualified health care professional to review and treat the medical condition in question. Referrals to non-contracting medical providers or facilities may be approved only when the requested services are not available within the Alliance network.

If the provider giving the second opinion recommends a treatment, diagnostic test, or service that is medically necessary and covered by the Alliance, the PCP must provide or arrange for the service.

For more information on obtaining a second opinion, please see Policy 404-1307 – Medical Second Opinions.

Status of Authorization Requests

Our Health Services Authorization Coordinators will review Authorization Requests for completeness and will help you with any aspect of the process, including answering questions regarding the status of the authorization. Please call 800-700-3874, ext. 5511.

Deferrals and Denials

As discussed earlier in this section, decisions about requests for authorization may be deferred or denied. The most common reasons for such decisions are outlined in the chart below.

When a request is denied, a Notice of Action letter will be mailed to the member no later than the second business day after the decision, with a copy sent to the provider. If the denial is a result of insufficient information from the provider, we will inform the member that the case will be reopened when complete information is received. The denial letter will explain the reason for denial of the request and will provide information about the member's right to appeal the decision.

If you need clarification of the reason your AR was denied, please call the Alliance's Authorization Coordinator at 800-700-3874, ext.5506.

Notes on the Status of Authorization Requests

Status	Comments
Approved as Requested	You may provide service as requested. Please remember to include the Authorization number on your claim.
Approved as Modified	Most Common Reasons for Approved as Modified: • Fewer visits are authorized than were requested on the Authorization Request. • Number of inpatient days requested on the Authorization Request is not within the guidelines on length of stay for the requested procedure. • Dates of service requested on the Authorization Request do not match the dates that the member is Alliance eligible.
Extended / Deferred	Most Common Reasons for Extended / Deferred Authorization Request: • Authorization Request incompletely filled out; often lacks Procedure (CPT) and/or diagnosis codes (ICD-10), and/or narrative information on the procedure and/or codes that are being requested. • Insufficient medical information supplied on or with the Authorization Request to enable appropriate medical decision. • Necessary equipment pricing catalog pages not submitted.
Denied	Common Reasons for a Denial: • Request is for dental care services, which are Medi-Cal services authorized and reimbursed by an agency *other than the Alliance*. • Request is for specialty mental health services, which are services, authorized and reimbursed by county Mental Health Plans. • Documentation insufficient to support the medical necessity for the requested procedure/equipment. • Request was not submitted in a timely fashion. • A denial letter will be sent to the member, explaining the denial and information about rights to appeal the decision. • If you need clarification of the reason your Authorization Request was denied, please call the Alliance's Authorization Coordinator at 800-700-3874, ext.5506.

For more details, see Policy 404-1109 – Disclosure of Utilization Management Process to Providers, Members, and the Public.

Alliance Utilization Management policies can be viewed on the Alliance website and copies can be requested by contacting the Alliance Authorization Coordinator at 800-700-3874, ext. 5506.

Self-Referrals (No Authorization or Referral Required): Alliance Care IHSS

Alliance Care IHSS members may access certain basic services without a referral from a PCP, as long as the provider they choose is a member of the Alliance network. *The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers:*

- Alliance Care IHSS members may self-refer to any contracted provider within the Alliance's service area for family planning services, annual well woman services and pregnancy services.

For more information about self-referral, please see the following policies:

404-1309 – Member Access to Self-Referred Services

404-1702 – Provision of Family Planning Services to Members

Newborn examinations and nursery care are covered while the mother is hospitalized; newborns may also be eligible for care during the first 30 days if they do not qualify for Medi-Cal.

No prior authorization is required for emergency/urgent services and emergency hospital admissions. For emergency inpatient admissions or emergency services, the hospital should contact the Alliance for verification of the member's eligibility. All inpatient hospital stays require an authorization after admission. Authorization can be obtained by sending a Hospital Admission Face Sheet and clinical documentation to the UM Department at Fax number 831-430-5850. Contracting facilities are obligated to notify the Alliance within one day of admission to obtain authorizations and to confirm the length of stay and level of care needed by the patient.

For after-hours authorization of post-stabilization requests by non-contracted facilities, the provider should contact The Alliance at 831-423-5560. For more information, please see Alliance Policy 404-1202 – After-Hours Availability of Plan or Contract Physician.

For more information on hospital services, please see Section 6: Alliance Covered Benefits and Services.

The Alliance will provide an external, independent review process to examine decisions regarding (a) denial, delay or modification of service based upon medical necessity and (b) experimental or investigational therapies. For additional information about external independent medical reviews, see Policy 404-1113 – External Independent Medical Review. For more details refer to Policy 404-1109 – Disclosure of Utilization Management Process to Providers, Members, and the Public.

Summary of Referral and Authorization Requirements for Medi-Cal

Referral Guidelines		
Service	**Linked members who are assigned to a Primary Care Physician.**	**Un-linked or administrative members who do not have a PCP assignment.**
Referral / specialty consultation (non-CCS) **– in-area**	*The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.*	Member may self-refer. Provider must accept Medi-Cal and bill the Alliance.
Referral / specialty consultation (CCS) Merced, Monterey, and Santa Cruz Co. **– in-area**	**Prior authorization approval may be required for noncontracted, non-credentialed providers.** PCP or specialist complete "Authorization Request" form and submit to Alliance for review.	PCP or specialist complete "Authorization Request" form and submit to Alliance for review.
Referral / specialty consultation **– out-of-area providers**	**Prior authorization approval is required.** PCP or specialist complete "Authorization Request" form and submits to Alliance for review. This is applicable to non-contracted, non-credentialed providers.	Member may self-refer. Provider must accept Medi-Cal and bill the Alliance.
Referral / Enhanced Care Management (ECM) Outreach and ECM Services	**Prior authorization approval is required for services.** PCP, ECM Provider, Member or any Member Related Support person may refer. Provider must be a contracted ECM provider and accept Medi-Cal and bill the Alliance. ECM Outreach can be approved once every 6 mos.	**Prior authorization approval is required for services.** Member, Providers, or member related may refer. Provider must be a contracted ECM provider and accept Medi-Cal and bill the Alliance. ECM Outreach can be approved once every 6 mos.
Physical therapy	The initial Physical Therapy evaluation and treatment of up to 12 PT encounters does not require referral for in-network providers for claims payment. Authorizations are required for out-of-network providers. Additional treatment requires a prior authorization request with approval from the Alliance. Refer to Policy 404-1706 – Physical Therapy Guidelines for frequency limits or additional information.	

Podiatry, Speech, Occupational Therapy	Members may self-refer for an initial evaluation. Treatment requires a prior authorization request with approval from the Alliance. The number of treatments is based upon current Alliance and Medi-Cal guidelines and benefits.
Chiropractic	Medi-Cal Members can self-refer up to a maximum of 2 treatments per month combined with limited allied health services. Additional treatments require a prior authorization request with approval from the Alliance.
Acupuncture	Acupuncture services are included in the Limited Allied Health Services benefit which allows the provision of two services per calendar month without primary care physician (PCP) referral (for out-of-network providers) or prior authorization. Members are eligible for up to two (2) visits per month under the Limited Allied Health Services and up to five (5) acupuncture visits per month. Prior authorization is required for more than five acupuncture treatments per month and is limited to 20 visits per authorization for treatment of pain. Note that members can self-refer for up to two visits per month.
Family planning and sensitive services	Member can self-refer to any provider that is a Medi-Cal provider.
OB care	Member can self-refer to any in-area Medi-Cal obstetrical provider.
Authorization required for:	
DME, medical supplies, prosthetics and orthotics	Purchase: individual item over $250.00; Rental: over $100/month Repair or Maintenance: over $500 Incontinence supplies: over $165 Authorization is required for all DME products exceeding the above thresholds (cumulative costs of related items within a group.)
Hospital care	Any elective admission including surgical procedures All transplants
Imaging procedures	MRI PET scans Unlisted ultrasound, nuclear medicine and CT
Diagnostic procedure	Cardiac catheterizations BRCA and oncotype testing Small bowel video endoscopy PCTA

Surgical or therapeutic procedures	Outpatient procedures done in a free-standing surgery center or outpatient hospital Implants surgically placed in an Outpatient/Ambulatory Surgical Center which exceed in aggregate $2500.00 Office based procedures that could be cosmetic in nature Nutritional supplements and TPN Immune globulin greater than one injection Auditory therapy
Home Health	Requires authorization. The Alliance will guarantee payment for the initial home health evaluation for members discharged from the hospital.
Enhanced Care Management (ECM) Services	Requires authorization. The Alliance will guarantee payment for the initial outreach while the ECM Provider completes the needs assessment, associated assessments, and member consent. The following months require authorization, usually approved in 6-month intervals.
Community Supports (CS)	Housing Deposit (once per lifetime, unless additional documentation is obtained to demonstrate the member would be more successful on the second attempt) Housing Tenancy and Sustaining Services (one authorization per household) Housing Transition Navigation Service (one authorization per household) Medically Tailored Meals Recuperative Care (post auth) Short Term Post Hospitalization Housing (post auth) Sobering Center (no auth required) Environmental Accessibility Accommodations/Home Modifications ($7,500 per lifetime, unless the member's place of residence changes or if the member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization). **Respite Care Services –** Limited to up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible. **Personal Care and Homemaker Services –** Member must be referred to the In-Home Supportive Services program when they meet referral criteria prior to receiving this CS.
Other	Hearing aids Non-emergency medical transportation – any medical transportation request requires prior authorization

Section 9
Coordination of Benefits

General Rules to Follow

Some Alliance members have Other Health Coverage (OHC) in addition to their Alliance coverage. Specific rules govern how benefits must be coordinated in these cases. The Alliance is not liable for the cost of services for members with OHC who do not obtain the services in accordance with the rules of their primary insurance. If a member elects to seek services outside of the framework of their primary insurance, the member is responsible for the cost.

An OHC denial letter for a service rendered by an out of network provider with the primary insurance will be accepted when the claim documents "Advisal given, recipient refused to utilize OHC" on the claim form.

This means that the Alliance will become primary in this situation.

Other health coverage entities include but are not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health Maintenance Organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champ VA.
- Medicare, including Medicare Part D plans, Medicare supplemental plans and Medicare Advantage (Preferred Provider Organization [PPO] HMO, and fee-for-service) plans.

Other health insurance information should be verified on the Alliance Provider Portal prior to submission of claims. To coordinate benefits for a member who has active OHC coverage, providers must bill the primary insurance first. If there is any balance remaining after payment is received from the primary insurer, you should submit a claim to the Alliance along with an EOB from the primary payer. Claims for members with one or more than one policy will be denied without the EOB from the primary carrier or proof that the member does not have OHC. For more information on coordination of benefits, see Policy 702-1750 – Coordination of Benefits Guidelines for Providers.

Medi-Cal

Federal and state laws require that all available health coverage be exhausted *before billing Medi-Cal.* Thus, when a Medi-Cal member has other health coverage, the Alliance becomes the *secondary payer*, with Medi-Cal always as the payer of last resort.

It is the responsibility of the provider to verify their patient's eligibility; this can be done on the Alliance provider website through the Provider Portal. If the member shows OHC or Medicare eligibility, the services rendered must be billed to the primary insurance first within the rules of the primary insurance. The claim is then sent to the Alliance with the primary insurer's explanation of benefits.

When an Alliance member's primary insurance has copayments and/or deductibles, the member cannot be asked to pay, as long as they are obtaining benefits within the rules of the primary insurance. The exception to this is the copayments a dual eligible member would have for their Medicare Part D drug plan. If the primary insurance covers the service, procedures that normally require prior authorization will not require it (with the exception of pharmacy services).

The Alliance bases billing limitations on the Medicare Explanation of Member Benefits (EOMB) or OHC Explanation of Benefits (EOB) date rather than the received date. Exceptions to the billing limit can be made if it is one of the reasons allowed by Medi-Cal for late billing. Please refer to the Delay Reason Code section of the Medi-Cal Provider Manuals for the exceptions to the billing limits allowed by Medi-Cal.

Medicare has the ability to reduce claims payment, often times in the form of a penalty. For Medicare/Medi-Cal crossover claims, the Alliance may coordinate payment based upon the amount the provider is eligible to receive from Medicare after these reductions are imposed, as is further discussed in Policy 600-1041 – Medicare and Coordination of Benefits Reimbursement.

Billing for Medi-Cal Members with Other Health Coverage

Claims that involve potential payment from another health insurance carrier are processed using a coordination of benefits methodology. Providers may bill Medi-Cal for the balance, including coinsurance and deductibles. California law limits Medi-Cal's reimbursement to an amount that, when combined with the primary's payment, should not exceed Medi-Cal's maximum allowed for similar services.

Hardcopy Crossover Claim Submission

To send a copy or an original claim, please confirm that your National Provider Identifier (NPI) number is on the claim. You may bill us in the same manner as you billed the primary insurer, using the same procedure codes and modifiers. It is essential that a code be given to indicate the place of service. Attach a full-page copy of the Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB), not a partial page, with the primary insurer's reason code descriptions to each page of the claim. Please draw a line through all other patient names and identifying numbers on all pages.

Electronic Medicare Crossover Claims

The Alliance currently receives Medicare/Medi-Cal automatic crossover claims from CMS electronically only for professional services. The Alliance may not receive the crossover claim electronically if all service lines were denied by Medicare, or if the service was billed on the UB claim form. In these instances, providers would be required to submit the hard copy claim to the Alliance. For all other situations, please do not submit hard copy Medicare claims if your Medicare claims have been submitted electronically to the Alliance, as it may prolong the processing time. If you believe that your secondary claim was processed incorrectly, please contact our Claims Department at 800-700-3874, ext.5503. Providers submitting crossover claims must still comply with Medi-Cal's timeliness guidelines as well as follow up timely on any claim issues or denials. For crossover claims,

timeliness is based on the Medicare RA date; for example, to receive 100% of reimbursement the crossover claim would need to be received within 6 months of the Medicare RA Date.

Coordination of Benefits for Medicare Non-Eligible Recipients

Medicare eligibility is received from the California Department of Health Care Services and cannot be changed by The Alliance. If providers receive an Identification of Overpayment notice stating their patient has Medicare, but the provider shows 'Member Not Eligible', the claim should still be billed to Medicare. The Alliance will only process claims as the primary payer with the EOMB showing Medicare Non-Eligible. Copies of Medicare cards or Common Working File (CWF) printouts are not acceptable documentation.

Medicare Retro Entitlement

The Alliance routinely conducts audits to identify patients with retroactive eligibility with Medicare or OHC. If the Alliance has paid as primary in error, the provider may receive an Identification of Overpayment notification. This letter will indicate the patient's information as well as the primary payer's name, if applicable. Claims paid as primary in error is an overpayment and should be returned to the Alliance. Providers should follow standard coordination of benefits guidelines and resubmit their claims as crossovers for processing.

If the Alliance finds a member has Retroactive Medicare Entitlement, providers should submit their claims to Medicare/CMS retro unit along with the following documents:

1. A copy of the Remittance Advice or Identification of Overpayment notification from the Alliance indicating the date overpayment was requested or recouped.
2. Documentation verifying that the beneficiary was retroactively entitled to Medicare before the date of the furnished service (i.e., the official letter to the beneficiary); and,

Additional information regarding Retroactive Medicare Entitlement can be found in the CMS Manual, Sections: 70.7.2 and 70.7.3.

Coordination of Benefits Examples

A claim is filed for $60.00. The Medi-Cal allowable amount is $32.00. Medicare paid $53.90. The Medi-Cal payment on this claim would be $0.00, not the difference of $6.10.

$32.00	Medi-Cal Allowed
$53.90	Medicare Paid
$0.00	Medi-Cal Reimbursement

Patients with a SOC are not eligible for Medi-Cal coverage until they meet their SOC for the month of service. The provider should ask for or accept obligation from the patient for their Medi-Cal share of cost. Remember that when Medi-Cal pays for any portion of the service, the total reimbursement received for the service may not exceed the Medi-Cal allowable amount.

Example A

Provider's Charge	$250.00
Medicare Allows	200.00
Medicare Pays (80% of Medicare allowed amount of $200.00)	160.00
Medi-Cal Allowable	180.00
Difference	20.00
Share of Cost Collected	25.00
Medi-Cal would pay	$0.00

Example B

Provider's Charge	$250.00
Medicare Allows	200.00
Medicare Pays (80% of Medicare allowed amount of $200.00)	160.00
Medi-Cal Allowable	190.00
Difference	30.00
Share of Cost Collected	25.00
Medi-Cal would pay	$5.00

Alliance Care IHSS

In most cases when an Alliance Care IHSS member has other OHC, the Alliance is the primary payer — the exception would be if the member is the primary subscriber and the policy was in effect before the member became covered through the Alliance.

OHC includes but is not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health Maintenance Organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champ VA.
- Medicare, including Medicare supplemental plans and Medicare Advantage (PPO, HMO and fee-for-service) plans (Medicare would be primary only if the member has end-stage renal disease).

When an Alliance Care IHSS member also has OHC that is primary, the member must treat the other insurance plan as the primary insurance company and access services under that company's rules of coverage.

Dual Coverage

Some of our Alliance Care IHSS members have dual coverage. They may have an employer or individual plan, Medicare or Medi-Cal. Alliance Care IHSS is a commercial health plan, so it is always primary over Medi-Cal and Medicare. In order for an Alliance Care IHSS member's OHC to be primary, the member would have to be the *primary subscriber* on the plan (rather than being a dependent) and must have been enrolled in the plan prior to the member becoming enrolled in Alliance Care IHSS.

For additional information on submitting claims for members with dual coverage, please see Section 10: Claims.

Alliance Members with Veterans Benefits

If the Alliance member is a veteran and is eligible for Veterans Affairs (VA) health care benefits, the member may choose to use VA services (hospitals, outpatient and other government clinics). A description of these services can be found at the VA website.

There are outpatient facilities in Capitola, Monterey, Atwater, Tulare and San Jose. There is a bus service through the VA for transportation to the Monterey, San Jose and Palo Alto facilities; the bus schedule can be found on the VA website. For inpatient facilities, contact VA Hospital in Palo Alto, which has an affiliation with Stanford or the VA Hospital in Fresno.

Members with VA benefits may use their own discretion in choosing whether to receive their care through the VA system or the Alliance — we cannot require or request that they do so but, if the member wishes, we will facilitate and coordinate their care.

Emergency Services for Veterans

Payment or reimbursement for emergency services for non-service-connected conditions in a facility other than a VA facility may be authorized under the "Millennium Bill Act." To be eligible for this authority, the veteran must satisfy *all* of the following conditions:

The emergency services must have been provided in a hospital emergency department or a similar facility that is known to provide emergency care to the public.

The claim for payment or reimbursement for the initial evaluation and treatment must be for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health.

This standard would be met in the presence of an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would seriously jeopardize the health of the individual, would result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

If we receive a claim for emergency services for a member who is known to have VA benefits, the claim will be held until the facility has received payment (or formal denial) for qualified services, as described above. Once the VA has made the determination, we will make a determination based on ongoing medical necessity but will accept responsibility for coverage even when the member could have been transferred.

VA System Referrals

In certain circumstances, the VA contracts services in non-VA facilities. If we become aware of such a service resulting from a VA referral, we will determine whether the VA has accepted financial responsibility and, if so, issue a denial.

For more information on coordination of VA benefits, please see Policy 404-1703 – Alliance Members with Veterans Benefits.

Section 10
Claims

Billing Guidelines

Medi-Cal

Since the Alliance serves Medi-Cal beneficiaries under a contract with the state to operate a County Organized Health System (COHS) the Alliance uses state policies and procedures as a point of departure. Unless there is an Alliance-specific policy, we rely on state Medi-Cal policies for the Medi-Cal program. Providers have access to all of the policies and procedures, as well as updates to the Medi-Cal Provider Manuals on the Alliance provider website.

Alliance Care IHSS

Please apply your commercial insurance office policies, including procedure codes and UB 04 and CMS form completion.

Clean Claim

A clean claim is defined as a claim that contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability. It is one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Total charges on a clean claim match all services billed on that page/form.

Where to Send Claims

Mail paper claims to the Alliance using the following addresses to facilitate timely processing and payment.

Medi-Cal (including Medi-Cal members with CCS eligibility)

ATTN: CLAIMS
Central California Alliance for Health
PO Box 660015
Scotts Valley, CA 95067-0015

Alliance Care IHSS

ATTN: CLAIMS
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Claims inquiries that require documentation may be faxed to the Claims Department at 831-430-5868.

Claim Questions

Alliance providers are encouraged to use the Provider Portal for claims inquiries. For additional questions, call the Claims Department at 831-430-5503 or 800-700-3874, ext.5503, Monday–Friday, 8:30 a.m.–4:30 p.m.

Office hours for the Claims Department phones are Monday–Friday, 8:30 a.m.–4:30 p.m., with a 24-hour voicemail available for messages. Any provider calling from outside of the local calling area may use the Alliance's toll-free number. The Alliance toll-free number may be dialed from anywhere in the United States (all 50 states) as well as Canada.

Alliance phone numbers are:

Main Office: 831-430-5500
Toll-free: 800-700-3874
TTY Line: 877-548-0857
Claims Department: 831-430-5503
Claims Department Fax: 831-430-5868
Provider Relations: 800-700-3874, ext. 5504

When calling about questions on a claim, please have the following information available:

1. The Alliance Claims Control Number (CCN) and/or the Member's Alliance ID number (if the inquiry is regarding a newborn claim billed under the mother's ID number, please indicate this at the beginning of the call)
2. Date of service
3. Dollar amount billed
4. Date the claim was sent to Alliance
5. Provider NPI/TIN

Turnaround Time for Claim Reimbursement

If you believe that the Alliance has not processed your file within 30 days of our expected received date, please contact the Alliance Claims Department at 800-700-3874, ext.5503. If you have received an RA where the claims were processed electronically and you have questions regarding the payment / denial outcome, please contact the Alliance Claims department at 800-700-3874, ext.5503.

Billing for State Medi-Cal Program

Effective 10/01/2019 DXC Technology serves as the Medi-Cal Fiscal Intermediary for the state Medi-Cal program. If you treat a member who is not an Alliance Medi-Cal member, you must bill DXC or the member's Medi-Cal plan for those services. This rule applies to members whose eligibility is through another county or who have an aid-code not covered by the Alliance.

For questions and inquiries, please contact DXC directly at 800-541-5555.

Electronic Claims Processing

The Alliance accepts and encourages claims submitted electronically. Electronic claims processing or Electronic Data Interchange (EDI) refers to the structured transmission of data between organizations by electronic means. Please see the "Information about Electronic Data Interchange (EDI) Transactions" content later in this section for a detailed description of the EDI submission process.

Claim Forms by Provider Type

The following table is a list of the types of paper claim forms used by different types of providers (e.g., PCPs, referral specialists, pharmacists, laboratories, hospitals, skilled nursing facilities and allied health practitioners).

Claim Forms Used by Different Types of Providers

Applies to	Type of Claim Form	Type of Provider	Service(s) Billed on This Form
Medi-Cal, Alliance Care IHSS	CMS	PCPs Specialists Clinics Pharmacies Laboratories Allied health practitioners Non-Emergent Transportation Provider	All professional services Electronic Medicare/Medi-Cal crossover professional claims effective on April 9, 2018. Pharmacies may also use this form for DME, medical supplies, incontinence supplies, orthotics and prosthetics. NEMT, NMT
Medi-Cal, Alliance Care IHSS	UB-04	Hospitals/Clinics Laboratories	All professional or facility services. LTC services SNF levels of care services when billed by approved facilities for Medi-Cal members.
Medi-Cal, Alliance Care IHSS	30-1	Pharmacies	Non-compound drug prescriptions.
Medi-Cal, Alliance Care IHSS	30-4	Pharmacies	Compound drug prescriptions
Medi-Cal	CMS Invoice* or CMS/EDI/ Clearinghouse	ECM/CS Providers	ECM and CS Services

*If an ECM/CS Provider lacks the technical capabilities to submit compliant claims, they may bill for services by invoice. An invoice template spreadsheet is loaded through the clearinghouse, Office Ally. An Office Ally account is required for this process. Providers should reach out to a Claims Customer Service Representative for guidance on setting up invoice billing. Similar to claims submission, all invoices will be required to contain specific data elements as outlined by DHCS CalAIM ECM/CS Billing and Invoicing Guidance.

Adherence to the following checklist for effective submission of claims will ensure timely payment:

1. Print/type clearly on Claim Forms: All claims submitted must be legible and dark enough for scanning, which will prevent your claims from being returned.
2. Bill on 8-1/2 x 11 paper (including attachments).
3. Be sure to include the patient's full name, without abbreviating.
4. Always include the member's Alliance ID Number (Box #1a on the CMS, Box #60 on the UB): Please bill all claims using the Alliance Member 9-digit ID number (the "-01" at the end of the Alliance ID number is not required). Please do not use the 14-digit Medi-Cal identification number.
5. Include Authorization Numbers (Box #63 on the UB or Box 23 on the CMS): Type all AR and referral numbers on the claim.
6. When services were provided in the ER, indicate this by marking box 24C on the CMS if you are not billing with a place of service in an ER setting.
7. Note that a quantity for each service rendered is required: please enter quantities as a single digit (e.g., "1" not "01," "001" or "010"). Do not add decimals.
8. For newborn services using mom's ID, see the following claim form completion instructions in the Medi-Cal Provider Manuals:
    a. CMS Completion (cms comp)
    b. UB-04 Completion: Outpatient Services (ub comp op)
9. For newborn services, if the infant is using the mother's eligibility (within the infant's month of birth and the month following birth), enter NEWBORN INFANT USING MOTHER'S ID or NEWBORN INFANT USING MOTHER'S ID (TWIN A) or (TWIN B) in the Reserved for Local Use field (box 19) on the CMS-On the UB-04 claim form, enter the infant's name in the Patient's Name field (Box 8B). Enter the infant's date of birth and sex in boxes 10 and 11. Enter the mother's name in the Insured's Name field (Box 58) and enter "03" (CHILD) in the Patient's Relationship to Insured filed (Box 59).
10. Please do not staple attachments, as scanning equipment requires that all staples must be removed; thus, if we must perform this task, your claim may be delayed.
11. Please do not fold claims, as this may delay processing. Claims control staff guarantees that all claims and attachments will be kept together exactly in the order you put them in the envelope.

Billing and Coding Information

The Alliance follows the billing, authorization, utilization management, and claims payment guidelines laid out by the Medi-Cal Provider Manual or the EOCs and related regulations for the other lines of business, as appropriate to the patient. However, there are a number of instances in which the Alliance has decided to differ from these standard procedures and practices. Please see below for areas where the Alliance's policies

and procedures differ from those of the state Medi-Cal program or to clarify how a provider is to operate pursuant to a policy and procedure for all lines of business.

For information on specific procedures pursuant to a policy for all lines of business, please see below for Alliance billing guidelines:

Who bills Medi-Cal for the services of rendering providers and locum tenens physicians?

Rendering providers cannot bill directly; the group entity bills Medi-Cal for services rendered by the providers enrolled in their group. In reimbursement for locum tenens/reciprocal billing, the recipient's regular physician may submit the claim and receive payment for covered Medi-Cal services (including emergency visits and related services) provided by a locum tenens physician who is not an employee of the regular physician. Providers should bill them with modifier Q6.

Allergen Immunotherapy, 95115

To enable contracted Ear Nose and Throat and allergist providers to accurately report and be reimbursed for services provided to all Alliance members, the Alliance will reimburse professional services for allergen immunotherapy (excluding provision of single allergenic extracts) billed with code 95115 when billed in conjunction with E&M codes 99202–99215 or 99242–99245.

Ambulatory Surgery Billing and Authorizations

Surgical Implants: Prior authorization is required for surgical implants. The provider must submit an Authorization Request requesting Plan approval and must attach supporting documentation regarding the implants to be used, their cost and the procedure in which they are to be used. If the implant is to be used in a procedure which itself requires prior authorization, a single Authorization Request should be used both requesting authorization for the procedure and for the implants. If the procedure itself would not otherwise require prior authorization, an Authorization Request for the implants only should be submitted.

Billing for Outpatient Surgical Facility Services: Unless otherwise specifically identified in this guide, covered outpatient surgical facility services and supplies which are not on a surgical tray, or a post-operative pain block, or a surgical implant should be billed using the appropriate Medi-Cal specific or CPT billing codes. As noted above, providers must follow any applicable prior authorization requirements applicable to the procedure being performed.

- Surgical Tray: The Alliance pays a case rate for surgical supplies provided on the surgical tray. Providers must bill with the appropriate CPT-4 codes (range 10000–64399 and 64531–69999) and must include either a UA or UB modifier on the claim form.
- Post-Operative Nerve Pain Blocks: The Alliance pays a flat rate for the provision of post-operative nerve pain blocks. Providers may bill for the provision of post-operative pain blocks administered to patients where the post-operative pain block was provided on the same date of service as the surgical procedure. Providers must bill using CPT-4 codes (range 64400–64530) and appropriate modifiers.

Surgical Implants: Providers billing for surgical implants must include a copy of the invoice for the item and the authorization number with the claim. See Policy 600-1011 – Surgical Implantable Devices Billed with HCPCS Z7610, Miscellaneous Drugs and Supplies Administered.

Biophysical and Modified Biophysical Profile

The Alliance will reimburse contracted providers for biophysical and modified biophysical profiles without referral or authorization.

CPT 76818 – fetal biophysical profile (BPP), a test to measure fetal well-being.

CPT 76819 – modified biophysical profile, combines a non-stress test and measurements of amniotic fluid (amniotic fluid index).

Services are reimbursed when providers use the appropriate billing codes for the following scenarios:

For same date of service (DOS) and same provider, replace billing code (59025 + 76805) with 76818 only.

For different DOS and any provider, with service billed within 7 days, replace (59025 + 76805) with (59025 + 76819).

For same DOS and any provider, replace (59025 + 76805) with (59025 + 76819).

There is a diagnosis restriction for high-risk pregnancy. The Alliance will reimburse contracted providers for biophysical and modified biophysical profiles without referral or authorization for high-risk pregnancy.

Members with CCS Eligibility

The CCS diagnosis code should only be added to claims in which the CCS condition is being treated.

Cardiac and Pulmonary Rehabilitation Services

The Alliance provides coverage of cardiac and pulmonary rehabilitation services for all Alliance members. When billing for these services, please use the following codes:

Cardiac Rehabilitation – Referral Required: 93797, 93798

Pulmonary Rehabilitation – Referral Required: 94625, 94626

For additional information, please see Policy 404-1720 – Private Duty Nursing EPSDT Benefit and Policy 404-1729 – Pulmonary Rehabilitation Services.

Chiropractic X-Ray Services

The Alliance will reimburse the following for contracted chiropractors when providing specific X-ray services to all Alliance members. When billing for these services, chiropractors should use only the codes shown below with an appropriate modifier: See Policy 600-1036 – Modifier Reference Grid for assistance.

- Billing code 72040: Radiologic examination of spine (including cervical spine). No modifier (both professional and technical component), or Modifier 26 (just professional component).
- Billing code 72052: Complete X-ray, including oblique and flexion and/or extension studies. No modifier (both professional and technical component), or Modifier 26 (just professional component).
- Billing code 72070: Radiologic examination, spine, thoracic. No modifier (both professional and technical component), or Modifier 26 (just professional component).

- Billing code 72100: Radiologic examination, spine, lumbosacral. No modifier (both professional and technical component), or Modifier 26 (just professional component).
- Billing code 72114: Complete, including bending views. No modifier (both professional and technical component), or Modifier 26 (just professional component).

A referral or an Authorization Request is not required.

Community Health Worker and Asthma Preventive Services

Effective for dates of service on or after July 1, 2022, Community Health Worker (CHW) services and Asthma Preventive Services (APS) are now benefits for the Medi-Cal program for the following codes:

Code	Description
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2–4 patients
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5–8 patients
T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs

CHW benefits must be billed with one of the following modifiers:

Modifier	Description
U2	Denotes services rendered by Community Health workers
U3	Denotes services rendered by Asthma Preventive Service providers

For specific information relative to each of these codes and how they apply to CHW or APS services, refer to Asthma Preventive Services (APS) and Community Health Worker (CHW) Preventive Services in Section 2 of the Medi-Cal Provider Manual. Rates information for these codes can be found on the Medi-Cal Rates page of the DHCS Medi-Cal Providers website.

Community Supports (CS) Housing Deposits

Housing Deposits are a one-time benefit for services or modifications necessary to enable the Member to establish a basic household. Members must also be receiving Housing Transition/Navigation services to qualify for this benefit. Prior authorization is required, and providers must submit an itemized housing support

plan indicating the associated costs with the authorization request. The total payment per member is not to exceed $5,000.

Use the following information when billing for Housing Deposits:

HCPCS	Modifier	Description	Billing
H0044	U2 U2, GQ	Housing Deposits	Bill once within the 6-month authorized period for the amount noted in the housing support plan. Providers must document in the description field of the claim form or invoice the county of residence and the number of bedrooms.

DME Travel

The Alliance will pay for mileage at $.32 per mile for a wheelchair vendor to go and repair a member's chair. It would also cover for the vendor to pick up and bring the chair back to their shop for repair. It would be paid under E1399 with remarks added to the claim X2999.

This benefit is limited to only Alliance eligible members. Alliance members with Medicare and other health insurance coverage would not be eligible. This benefit was effective 1/1/99.

DME Policies and Instruction

600-1006 – Breast Pumps and Coordination of Benefits

600-1007 – DME Rent-to-Purchase Pricing

600-1022 – Charpentier Billing Procedure

600-1024 – DME Pricing

600-1026 – Incontinence and Medical Supply Pricing

600-1029 – Orthotics and Prosthetics Pricing

600-1032 – Wheelchair and Scooter Repair Mileage and Medicare Denials

600-1033 – Wheelchair, Wheelchair Accessories and/or Replacement Parts for Patient-Owned Equipment Pricing

600-1034 – Slings (A4565) Reimbursement

600-1801 – Claims Submission Guidelines and Rental Timeframes for Nebulizers

600-1802 – Claims Submission Guidelines and Rental Timeframes for TENS Devices

600-1803 – Claims Submission Guidelines and Rental Timeframes for Wheelchairs

600-1804 – Claims Submission Guidelines for an Osteogenesis Stimulators

600-1805 – Claims Submission Guidelines for Speech Generating Devices

Ear, Nose and Throat Services

The Alliance will reimburse for outpatient ear nose and throat (ENT) procedures without the need for an Authorization Request (AR); as long as the services are performed by an In-Service Area or Local Out of Service Area contracted ENT physician and the correct codes and billing processes are used.

An In-Service Area Provider is any provider based in the Alliance's Service Area, regardless of contract status. A Local Out of Service Area Provider is a specialist physician, hospital or allied provider based in an area adjacent to the Service Area, with whom the Alliance has contracted based on an existing referral pattern and claims payment to the provider, and the need for access to the provider's specialty type.

Procedures

A referral from the member's PCP will be required unless the member is an Administrative Member.

Use the following CPT codes when billing for ENT services: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42860, 69424, 69433, 69436, 69440, 69450, 69631.

CCS review referral required for the following CPT codes: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42860, 69424, 69433, 69440, 69450.

CCS referral exception to the following CPT codes only: 69436 and 69631.

Doula

As of January 1, 2023, the Alliance offers doula services to prenatal, perinatal and postpartum members.

When billing, use Modifier XP to denote Doula Services.

BILLING CODE	DESCRIPTION	FREQUENCY	REQUIRED MODIFIER	ALLOWED MODIFIER
Z1032	Extended initial visit 90 minutes. (Visit must be at least 90 mins)	1 per pregnancy	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video
Z1034	Prenatal visit	8 total combined prenatal and postpartum visits per pregnancy	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video
Z1038	Postpartum visit	8 total combined prenatal and/or postpartum visits per pregnancy	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video
T1032	Extended postpartum visit, per 15 minutes	2 visits per pregnancy 12 units per visit (3 hours)	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video
59409	Doula support during vaginal delivery	1 per pregnancy	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video
59612	Doula support during vaginal delivery after previous cesarean section	1 per pregnancy	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video
59620	Doula support during cesarean section	1 per pregnancy	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video
T1033	Doula support during or after a miscarriage	1 per pregnancy	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video
59840	Doula support during or after abortion	1 per pregnancy	XP: Separate practitioner	93: Telehealth audio only 95: Telehealth w/audio video

Dyadic Service Codes

BILLING CODE	DESCRIPTION	
H2015	Comprehensive Community Support Services, Per 15 Minutes (Not Payable By Medicare)	
H2027	Psychoeducational Service, Per 15 Minutes (Not Payable By Medicare)	
T1027	Family Training And Counseling For Child Development, Per 15 Minutes (Not Payable By Medicare)	
G9919	Screening Performed And Positive And Provision Of Recommendations	
G9920	Comprehensive Community Support Services, Per 15 Minutes (Not Payable By Medicare)	
G0442	Annual Alcohol Misuse Screening, 15 Minutes	
H0049	Alcohol And/or Drug Screening (Not Payable By Medicare)	
H0050	Alcohol And/or Drug Services, Brief Intervention, Per 15 Minutes (Not Payable By Medicare)	
96127	Brief Emotional/Behavioral Assessment (eg, Depression Inventory, Attention Deficit/Hyperactivity Disorder [Adhd] Scale), With Scoring And Documentation, Per Standardized Instrument	
G8431	Screening for depression is documented as being positive and a follow-up plan is documented	The combined total claims for screening pregnant or postpartum recipients using HCPCS codes G8431 and/or G8510 may not exceed two per year, per recipient, by any provider of prenatal or postpartum care
G8510	Screening for depression is documented as negative, a follow-up is not required	The combined total claims for screening pregnant or postpartum recipients using HCPCS codes G8431 and/or G8510 may not exceed two per year, per recipient, by any provider of prenatal or postpartum care
96156	Health Behavior Assessment, Or Re-Assessment (Ie, Health-Focused Clinical Interview, Behavioral Observations, Clinical Decision Making)	One per day, any provider
96167	Health Behavior Intervention, Family (With The Patient Present), Face-To-Face; Initial 30 Minutes	One per day, any provider
96168	Health Behavior Intervention, Family (With The Patient Present), Face-To-Face; Each Additional 15 Minutes (List Separately In Addition To Code For Primary Service)	Six per day, any provider
96170	Health Behavior Intervention, Family (Without The Patient Present), Face-To-Face; Initial 30 Minutes	One per day, any provider
96171	Health Behavior Intervention, Family (Without The Patient Present), Face-To-Face; Each Additional 15 Minutes (List Separately In Addition To Code For Primary Service)	One per day, any provider
90791	Psychiatric Diagnostic Evaluation	
90792	Psychiatric Diagnostic Evaluation With Medical Services	
99406	6 Smoking And Tobacco Use Cessation Counseling Visit; Intermediate, Greater Than 3 Minutes Up To 10 Minutes	One session per day
99407	Smoking And Tobacco Use Cessation Counseling Visit; Intensive, Greater Than 10 Minutes	One session per day

Eligibility Street Medicine

Medi-Cal allows qualified providers determining presumptive eligibility under the Hospital Presumptive Eligibility (HPE) program, to complete HPE determinations off the premises of hospitals and clinics, such as in mobile clinics, street teams, or other locations. Third-party vendors may also be enlisted by hospitals to help individuals complete the paper version of the HPE application in these off-premise locations, although completion of the application must be performed by the qualified HPE provider through the HPE Application Portal. More information about the HPE program may be found on the HPE Program and HPE Program FAQs pages of the Medi-Cal Providers website.

Services

Qualified individuals presumptively enrolled into Medi-Cal under the HPE program are allowed immediate access to temporary, no-cost Medi-Cal services, while they apply for permanent Medi-Cal coverage or other health coverage. Providers rendering services to qualified individuals may provide and bill fee-for-service Medi-Cal for appropriate and applicable services within their scope of service.

Providers must follow Medi-Cal submission guidelines when billing for services rendered. Guidelines on how to submit claims to Medi-Cal, as well as additional documentation or billing requirements that providers

should consider, may be found in the appropriate Medi-Cal Provider Manual. Some sections that providers may find immediately helpful include:

- Claim Submission and Timeliness Overview
- CMC (Computer Media Claims submission)
- The Clinics and Hospitals Part 2 Provider Manual

Billing

Street medicine services should be claimed to place of service (POS) code 27 (Outreach Site/Street) when rendering services for street medicine, as defined in APL 24-001.

> 27 – Outreach Site/Street (A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.)

DHCS is clarifying that POS codes 04 (Homeless Shelter), 15 (Mobile Unit), and 16 (Temporary Lodging) should continue to be utilized for services provided in those respective settings, whether or not they are provided by a "street medicine provider." In the instance of street medicine, the POS code claimed should equate to the location of the service provided, rather than the provider type.

Medi-Cal providers rendering services to an individual in these locations are responsible for determining and rendering appropriate and applicable eligible Medi-Cal services.

Services billed must also be submitted on a CMS-1500 paper claim form, or the equivalent electronic ASC X12N 837P v.5010 transaction. Instructions on how to submit either type of claim may be found in the following locations:

- Paper Claims
  - CMS-1500 Submission and Timeliness Instructions
  - CMS-1500 Completion
  - CMS-1500 Special Billing Instructions
  - CMS-1500 Tips for Billing
- Electronic Claims
  - HIPAA 5010 Medi-Cal Companion Guide
  - Relevant sections of the 5010 CMC Billing and Technical Manual

Lastly, reimbursement for rendered services is limited to the provider's applicable scope of services.

ECG Services

The Alliance will reimburse for outpatient ECGs without the need for a referral, as long as the services are performed by in an In-Service Area or Local Out of Service Area contracted cardiologist (provider specialty 06), radiologist (provider specialty 30), or pediatric cardiologist (specialty 35) and the correct codes and billing process are used.

Specified ECG services will be covered when place of service 21 and/or 22 are billed in conjunction with ECG readings. No referral is required.

Use the following CPT codes when billing for ECG services:

93000	93005	93010	93015
93016	93017	93018	93024
93025	93040	93041	93042
93224	93226	93227	93228
93229	93268	93270	93271
93303	93304	93306	93307
93308	93312	93315	93318
93320	93321	93325	93350
93880			

Enhanced Care Management (ECM) Outreach

An ECM "outreach attempt" is defined as an in-person or telephonic/electronic attempt to connect with an individual member for the purpose of explaining and extending ECM services to members that have been identified as meeting ECM eligibility requirements. ECM outreach payments are a one-time payment to the ECM Provider who has been assigned to the member. Outreach payment will be made to ECM Provider regardless of whether member agrees to receive ECM services or not, as long as there is documentation of adequate outreach attempts. Additional ECM outreach authorizations may be approved by the Alliance after a six-month period, for those members who declined services or were unable to contact initially and have received an additional referral for ECM services.

ECM Providers shall conduct outreach primarily through in-person interaction where members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Providers may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the member's consent.

ECM Providers shall use the following modalities, as appropriate and as authorized by the member, if in-person modalities are unsuccessful or to reflect a member's stated contact preferences:

- Mail
- Email
- Texts
- Telephone calls
- Telehealth

In developing the ECM benefit and optional CS services, DHCS estimates that 60% of member's outreached are reachable, and 60% of reachable members will need repeat outreach attempts. DHCS also assumes that outreach engagement will require approximately two hours per member, on average.

Providers are required to document their ECM Outreach attempts. The Alliance collects this information through claims data while Providers must maintain their own records of outreach attempts.

The required data to be tracked for all outreach efforts:

Data Element	Documentation
Member Number	Entered on the claim form or invoice
Provider Type	Entered in the "Description" field of the claim or invoice
Date of Outreach Attempt	Entered as the DOS on the claim or invoice
Outreach Attempt Method	The procedure code/modifier combination on the claim or invoice

Use the following HCPCS codes and modifiers when billing for ECM Outreach services:

HCPCS	Modifier	Description	Billing
G9008	U8	ECM Outreach in Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified. ECM Outreach	Bill in 15-minute increments. 1 unit= 15 minutes
	U8, GQ	Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	
G9012	U8	ECM Outreach in Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	Bill in 15-minute increments. 1 unit= 15 minutes
	U8, GQ	ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is a federally mandated telephone and computer-based application program that electronically verifies in-home service visits. As a result, this program will aid in reducing fraud, waste, and abuse. The EVV program must verify each type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

Effective 1/1/2023, EVV is required for all Medi-Cal Home Health Care Services (HHCS) and Personal Care Services (PCS) that are delivered during in-home visits by a provider, including PCS. These may include, but are not limited to, HHCS and PCS delivered as part of Community-Based Adult Services. PCS consist of services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and

personal hygiene. PCS can also offer support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.

The State of California contracted with Sandata Technologies, LLC (Sandata) to provide a state sponsored EVV system. Sandata is providing California with an EVV system that includes the ability to capture data elements during the visit, data portals that allow providers to view and report on visit activity, and an EVV Aggregator to provide California with EVV program oversight and analytics. For more information, please see Policy 300-4190 – Electronic Visit Verification.

Exclusions

The following services are not subject to EVV requirements:

- HHCS or PCS that do not require an in-home visit are not subject to EVV requirements.
- HHCS or PCS provided in congregate residential settings where 24-hour service is available are not subject to the EVV requirements.
- HHCS or PCS rendered by an individual living in the member's residence does not constitute an "in-home visit" and is not subject to EVV requirements.
- Any services rendered through the Program of All-Inclusive Care for the Elderly.
- HHCS or PCS that are provided to inpatients or residents of a hospital, nursing facility including skilled nursing facility or residence of nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases.
- Durable Medical Equipment is not subject to EVV requirements.

Requirements

All applicable HHCS and PCS providers must complete the self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator, including providers of Community Supports – Personal Care and Homemaker Services, and Respite Services. Once registered, Network Providers and Subcontractors will gain access to extensive training and technical assistance, including self-guided learning modules and EVV system demonstrations, provided by Sandata. Self-registration, resources, and additional training are available at https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx.

All Medi-Cal PCS and HHCS providers must capture and transmit the following six mandatory data components:

1. The type of service performed;
2. The individual receiving the service;
3. The date of the service;
4. The location of service delivery;
5. The individual providing the service; and
6. The time the service begins and ends.

All claims for PCS and HHCS services must be submitted with allowable Current Procedural Terminology or Healthcare Common Procedure Coding System codes as outlined in the Medi-Cal Provider Manual. MCPs and/or providers must also indicate the proper Place of Service Code or Revenue Code on claims and/or encounters to indicate the rendering of PCS or HHCS in a member's home.

All Network Providers are required to comply with the EVV requirements when rendering PCS and HHCS, subject to federal EVV requirements. The Alliance monitors and ensures compliance with these requirements, and alerts DHCS to any compliance issues, as below:

- Monitors providers for compliance with the EVV requirements and CalEVV Information Notice(s), and alert DHCS to any compliance issues;
- Supplies providers with technical assistance and training on EVV compliance;
- Requires providers to comply with an approved corrective action plan; and
- Denies payment if the provider is not complying with EVV requirements and arrange for the participants to receive services from a provider who does comply.

When a Network Provider is identified as non-compliant with these requirements, the Alliance will not authorize the Network Provider to perform services and/or will withhold the payment.

Emergency Room Casting or Treatment

Referral will not be required for Alliance members who are referred by the emergency room to an orthopedic surgeon within the Alliance in-service and local out of service area, for casting or treatment of bone fracture, including sprains and strains when services are billed with Diagnosis Code Ranges: M84-M8468XS, S02-S0292XS, S12-S129XXS, S22-S229XXS, S32-S329XXS, S42-S4292XS, S52-S5292XS, S62-S6292XS, S72-S7292XS, S82-S8292XS, S92-S92919S, T148, S93- S93699S.

Fecal Occult Blood Testing

The Alliance will authorize payment for fecal occult blood testing that is part of routine screening examination to rule out colorectal cancer in members between age 50 and 75. Billing code: 82270

Hearing Aids

The Alliance covers hearing aids when supplied by a hearing aid dispenser, the prescription of an otolaryngologist or the attending physician when no otolaryngologist is available in the community. An audiological evaluation, including a hearing aid evaluation performed by, or under the supervision of, the above prescribing physician, or by a licensed audiologist, is required. Prior authorization is required for the purchase or rental trial period of hearing aids and for repairs that cost more than $25 per repair service. The following CPT/HCPCS codes related to hearing aids will not be capped annually: V5014, V5264, V5265, V5030, V5040, V5050, V5060, V5070, V5080, V5298, V5120, V5130, V5140, V5150, V5180, V5171, V5172, V5181, V5190, V5210, V5220, V5230, V5267, V5298, V5211, V5212, V5213, V5214, V5215, V5221.

Mileage Cost Reimbursement for Travel to Repair Wheelchairs/Scooters

The Alliance will cover mileage costs incurred by a provider when the provider goes to and from an Alliance member's home to repair wheelchairs/scooters.

Procedure code E1399 is an Alliance-only benefit that allows reimbursement for mileage when a provider goes to and from a member's home to make wheelchair repairs.

- Reimbursement is $0.32 per mile.
- E1399 falls under the same guidelines for Authorization Requests as repairs — i.e., an AR is required only if maintenance or repair (and/or travel) exceeds $500 (cumulative cost of related items within a group).
- This applies to Alliance primary members and Medicare/Alliance members only.

  *Travel repair wheelchairs/Scooter should be added to remarks.

Wheelchair Replacement Rentals

When the member's wheelchair needs to be repaired and will take multiple days, the Alliance will pay claims as a daily rental when claims are submitted per the following guidelines:

- Providers must bill with code E1399 which requires an authorization.
- Providers are required to bill their units as the number of days that the wheelchair was needed.
- The base code for the member's existing wheelchair must be entered in box 19.
    - For example, "member owns a K0823."
- The Alliance will pay these as a daily rental using the monthly rental rate divided by 30 for the daily rate.

DME Serial Numbers

Providers will be required to include DME serial number notation when filing a claim for the following items: Concentrators and Ventilators, Speech Generating Devices, Hospital Beds, Wheelchairs and accessories, Lift Devices and accessories.

Miscellaneous Policies and Instruction

600-1001 – Claims Processing

600-1009 – Corrected Claims Submissions

600-1010 – Miscellaneous Drugs and Medical Supplies

600-1011 – Surgical Implantable Devices Billed with HCPCS Z7610, Miscellaneous Drugs and Supplies Administered

600-1013 – Billing Epidural, Subarachnoid and Nerve Block Injections for Postoperative Pain Management

600-1015 – National Correct Coding Initiative

600-1016 – Non-Covered Service Billed with a GA, GY or GZ Modifiers to Medicare

600-1017 – Provider Inquiry and Dispute Resolution

600-1018 – Modifier Placement

600-1019 – Modifier 99 – Multiple Modifiers Not Recognized

600-1030 – Reimbursement for Medicare/Medi-Cal Crossover Nephrology and Dialysis Services

600-1031 – Twins Delivery Reimbursement

600-1036 – Modifier Reference Grid

600-1037 – Global Surgery

600-1039 – Billing for Time Based Anesthesia Services

600-1040 – Unbundled ENT CPT Codes

600-1041 – Medicare and Coordination of Benefits Reimbursement

600-1043 – CHDP Reimbursement for Snellen Test

600-1044 – H0049 and G0442 CHDP Program Reimbursement for Alcohol Misuse Screening

600-1046 – Contraceptive Products and Services

600-1047 – Place of Service 20 (Urgent Care) Billing Location Expansion

600-1048 – Manual Pricing of a Service When There is No Medi-Cal Rate

600-1050 – Implementation of Medi-Cal Rates

600-1072 – AB 72

600-2201 – Reimbursement for Non-Emergency Medical Transportation (NEMT), Non-Medical Transportation (NMT), and Invoice Requirements

Contraceptives

Contraceptives A4267, A4268, A4269U1, A4269U2, A4269U3, A4269U4, A4269U5 and S5199

When billing for contraceptives using the above codes, please bill by adding the total quantity dispensed in box 24G (Days or Units) of the CMS form or box 46 (Serv Units) of the UB04 claim form. Please note this process differs from Medi-Cal guidelines that instruct providers to bill with a quantity of 1 and then to add the description, quantity dispensed and at cost expense of the item to Remarks.

MMRV Vaccination

For Alliance Care IHSS members, this vaccination combines the attenuated virus MMR (measles, mumps, rubella) vaccine with the addition of the chickenpox vaccine (varicella).

- Providers billing for services rendered to non-Medi-Cal members should bill the MMRV using vaccine CPT code 90710.
- Each claim must be submitted with an invoice.
- These claims will be reimbursed at invoice cost plus an additional 5%.

Occupational and Speech Therapy Codes

The following CPT codes are to be used for claims submission:

- Occupational Therapy: Billing Codes and Reimbursement Rates
- Speech Therapy: Billing Codes and Reimbursement Rates

In addition to the billing codes listed in the Medi-Cal manual, CCAH allows the following codes to be billed for Occupational Therapy and Speech Therapy.

Occupational Therapy Codes (if CPT criteria met)		**Speech Therapy Codes (if CPT criteria met)**	
		92507 Medi-Cal and Commercial claims	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
		92508 Medi-Cal and Commercial claims	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
97140 Medi-Cal and Commercial claims	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes		
97535 Medi-Cal and Commercial claims	Self-care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes		

Physical Therapy Codes

The following CPT codes are to be used for Medi-Cal and commercial lines of business claims submission.

Do not use the billing codes in the Medi-Cal Manual.

Please note:

- Authorizations should not have overlapping days.
- X codes will not be accepted for claims or authorization submissions.
- Failure to use the appropriate modifier when billing physical therapy codes may result in denial of the claim.

Physical Therapy Codes for Medi-Cal Lines of Business (if CPT criteria met)			
99243	An initial Physical Therapy Evaluation – requires a referral from the member's linked Primary Care Physician (PCP) or treating physician.	97124	Massage, including effleurange, petrissage and/or tapotement (stroking, compression, percussion)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes, therapeutic exercises to develop strength and endurance, range of motion and flexibility.	97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97014	Application of a modality to 1 or more areas: electrical stimulation therapy		
97112	Neuromuscular reeducation (97112) of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities	97530	Therapeutic activities direct (one on one) patient contact by provider, each 15 minutes.
97113	Aquatic therapy with therapeutic exercises	97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97116	Gait Training includes stair climbing		

Refractive State Services Used for Claims Payments

Determination of refractive state includes determination of visual acuity with corrective lenses. It is usually performed with an instrument called a phoropter. While looking at an eye chart through the phoropter, the ophthalmologist adjusts the lenses until the chart appears the clearest possible.

Medi-Cal

- Non-refractive services billed by ophthalmologists are potentially payable by the Alliance when billed with a primary medical diagnosis.
- Non-refractive services billed by approved optometrists are potentially payable by the Alliance when billed with a primary medical diagnosis.
- A referral is required from the member's PCP if the Alliance is the primary payer and the referring provider is within the Alliance's in-service area or local out of service area.
- An authorized referral is needed from a member's PCP if the Alliance is the primary payer and the referred to provider is out of the service area

For information on how to become an approved optometrist, please reference Policy 300-4160 – Optometrist Reimbursement for Medical Services.

Wheelchair Evaluations

The Alliance will reimburse for wheelchair evaluation to help identify the wheelchair that best fits the members need. The evaluation can be requested by member, medical professional or Alliance staff.

Referral is required for evaluation by local qualified Network PT or Physiatrist and may be reimbursed when billed using one of two Billing Codes:

- E1399: Simple wheelchair evaluation Code X2995 in remarks
- E1399: Complex wheelchair evaluation code X2997 should be added to the remarks

Evaluation by contracted DME Evaluator may be requested by DME provider, Alliance staff or provider. Referral is not necessary.

Information about Electronic Data Interchange (EDI) Transactions

About EDI

To expedite claims processing, the Alliance offers an electronic claims submission service for its providers. This section is designed to provide a broad understanding of EDI transactions and serves as a guide to electronic claims processing at the Alliance.

The 837 transaction is used to submit medical claims for payment or submission of encounter data used to satisfy regulatory reporting requirements. Use of EDI transactions allows a provider to submit transactions faster and be paid for claims faster, and to accomplish this at a lower cost than is generally the case for paper or manual transactions. For additional details on transaction instructions, and the Alliance's business and processing rules relevant to the implementation of 837 transactions, reference the Alliance's EDI Companion Guide.

If you are interested in submitting electronic claims either directly to the Alliance or through an established clearing house, please complete, **sign** and submit the EDI Claims Enrollment form or complete the online EDI Enrollment form. Please contact the EDI Support Team for more information at edisupport@thealliance.health.

Benefits

There are many benefits to sending your claims electronically to the Alliance, including:

1. Ability to submit 24/7
2. Immediate verification of claims received
3. Decreased data entry errors > Faster payment
4. Reduced paper claim costs > No paper claims to print
5. Lower print costs > No ribbon or toner expense
6. Reduced mailing costs > No envelopes or stamps to buy
7. Decreased office costs > No overhead to print, sort, stuff and mail claims
8. Increased staff efficiency > Quicker claims turnaround time

Acceptable Transaction File Formats

The Alliance accepts ANSI X12 HIPAA mandated compliant transactions.

For more information, please see the WEDI-Snip website and the X12 website.

Clearinghouses

If you do not have the ability to submit EDI claims directly to the Alliance, we have partnered with many established clearinghouses.

The most commonly used clearinghouses are:

- Office Ally — Contact Office Ally customer service at 866-575-4120 or email support@officeally.com.
    - Payer ID is CCA01 (non-ECM/Community Supports claims)
- Athena Health — Contact Athena Health customer service at enrollmentservices@athenahealth.com.
    - Payer ID is SX169 (Professional and Institutional)
- Availity — Contact Availity customer service at edienrollment@availity.com.
    - Payer ID is SX169 (Professional and Institutional)
- eSolutions — Contact eSolutions customer service at enrollment@waystar.com.
    - Payer ID is SX169 (Professional and Institutional)
- TriZetto — Contact TriZetto customer service at support+trizetto@madakethealth.com.
    - Payer ID is SX169 (Professional and Institutional)

If providers choose to work with Office Ally and do not already have an existing account established with Office Ally, **they can submit claims at no charge once approved by the Alliance.** Please email the Alliance EDI Support Team at edisupport@thealliance.health for further details.

Change Healthcare and ECHO Health, Inc. for all Fee-For-Service (FFS) and Capitation Payments

The Alliance collaborates with third party vendors, Change Healthcare (CHC) and ECHO Health, Inc., to assist with payment processes. Providers receive payments directly from ECHO for Fee-For-Service (FFS) and capitation payments.

ECHO consolidates individual provider and vendor payments into a single ERISA and HIPAA compliant format, remits electronic payments and supplies an explanation of provider payment details to providers.

There are three types of payment options available through ECHO:

- Virtual Credit Card (VCC)
- Electronic Funds Transfer (EFT)
- Paper Checks

An 835 file, also known as an Electronic Remittance Advice (ERA) file, is an EDI file that contains claim payment information, and it documents the EFT in healthcare insurance. To enroll and receive 835 files from your desired clearinghouse for ECHO payments, complete one of the following options:

- ECHO can supply the hard copy ANSI 835 Enrollment Form, OR
- Access https://enrollments.echohealthinc.com and select the option to enroll in an ERA only.

If you have additional questions regarding your payment options, contact ECHO Health at 888-984-0804.

For assistance with any technical support issues, contact ECHO Health customer service at 888-834-3511.

Frequently Asked Questions about Claims

- **Does the Alliance follow the same timeliness guidelines as Medi-Cal?**

  Yes. For our Medi-Cal lines of business, the Alliance follows Medi-Cal Timeliness and Delay Reason Codes guidelines. Please see the Medi-Cal Provider Manual for further information.

- **How do I interpret information on the Alliance Remittance Advice (RA)?**

  Please refer to the Alliance Remittance Advice Guide available on our provider website.

- **Will the Alliance accept electronic claims?**

  Yes. The Alliance accepts and encourages electronic claims submission. If your practice or facility is interested in having your Alliance claims processed electronically, please complete, sign and submit the EDI Claims Enrollment form online.

- **When and how should I follow-up on claims possibly held for processing by the Alliance?**

  Please consider the date the claim was mailed in estimating if follow-up or a request to re-bill is appropriate. Claims are processed based on the date of their receipt at our office. For most practices, the appropriate timeframe for follow-up would be 45 calendar days after the claim was originally mailed. We suggest that providers use the electronic tracking of claims available through our Provider Portal Services or call a Claims Customer Service Representative Monday–Friday, 8:30 a.m.–4:30 p.m. at 800-700-3874, ext. 5503, choose Option 1.

- **Can previously denied claims be resubmitted via the web?**

  Contracted providers may use the Provider Portal to search for claims and resubmit previously denied claims. If your office is not set up to use our Provider Portal, please contact your Provider Relations Representative for instructions on how to set up an account

- **How should claims for newborns be submitted?**

  Services rendered to an infant in the month of birth and the month following birth may be billed under the mother's Alliance ID number as a Mom/Baby claim following Mom/Baby claim guidelines. A referral for services is not required during this timeframe. After this timeframe, the infant must have their own Alliance ID number.

  - To bill correctly on the CMS form, ensure that the mother's Alliance ID number is in field 1A, the infant's name is in field 2, the infant's birth date is in field 3, and the Child box is checked in field 6.
  - To bill correctly on the UB 04 form, ensure that the infant's name is in Box 8B, the infant's date of birth and sex are in Boxes 10 and 11, the mother's name is in Box 58, "03" (CHILD) is in Box 59, and the mother's Alliance ID number is in Box 60.

- **How does the Alliance process claims for children eligible for California Children's Services (CCS)?**

  The Alliance will process CCS claims, with a few exceptions that are billed to State Medi-Cal.

Include the CCS diagnosis code on claims submitted to the Alliance when treating the member for the CCS condition. Prior authorization is required – see Health Services Policy 404-1305 Screening and Referral of Medically Eligible Children to California Childrens Services (CCS) Program.

Since the Alliance has not changed the Medi-Cal coding/billing requirements from those required by Medi-Cal, you may use the Medi-Cal Provider Manual as your Alliance billing guide.

- **How should I handle Share-of-Cost (SOC) collection and billing?**

  Share-of-Cost (SOC) collection and billing is an important function for every provider's office. The Point of Service (POS) device or Automated Eligibility Verification System (AEVS) at 800-456-2387 will inform you of a member's outstanding SOC and allow you to clear the amount collected (or the amount that the member is obligated to pay). Members with outstanding SOC amounts are not eligible to receive services under their Alliance membership until the SOC is collected and cleared. Once the amount collected (or the amount obligated) is cleared, the Alliance member will be eligible to obtain services (or will be closer to being eligible to obtain services if there is a remaining SOC amount). It is important for all providers to collect and clear SOC each month to ensure a member's ability to obtain services from other providers later that month.

  Once a SOC has been collected, the Alliance will compute the Medi-Cal allowance and subtract the amount already paid by the member. If the member's payment exceeds the Medi-Cal allowance, then the Alliance reimbursement will be $0 (in such a case, you would not need to bill the Alliance for the services because you will have been paid more than Medi-Cal allows). If the member's payment is less than the Medi-Cal allowance, then the net reimbursement will be the difference.

  - CMS claim form: Enter the amount collected (or obligated) in box #10d of the CMS claim form. The amount collected (or obligated) should also be entered in box #29 and should be subtracted from the total balance due (box #30).
  - UB-04 claim form: Enter code "23" and the amount of the patient's SOC in box 39. In box 55 enter the difference between "Total Charges" (box 47) and SOC collected.

- **How are refunds or reversals/takebacks processed?**

  Alliance Identified Overpayment:

  Research is completed by Alliance staff to identify overpayments on claims. Overpayments may have been made due to a duplicate claim payment, lack of coordination of benefits with the member's primary health care insurance policy or incorrect billing procedures. When an overpayment is identified, the Alliance will mail a notification of overpayment to the provider requesting a refund.

  Provider Identified Overpayment:

  If a provider's business office identifies an overpayment, they are required to report when they received an overpayment, to return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Alliance in writing of the reason for the overpayment. Providers may fill out the Provider Identified Overpayment form that can be found in the Finance section of the Provider Forms Library on the Alliance website.

The provider should issue a refund check payable to:

Recoveries Department
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981

Please include the refund check with the Financial Control Number (FCN), date of service of the claim overpayment, patient's member ID number, reason for the refund and the claim number so that the recovery can be recorded to the proper account.

Alternatively, some providers prefer that recoveries are made electronically. If an electronic refund or reversal of an overpayment is preferred, please notify Recoveries staff at 800-700-3874, ext. 2505.

- **What do I do if I disagree with how a claim was paid or denied?**

  Providers may disagree with how a claim was priced/paid or whether or not it was denied appropriately. These issues can often be handled directly by the Claims Department without the involvement of Provider Services or Health Services departments. Please contact an Alliance Claims Customer Service Representative Monday–Friday, 8:30 a.m.–4:30 p.m. at 800-700-3874, ext. 5503.

  In situations where you disagree with the Claims Department decision after calling, please contact your Provider Relations Representative who will evaluate the issues. For further information, please refer to Section 17: Resolution of Disputes and Grievances in this manual.

- **When can I bill an Alliance member for unpaid service?**

  You may not bill an Alliance member for any unreimbursed amount, including a deductible/co-insurance or copay amount, unless one of the following exceptions applies:

  - The member has an unmet monthly Medi-Cal share-of-cost amount.
  - The member does not disclose their Alliance/Medi-Cal coverage.
  - The member consents to receive services that are not covered by the Alliance.
  - The member chooses to see a physician/provider who does not accept Medi-Cal or is not a Medi-Cal provider.
  - The member waives their Medi-Cal benefits.
  - The member does not obtain or access primary insurance benefits correctly.

  Note also that, unless you have provided benefits to the member according to the primary insurance authorization/benefit requirements, you may not charge the Alliance member for the service.

Section 11
Care Management Services

Continuum of Health Care Management

The Alliance's Community Care Coordination team works with members and PCPs/providers to provide basic population health management (BPHM) services and supports to improve and/or maintain health and quality of life. All members receive BPHM regardless of their current health and social status. For members identified as having medium/rising or high-risk health/social needs, complex care management or ECM/CS services may be offered. The multidisciplinary team consists of experienced nurses, medical social workers, and care coordinators, who collaborate with the PCP and specialty providers to provide coordinated care through the Patient Centered Medical Home (PCMH). The team's main focus is to improve quality of life through the promotion of realistic self-care goals and management of chronic health conditions. Care Management services are voluntary and available to all eligible Alliance members at no cost to them. Members who do not wish to participate in the program can opt out at any time.

The team works with members and their PCPs by:

- **Facilitating** optimal connections between the PCP and the member
- **Educating** members on a variety of health-related topics, including appropriately navigating the health care and social systems
- **Empowering** members to take charge of their own health care needs
- **Linking** members to available community resources, including Community Supports

Complex Care Management

The Alliance Complex Care Management (CCM) team partners with the PCP and specialists to support members with medium/rising risk stratification in managing their acute or chronic condition(s). This may include intense coordination of resources from the multidisciplinary team to ensure the member regains optimal health or improved functionality, according to NCQA standards for CCM. After comprehensive assessments, individualized person-centered care plans are created with the involvement of the care team, member, and member support system. The support may include services that address emotional, physical, and social support needs.

The Complex Care Management Team collaborates with you as the PCP to provide the following services:

- Comprehensive assessments
- Promotion of the PCMH by fostering the member-PCP relationship
- Care coordination
- Promotion of self-management through engagement
- Linkage to community and social support resources

- Creation of mutually agreed upon care plans, including targeted interventions
- Engagement of members telephonically and in-person
- Support across the health care continuum
- Management of a member's CCS eligible condition and care

What is suitable for referral to Complex Care Management Services? *(Note: this is not an all-encompassing list)**:***

Complex Care Management

- Newly diagnoses life limiting disease
- A physical health condition and severe mental illness of substance use disorder
- Poorly controlled diseases states with high utilization
- Multiple comorbidities

And two or more of the following needs:

- Compliance with treatment plan
- Care coordination
- Patient education
- Community Resources
- PCP connection
- Social determinants of health

What is not suitable for referral to Complex Care Management Services? *(Note: this is not an all-encompassing list)**:***

- Members with disruptive, violent, or abusive behaviors
- Members who are unable to be reached or who refuse to participate
- Members in long-term care

For additional information about Complex Care Management, please see the following policies:

- Policy 405-1313 – Adult Complex Case Management
- Policy 405-1318 – Pediatric Complex Case Management

Basic Population Health Management (BPHM)

BPHM includes access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the new CHW benefit, health and wellness programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under EPSDT Basic Case Management is provided by PCPs. Case Management, as defined by the California Department of Health Care Services (DHCS),

is "guiding the course of resolution of a personal medical problem (including the problem of the need for health education, screening or preventive services) so that the recipient is brought together with the most appropriate provider at the most appropriate times, in the most appropriate setting." It is essentially a program that enables providers and caregivers to identify members with ongoing health care needs, so that an effective plan may be developed that enables the efficient use of health care resources -- with a goal of achieving the best possible health outcomes.

Four requirements are necessary for the BPHM system to function:

1. Members receiving basic case management must be assigned to a PCP.
2. Through prior authorization, PCPs will refer members directly to all necessary services, with the exceptions of Emergency, Limited Allied Services (Medi-Cal line of business only), OB-GYN and certain family planning services that qualify for self-referral.
3. PCPs in either individual or group practice — and in private and/or public settings — will be geographically located throughout Santa Cruz, Monterey, Merced, Mariposa, and San Benito counties to facilitate members' access to health care services.
4. The objectives of BPHM are:
    - To foster continuity of care -- as well as good relationships -- between providers and members.
    - To coordinate the care of Alliance members so that satisfactory health outcomes are achieved.
    - To contribute to a decreased use of hospital ERs as a source for non-emergency, first contact and urgent medicine by our members.
    - To reduce the incidence of members' unnecessary self-referral to specialty providers.
    - To discourage medically inappropriate use of pharmacy and drug benefits by our members.
    - To facilitate members' understanding and use of disease-prevention practices and early diagnostic services.
    - To provide a structure within which our providers can manage members' health care services in a manner that ensures a high quality of care delivered in a cost-effective manner.

For complete details on physician case management responsibilities, please see Policy 405-1312 – Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.

Transitional Care Services (TCS)

Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings. The following elements are included in Transitional Care Services:

- Coordination of Admissions, Discharges, and Transfers
- Plan support with Prior Authorizations and Timely Discharges

- Single point of contact that is responsible for ensuring completion of all transitional care management.
- Coordinating and verifying that members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations.
- Ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions.
- Ensuring needed post-discharge services are provided, and follow-ups are scheduled, including but not limited to follow-up provider appointments, SUD and mental health treatment initiation, medication reconciliation, referrals to social service organizations, and referrals to necessary at-home services.
- Referrals and coordination with community resources and services, including other Case Management programs, Local Education Agencies, Regional Centers, etc.

Common support that the Care Coordination Team assist members with are:

- Follow-up care with specialists, including referrals for ancillary services and Durable Medical Equipment (DME)
- Assistance with making appointments and retrieval of medical records
- Appointment reminders and linkage to transportation resources
- Assessments of members requesting Community Based Adult Services (CBAS)

For information or referrals to Care Management Services, including Complex Care Management and Care Coordination, please call the Case Management Line at 800-700-3874, ext. 5512.

Care Management Support for Members with Disabilities or Special Needs

Children with Special Health Care Needs

The Alliance pediatric Complex Care Management team helps members and their parents/guardians with obtaining the care and services that are needed. Case Management and Care Coordination support are offered to all members who are enrolled in the CCS program. Complex Care Management is offered to Alliance pediatric members who have been identified as having medium/rising risks based upon risk stratification.

For more information on children with special health care needs, please see Policy 405-1315 – Children with Special Health Care Needs (CSHCNs).

Individuals with Disabilities

The Community Care Coordination team coordinates services and helps members obtain the equipment they need.

Members with Developmental Disabilities: Medi-Cal

During the Initial Health Appointment performed when enrolling new members into your practice, providers will identify those who have, or are at risk of acquiring, developmental delays or disabilities; this includes signs and symptoms of intellectual disability, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to intellectual disability or requiring treatment similar to that required for individuals with intellectual disability. Additionally, developmental screening is a part of each well-baby and well-child visit.

A *developmental disability* is a disability attributable to an intellectual disability, cerebral palsy, epilepsy, autism, or other conditions similar to an intellectual disability that originates before the age of 18 years, is likely to continue indefinitely, and constitutes a significant handicap for the individual. A *developmental delay* is impairment in the performance of tasks or the meeting of milestones that a child should achieve by a specific chronological age.

The Alliance is required to cover all medically necessary and appropriate developmental screenings, primary preventive care, diagnostic and treatment for members who (a) have been identified or are suspected of having developmental disabilities; and (b) are at high risk of parenting a child with a developmental disability. The Alliance works with PCPs and specialists to ensure that members with developmental disabilities receive all medically necessary screening, preventive, and therapeutic services as early as possible and determines medical necessity for covered services.

Such members are referred to the appropriately funded agency, such as the Local Education Agencies (LEA), the San Andreas Regional Center (SARC) in Santa Cruz, San Benito and Monterey Counties, and the Central Valley Regional Center (CVRC) in Mariposa and Merced Counties. SARC and CVRC are part of a statewide system of locally based regional centers that offer supportive services programs for California residents with developmental disabilities. Regional centers provide intake and assessment services to determine client eligibility and needs and work with other agencies to provide the full range of early intervention services. Local regional centers can provide specific information on the services available in the member's service area. Services include respite day programs, supervised living, psychosocial and developmental services, and specialized training.

Members with developmental disabilities are linked to a PCP, who provides them with all appropriate preventive services and care, including necessary Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Preventive care is provided per the current guidelines of the American Academy of Pediatrics Bright Futures and the United States Preventive Services Task Force for Adults. PCPs are required to provide or arrange for medically necessary care to correct or ameliorate developmental disabilities and provide/arrange for all medically necessary therapies and items of durable medical equipment within the scope of their practices. For those necessary services that are beyond the scope of their practices, PCPs should make the necessary referrals and coordinate with the appropriate funding agency.

PCPs should collaborate in the development of a child's IEP (the school district's Individualized Education Plan), IFSP (the Regional Center's Individual Family Service Plan), or IPP (the Regional Center's Individual Program Plan), when applicable. PCPs should monitor and coordinate all medical services with Regional Center Staff, when applicable.

Contact information for the local regional center field offices in Santa Cruz, Monterey and Merced Counties:

SARC Santa Cruz Field Office	**SARC Monterey Field Office**	**CVRC Merced Field Office**
1110 Main Street Watsonville, CA 95076 Phone: 831-900-3737 Fax: 831-498-9844	1370 South Main Street Salinas, CA 93901 Phone: 831-900-3636 Fax: 831-424-3007	3172 M Street Merced, CA 95348 Phone: 209-723-4245 Fax: 209-723-2442

SARC San Benito County	**Central Valley Regional Center**
6203 San Ignacio Avenue, Suite 200 San Jose, CA 95119 Phone: 408-374-9960 Fax: 408-281-6960	4615 North Marty Avenue Fresno, CA 93722 Phone: 559-276-4300 TTY: 559-276-4441 Fax: 559-276-4360

For additional information about patients with developmental disabilities and the use of regional centers, please see the following policies:

- Policy 405-1304 – Developmental Disabilities – Services to Plan Members
- Policy 405-1317 – Early Intervention Services
- Policy 405-1315 – Children with Special Health Care Needs (CSHCNs)

Coordination of Care: Medi-Cal and Alliance Care IHSS

As a PCP, you are part of the interdisciplinary team supporting the member's medical, as well as psychosocial and environmental needs. Screening, preventive, and medically necessary and therapeutic services that are covered benefits will continue to be covered by the Alliance.

The Alliance will continue to provide for normally covered medical services for members receiving services related to CCS, from San Andreas Regional Center (SARC), Central Valley Regional Center (CVRC), or the Early Start Program and will coordinate with the PCP and the designated center to assist with the development of a care plan, or in meeting the care plan that has been developed.

The Alliance maintains Memoranda of Understanding (MOU) with the SARC, CVRC, Santa Cruz County Health Services Agency, Monterey County Health Services Department, San Benito County Health and Human Services Department, Mariposa County Public Health and Merced County Department of Public Health. An MOU is an agreement that delineates how two entities will coordinate the provision of covered and/or public health services, as appropriate. The MOU also delineates the roles and responsibilities of each agency related to specific public health services.

Enhanced Care Management and Community Supports

Enhanced Care Management

As of January of 2022, the Alliance began offering Enhanced Care Management (ECM) services consistent with Medi-Cal benefit guidelines.

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Alliance members through systematic coordination of services and comprehensive, community-based care management. ECM is part of a broader population health system design within CalAIM.

ECM is one of the components of the state's CalAIM efforts. CalAIM is a multi-year initiative led by the Department of Health Care Services (DHCS) that aims to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing delivery system and payment reforms across the program. CalAIM leverages Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents and takes a person-centered approach that targets social determinants of health and reduces health disparities and inequities.

Target Populations Eligible to Receive ECM

ECM will be provided the following populations of focus:

1. Individuals and families that are experiencing homelessness with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.
2. Adults at risk for avoidable hospital or ED utilization: Adults with 5 or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; And/or 3 or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
3. Children and Youth At Risk for Avoidable Hospital or ED Utilization: Children and youth who meet one or more of the following conditions: Three or more emergency room visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; and/or Two or more unplanned hospital and/or short-term SNF stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
4. Adults with Serious Mental Illness and/or Substance Use Disorders: Adults who meet the eligibility criteria for participation in or obtaining services through:
    - The County Specialty Mental Health (SMH) System; AND/OR
    - The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program; AND
    - Are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the

community, history of ACEs, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors); AND

- Meet one or more of the following criteria:
    - High risk for institutionalization, overdose and/or suicide;
    - Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care;
    - Two or more ED visits OR two hospitalizations due to SMI or SUD in the past 12 months;
    - Pregnant and post-partum women (12 months from delivery).

5. Children and Youth with Serious Mental Health and/or SUD Needs

   Children and youth who meet the eligibility criteria for participation in or obtaining services through one or more of: (i) SMHS delivered by MHPs; (ii) The DMC-ODS OR the DMC program. No further criteria are required to be met for children and youth to qualify for this ECM Population of Focus.

6. Adults Living in the Community who Are at Risk for LTC Institutionalization

   - Adults living in the community who meet the Skilled Nursing Facility (SNF) Level of Care criteria;
   - OR who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;
   - AND are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring),
   - AND (3) are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

7. Nursing Facility Residents Transitioning to the Community

   - Nursing facility residents who are:
       - Interested in moving out of the institution;
       - Are likely candidates to do so successfully; and
       - Able to reside continuously in the community

8. Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition

   Children and youth who: 1. Are enrolled in CCS or CCS WCM; and 2. Are experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health and/or substance use symptoms.

9. Children and Youth Involved in Child Welfare Children & Youth

   Children and youth who meet one or more of the following conditions: 1. Are under age 21 and are currently receiving foster care in California; 2. Are under age 21 and previously received foster care in California or another state within the last 12 months; 3. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; 4. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program; 5. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.

10. Pregnancy, Postpartum and Birth Equity Population of Focus (Adults and Youth)

    Pregnancy, Postpartum and Birth Equity Population of Focus (Adults and Youth) Adults and youth who: (1) Are pregnant OR are postpartum (through 12 months period); AND (2) Qualify for eligibility in any other adult or youth ECM Population of Focus

11. Adults with an I/DD Adults

    Adults with an I/DD Adults who: (1) Have a diagnosed I/DD; AND (2) Qualify for eligibility in any other adult ECM Population of Focus

12. Children and Youth with an I/DD

    Children and youth who: (1) Have a diagnosed I/DD; AND (2) Qualify for eligibility in any other children and youth ECM Population of Focus

    Adults Transitioning from Incarceration

    Adults transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) or transitioned from correctional facility within the past 12 months; AND have at least one of the following conditions: Mental illness, SUD, Chronic Condition/Significant Non-Chronic Clinical Condition, Intellectual or Developmental Disability (I/DD), Traumatic Brain Injury (TBI), HIV/AIDS, or Pregnant or Postpartum.

13. Children and Youth Transitioning from a Youth Correctional Facility

    Children and youth who are transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months. 32 No further criteria are required to be met for Children and Youth to qualify for this ECM Population of Focus.

Eligibility will be expanded to additional populations in accordance with Medi-Cal guidelines.

ECM Core Services

ECM contracted Providers will offer the following services to qualifying members:

- Outreach and Engagement
- Comprehensive Assessment and Care Management Planning
- Enhanced Coordination of Care
- Health Promotion Activities
- Comprehensive Transitional Care Planning
- Member and Family Supports
- Coordination of and Referral to Community and Support Services

Making a Referral for ECM

Referrals for ECM may be made by a physician, the member or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Services provider. More information on ECM referrals can be found on the ECM/CS page of the Alliance provider website.

There are three ways to submit ECM referrals:

1. Submit a ***referral form***.

   ECM forms:

   - Adult ECM Provider Referral Form (age 21 and over)
   - Youth ECM Provider Referral Form (age 20 and under)

2. Submit a ***TAR form*** requesting the services via fax.

   Attach appropriate documentation with your submission. The fillable TAR form is available on the ECM/CS Provider Referrals page of the Alliance provider website and here.

3. Submit an authorization through the ***Provider Portal***.

   - Reason for Request: *ECM*
   - Service Type: *Enhanced Care Management*
   - Code Type: *CUS*
   - Service Code: *ECM02 ECM Enrolled in Services*

     *Note that ECM01 for ECM Outreach does not require authorization.

ECM Authorizations

Authorization through the Alliance is required for members to enroll in ECM services. Alliance staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to the Alliance to determine eligibility. The authorization process entails eligibility screening,

identification of a lead ECM case manager, member consent to receive ECM services, and decision-making by the Alliance. If approved after the Alliance assessment, the members may receive ECM services. Reauthorization is required every 12 months by submitting an Authorization Request to the Utilization Management Department, along with necessary documentation for review. Documentation for the reauthorization may be submitted through the care coordination platform.

ECM Encounter Requirements

ECM Providers are required to provide ECM services to each of their assigned members at least once per month. ECM Providers are also required to provide the Alliance with encounter data within 30 days of the encounter occurring to ensure that the Alliance can comply with DHCS requirements for oversight of the ECM benefit. Encounter data is tracked through submitted claims. ECM Providers should aim for a 90% compliance rate with submission of monthly encounter claims.

For more information regarding ECM Encounter Submission requirements, see Policy 300-4175 – Enhanced Care Management Encounter Data.

Discontinuing ECM Services

The ECM Provider will notify the Alliance to discontinue ECM for members when any of the following circumstances are met:

1. The Member has met all care plan goals.
2. The Member is ready to transition to a lower level of care.
3. The Member no longer wishes to receive ECM.
4. The ECM Provider has not been able to connect with the Member after multiple attempts
5. Incarcerated
6. Declined to participate
7. Enrolled in a duplicative program
8. Lost Medi-Cal coverage
9. Switched health plans
10. Moved out of the county
11. Moved out of the country
12. Unsafe behavior or environment
13. Member not reauthorized for ECM services
14. Deceased
15. Other

If the member is discontinued from ECM during a current authorization period, the ECM provider will submit a PCR or complete a Disenrollment Form. For more information on ECM, please see Policy 405-1308 – ECM Overview and Policy 405-1309 – ECM Core Services.

Community Supports

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations, and the Alliance has elected to offer some Community Support services.

Community Supports are optional services for the Alliance to offer and are optional for members to receive. As of January 1, 2024, the Alliance offers the following Community Supports:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Medically Tailored Meals
- Sobering Center (Merced and Monterey County only)
- Recuperative Care
- Short Term Post Hospitalization Housing
- Environmental Accessibility Adaptations/Home Modifications
- Respite Services for Caregivers
- Personal Care and Homemaker Services
- Sobering Centers (Available in Monterey and Santa Cruz Counties)
- Asthma Remediation (Will begin January 2025)

Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members. Community Supports will typically be provided by community-based organizations and providers. ECM Providers may also serve as Community Supports Providers, if they have appropriate experience.

Members Eligible to Receive Community Supports

The Alliance must determine eligibility for a pre-approved Community Supports using the DHCS Community Supports definitions, which contain specific eligibility criteria for each Community Supports. The Alliance is also expected to determine that a Community Supports is a medically appropriate and cost-effective alternative to a Medi-Cal Covered Service. When making such determinations, the Alliance must apply a consistent methodology to all members within a particular county and cannot limit the Community Supports only to individuals who previously were enrolled in the WPC Pilot. Some Community Supports are once in a lifetime, or have specific funding caps.

Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

For continuity of care those community supports services that were offered by San Benito and Mariposa County will continue to be offered to San Benito and Mariposa County residents that were previously receiving Community Support services that are not currently being offered within the Alliance's service area.

The sections below are the service definitions for the approved Community Supports within the Alliance's service area.

Housing Transition Navigation Services

Housing transition services assist Members with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the member's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as HUD's Housing Choice Voucher Program (Section 8), or state and local assistance programs) and matching available rental subsidy resources to Members. This community support does not cover direct rent payments or assistance, only assistance finding and applying for other programs that may do so.
7. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the Member with landlords.
12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations Community Support).

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access only a subset of the services listed above. Only one household member will be authorized for Housing Transition and Navigation Services unless the individualized housing support plans indicate a significant difference in needs for the members in the household.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing providers, local housing agencies, and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full-Service Partnership Members) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted Community Supports providers.

Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation Services Community Support. Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Housing Deposits

Housing Deposit is a once in a lifetime benefit to assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Housing Tenancy and Sustaining Services

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights, and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).
13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above. Only one household member will be authorized for Housing Tenancy and Sustaining Services unless the individualized housing support plans indicate a significant difference in needs for the members in the household.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy. Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless serving to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Support.

Services do not include the provision of room and board or payment of rental costs.

Short-Term Post-Hospitalization Housing

Short-Term Post-Hospitalization Housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of State plan services.

This setting must provide individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports such as Housing Transition Navigation.

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Members must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization Housing.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Recuperative Care (Medical Respite)

Recuperative Care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative Care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to Members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other available housing Community Supports should be provided to Members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care

Respite Services

Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who

normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. Respite Services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the Member in their own home or another location being used as the home.

Facility Respite Services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Personal Care and Homemaker Services

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Includes services provided through the In-Home Supportive Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

The Personal Care and Homemaker Services Community Support can be utilized:

1. Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
2. As authorized during any In-Home Supportive Services waiting period (Member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
3. For Members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Service

Environmental Accessibility Adaptations (Home Modifications)

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization. Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist Members in accessing the home;
- Doorway widening for Members who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and
- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as a Community Support, the managed care plan must receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

The managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
    a. An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;
    b. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and

c. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and
3. That a home visit has been conducted to determine the suitability of any requested equipment or service. The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Medically Tailored Meals/Medically-Supportive Food

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among Members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved Member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status, and increased Member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.
2. Medically Tailored Meals: meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically Tailored meals are tailored to the medical needs of the Member by a Registered Dietitian (RD), reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.
4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.
5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

For more information on Medically Tailored Meals/Medically Supportive Foods, please see Policy 404-1745 – Medically Tailored Meals/Medically Supportive Foods.

Sobering Centers

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and

warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Making a Referral for Community Supports

Referrals for Community Supports may be made by a physician, an Alliance member or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Supports provider. More information on CS referrals can be found on the ECM/CS page of the Alliance provider website.

There are three ways to submit CS referrals:

1. Submit a ***referral form***.

   CS forms:

   - CS Housing Form
   - CS Environmental Accessibility and Adaptability Form
   - CS Meals Form
   - CS Personal Care and Home Maker Services and Respite Services for Caregivers Form

2. Submit a ***TAR form*** requesting the services via fax.

   Attach appropriate documentation with your submission. The fillable TAR form is available on the ECM/CS Provider Referrals page of the Alliance provider website and here.

3. Submit an authorization through the ***Provider Portal***.

   - Reason for Request: *ECM CS*
   - Service Type: *Community Supports*
   - Codes to use on Auths:
     - Transition/Navigation: **CS02** Housing Transition/Navigation Services per Month
     - Tenancy/Sustaining: **CS01** Housing Tenancy/Sustaining Services per Month

- Housing Deposits: **CS03** Housing Deposits
- Medically Tailored Meals:
    a. **S5170** Home Delivered Meals, Including Preparation; Per Meal (Not Payable By Medicare)
    b. **S9977** Meals, Per Diem, Not Otherwise Specified (Not Payable By Medicare)
    c. **S9470** Nutritional Counseling, Dietitian Visit (Not Payable By Medicare)
- Environmental Accessibility Adaptations: **CS06** Environmental Accessibility Adaptations
- Respite Services for Caregivers: **CS07** Respite Services Per Hours
- Personal Care / Homemaker Services: **CS08** Personal Care / Homemaker Services Per 15 Minutes
- Sobering Center: **H0014** Alcohol And/Or Drug Services; Ambulatory Detoxification (Not Payable By Medicare)

Community Supports Authorizations

Authorization through the Alliance is required for members to obtain Community Supports, except for Sobering Centers. Alliance staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to determine eligibility. The authorization process entails eligibility screening, completion of a Member Care Plan by the ECM Provider (if receiving ECM services), and decision-making by the Alliance. If approved after the Alliance assessment, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime. Utilization management procedures will consider the goals of each Community Supports and the Alliance will not categorically deny or discontinue a Community Supports irrespective of member outcomes or circumstance. Community supports requests that are inherently time-sensitive will be accepted and reviewed by the Alliance as post service requests to avoid delays or disruptions in member services, examples of Community Supports that will be processed post service include, but are not limited to, Recuperative Care, and Medically Tailored Meals post-acute care, as outlined in Policy 404-1201 – Authorization Request Process.

Some Community Supports will require periodic reauthorization by submitting an Authorization Request to the ECM/CS team, along with any necessary documentation for review. Documentation for the reauthorization may be submitted through the Provider Portal, a TAR form, or provider referral form.

Community Supports Service Delivery Notification

Provider shall immediately notify plan in writing if there is a disruption or anticipated disruption that will impact service delivery to members during an approved authorization timeframe. Providers must notify the Alliance within 48 hours of the identified disruption. This notification should include the date the disruption occurred and potential end date of disruption of services. The Alliance will work with the provider to submit any additional documentation including a PCR if needed.

Discontinuing Community Supports Services

Housing Community Supports are ongoing services that must be discontinued when services end. For these Community Supports, the Community Supports Provider will notify the Alliance to discontinue Community Supports for members when any of the following circumstances are met:

1. The Member has met all care plan goals.
2. The Member is ready to transition to a lower level of care.
3. The Member no longer wishes to receive Community Supports.
4. The Community Supports Provider has not been able to connect with the Member after multiple attempts.
5. The Member is incarcerated.
6. The Member declined to participate.
7. The Member enrolled in a duplicative program.
8. The Member lost Medi-Cal coverage.
9. The Member switched health plans.
10. The Member moved out of the county.
11. The Member moved out of the country.
12. The Member exhibited unsafe behavior or environment.
13. Member is not reauthorized for Community Supports services.
14. The Member is deceased.
15. Other

If the member is discontinued from Community Supports during a current authorization period, the Community Supports provider will submit a PCR or complete a Disenrollment Form.

For more information on Community Supports, please see Policy 405-1310 – Community Supports Overview and Policy 300-4185 – Community Supports Encounter Data.

Section 12
Chronic Disease Management Programs

The Alliance Chronic Disease Management Programs are designed to engage members diagnosed with diabetes, asthma, or other chronic health conditions and provide self-management tools to manage their condition(s). The ultimate goals are to improve patients' current health status, achieve optimal health outcomes, and to avoid future complications of chronic disease(s).

Alliance Chronic Disease Management Programs

The Alliance offers the following programs to support members diagnosed with chronic disease(s):

- **Healthier Living Program (HLP):** The HLP is a series of self-management workshops designed to help adult members diagnosed with chronic disease(s) such as cardiovascular disease, asthma, anxiety, depression or any other chronic disease(s). The HLP utilizes an evidence-based self-management program originally developed at Stanford University. The program is delivered as a 6-week workshop series. Workshops are offered in multiple modalities to encourage access including sessions offered via telephone calls, virtual classes and in-person classes.
- **Live Better with Diabetes (LBD) Program:** The LBD is a series of self-management workshops designed to help adult members diagnosed with diabetes and prediabetes. The LBD utilizes an evidence-based self-management program originally developed at Stanford University. The program is delivered as a 6-week workshop series. Workshops are offered in multiple modalities to encourage access including sessions offered via telephone calls, virtual classes and in-person classes.

Referring Members to Health Programs

To refer an Alliance member to one of the Health Programs, please complete the Health Programs Referral Form (from the Health Education and Disease Management page) on the Alliance provider website. Providers and members may also call the **Alliance Health Education Line at 800-700-3874, ext.5580** for more information.

Section 13
Health and Wellness Programs

The Alliance offers a variety of culturally and linguistically appropriate health and wellness programs to Alliance members at no charge. For information, please visit the Alliance Health Education and Disease Management page on the Alliance provider website. Providers and members may also call the **Alliance Health Education Line at 800-700-3874, ext.5580** for more information.

Alliance Health and Wellness Programs

The Alliance offers the following programs to support members:

Healthy Weight for Life Program: is available for parents or guardians of Alliance members ages 2–18 who are at-risk or diagnosed with childhood obesity. The program is offered in a 10-week workshop format for the parents or guardians. There is no cost for Alliance members to participate. Workshops are conducted in English and in Spanish. Members can be referred by their PCP, Alliance staff, or members can self-refer.

Adult Weight Management Program: Available for adult members 18 years or older. The program provides access and support with participation in the WeightWatchers program. Adult members at-risk or diagnosed with obesity can participate. This program is not a Medi-Cal benefit, but an Alliances covered service. Members can be referred by their PCP or Alliance staff, or members can self-refer. Only members with the Alliance as their primary insurance can participate.

Healthy Moms and Healthy Babies Program: Available for members that are pregnant or postpartum to provide resources and support for a healthy pregnancy and healthy postpartum outcomes. Members are provided information on a variety of topics, including breastfeeding, pediatric care, prenatal and postpartum health, and parenting. Members also receive referrals to local resources, including Women, Infants and Children (WIC) and free or low-cost community resources.

Breastfeeding Support and Breast Pumps: The Healthy Moms and Healthy Babies program will provide members breastfeeding support referrals to the Women, Infants and Children (WIC) program.

The Alliance covers breast pumps for new moms see Policy 600-1006 – Breast Pumps and Coordination of Benefits.

Tobacco Cessation Support Program: The Alliance is committed to supporting members who wish to stop smoking and/or using tobacco products. The Tobacco Cessation Support Program (TCSP) offers members referrals to Kick It California at 800-300-8086, which provides free cessation counseling over the phone for anyone in California. Members can be referred by their PCP or Alliance staff, or members can self-refer.

Referring Members to Health Programs

To refer an Alliance member to one of the Health Programs, please complete the Health Programs Referral Form (from the Health Education and Disease Management page) on the Alliance provider website. Providers and members may also call the **Alliance Health Education Line at 800-700-3874, ext.5580** for more information.

Women's Health

The Alliance encourages providers to perform routine screening for chlamydia, cervical cancer and breast cancer, as well as to educate women on the importance of routine breast self-exams. The Alliance provides monthly and quarterly reports via the Provider Portal to assist in monitoring women who may be due for these screenings.

Health Education Materials

If providers are in need of resources for health education materials for members, the Alliance maintains a DHCS approved vendor list for health education materials. The vendors are approved for readability and suitability for Med-Cal populations. Materials are available in English and Spanish; materials in Hmong, Braille, large font and audio files can be made available upon request. For assistance, please contact the Alliance Health Education Line at 800-700-3874, ext. 5580.

Materials In Different Languages

The Alliance can provide a brief list of translation agencies, should you choose to have your own English materials translated into other languages.

Outreach to Members and Providers

The Alliance reaches out to providers and members on a regular basis to encourage health maintenance, disease prevention, and a healthy lifestyle. Following are some of the tools the Alliance utilizes in the outreach program:

- *Living Healthy,* quarterly Member Newsletter.
- Health Programs and Cultural and Linguistic updates in the quarterly *Alliance Provider Bulletin*.
- The provider website with health programs and Cultural and Linguistic services and resources for both providers and members.

Section 14
Quality and Performance Improvement Program

The Alliance Quality and Performance Improvement Program (QPIP) exists to assure and improve the quality of care for Alliance members, in fulfillment of state and federal requirements, and incorporates various best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) as deemed appropriate.

Quality Improvement & Health Equity Transformation Program (QIHETP) Goals

The goal and objective of the QIHETP is objectively and systematically monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity. Goals and objectives of the QIHETP include:

- Quality and safety of healthcare and services the Alliance's provider network provides:
    - Incorporate provider and other appropriate professional involvement in the QIHETP through review of findings, study outcomes, and on-going feedback for program activities
    - Conduct facility site reviews/medical record reviews at provider sites and reviewing quality issues or trends referred for further investigation and follow-up actions
    - Develop and maintain a high-quality provider network through credentialing, re-credentialing, and peer review processes
    - Maintain an ongoing oversight process by incorporating performance metrics of QIHETP-related functions performed by practitioners, providers, and delegated or independently contracted/sub-contracted delegates
    - Ensure that care and resources are available, appropriate, accessible, and timely for all members according to standards of care and evidence-based practices
    - Mechanisms to detect both over/underutilization of services, but not limited to, outpatient prescription drugs. Refer to Policy 404-1108 – Monitoring of Over/Under Utilization of Services.
- Quality of services the Alliance provides to its members, providers, the community, and internal staff:
    - Align quality improvement activities with activities that promote the continuous development of a provider network that meets member needs, such as the annual Access Plan
    - Implement innovative practices, such as telephonic or virtual means, to ensure that members obtain care which is timely and meets their needs
    - Utilize data-driven approaches and effective analysis, implementation, and evaluation towards improved clinical outcomes, services, and experiences
    - Ensure care is provided regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or

physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and linguistically appropriate manner

- Identify population-based strategies to identify, evaluate, and reduce healthcare disparities through analysis, equity-focused interventions, and meeting disparity reduction targets
- Provide access to services and communication in alternate formats to ensure non-discrimination of members as defined in Section 1557 of the Patient Protection and Affordable Care Act
- Provide education regarding accessing the health care system and support on obtaining care and services when needed
- Resolve concerns quickly and effectively, including the right to voice complaints or concerns without fear of discrimination
- Engage in the discussion about services, regardless of cost or benefit coverage
- Instill confidence that the Alliance can be reached quickly and will provide satisfactory information.
- Maintain Member confidentiality in quality improvement discussions.

- Members' experience of care and service provided by the Alliance and its contracted providers:
  - Monitor member satisfaction with quality of care and services received from network providers, practitioners and delegates and acting upon identified opportunities
  - Obtain information on member's values, needs, preferences, and health-related goals through feedback mechanisms and touch points, such as surveys, focus groups, member outreach, care management, and other means
  - Establish population health programs to empower and encourage members to actively participate in and take responsibility for their own health through the provision of health education, evidence-based tools, and shared goals for optimal health
  - Create a trusted health care system to assure feelings of safety, self-efficacy, and effective communication with all their care partners
  - Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all members; Integrate with current community health priorities, standards, and public health goals

The Quality Improvement Health Equity Committee (QIHEC) is the contractually required quality improvement committee with oversight and performance responsibility of the QHIETP — excluding credentialing/recredentialing activities, which are directed by the PRCC. Annually, the QIHEC reviews and approves QHIETP and Utilization Management Program policies (Policy 401-1101 – Quality Improvement & Health Equity Transformation Program (QIHETP) and Policy 401-1305 – Provider Preventable Conditions) and work plans [the Quality Improvement Health Equity Work Plan (QIHE-WP) and Utilization Management Work Plan (UMWP)]. Once approved, the QIHEC monitors QIWP and UMWP activities quarterly, ensuring implementation of interventions and re-measurement of performance goals and benchmarks.

For more information about the QHIETP, please see Policy 401-1101 – Quality Improvement & Health Equity Transformation Program (QIHETP).

Member Satisfaction Surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Consumer Assessment of Healthcare Providers and Systems (CAHPS) was developed by the Agency for Healthcare Research and Quality (AHRQ) to advance understanding of patient experience with healthcare. The Department of Health Care Services (DHCS) conducts the CAHPS survey every two years, but the Alliance contracts with a vendor to conduct the survey every year to have an understanding of our member's satisfaction with healthcare.

CAHPS is considered the national standard for measuring member's experience related to the Health Plan and its services. This also includes member's experience with interacting with providers and staff, as well as health care facilities.

The survey measures child and adult experiences. The child surveys are completed by the parent/guardian on behalf of the child. The survey includes the following measures:

- Rating of the Health Plan
- Getting Needed Care
- Getting Care Quickly
- Health Plan Customer Service
- How Well Doctors Communicate
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Care

For additional information on CAHPS please visit the AHRQ website at https://www.ahrq.gov/cahps/about-cahps/index.html. Please refer to the Alliance's Member Satisfaction Tool Kit for additional resource information.

Healthcare Effectiveness Data and Information Set (HEDIS)

The Alliance is contractually required by the California State Department of Healthcare Services (DHCS) to perform a quality measure audit that complies with DHCS' Managed Care Accountability Set (MCAS). The MCAS aligns with Centers for Medicare and Medicaid Services'(CMS) Child and Adult Core Sets, as well as with the National Committee for Quality Assurances' (NCQA) Healthcare Effectiveness Data Information Set (HEDIS) quality measures. The audit assesses how well the Alliance network is providing services to our members, while ensuring accurate and reliable measurement.

HEDIS Measurement Year (MY) 2024

The Alliance's Quality Improvement Population Health Department is preparing for the upcoming season by reviewing current rates and possible target areas for improvement. This is accomplished by evaluating Administrative Data consisting of claims, pharmacy, immunization registry, provider submitted data and other supplemental data.

Hybrid/Administrative measures are subject to medical record review. If these measures are not identified as compliant through administrative data, the Alliance may request specific medical records from clinics to establish additional measure compliance.

The DHCS MCAS for Measurement Year 2024 (MY 2024) includes a total of 41 measures. The Alliance is held to the NCQA 50th Percentile benchmark for 18 of these measures. Should the Alliance fall beneath the benchmark in any measures, it may be subject to economic sanctions and corrective action plans.

Please see below the comprehensive list of MY 2024 draft MCAS measures available at the time of this publication.

MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL[i]
Behavioral Health Domain Measures				
Follow-Up After ED Visit for Mental Illness – 30 days[*, iv]	FUM	NCQA	Administrative	Yes
Follow-Up After ED Visit for Substance Abuse – 30 days[*]	FUA	NCQA	Administrative	Yes
Children's Health Domain Measures				
Child and Adolescent Well-Care Visits[*]	WCV NCQA	NCQA	Administrative	Yes
Childhood Immunization Status – Combination 10[*]	CIS-10	NCQA	Hybrid/Admin[**]	Yes
Developmental Screening in the First Three Years of Life	DEV	CMS	Administrative	Yes[iii]
Immunizations for Adolescents – Combination 2[*]	IMA-2	NCQA	Hybrid/Admin[**]	Yes
Lead Screening in Children	LSC	NCQA	Hybrid/Admin[**]	Yes
Topical Fluoride for Children	TFL-CH	DQA	Administrative	Yes[iii]
Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	NCQA	Administrative	Yes
Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits[*]	W30-2+	NCQA	Administrative	Yes

MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL[i]
Chronic Disease Management Domain Measures				
Asthma Medication Ratio*	AMR	NCQA	Administrative	Yes
Controlling High Blood Pressure*, iv	CBP	NCQA	Hybrid/Admin**	Yes
Glycemic Status Assessment for Patients with Diabetes (>9%)*, iv	GSD	NCQA	Hybrid/Admin**	Yes
Reproductive Health Domain Measures				
Chlamydia Screening in Women	CHL	NCQA	Administrative	Yes
Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	NCQA	Hybrid/Admin**	Yes
Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	NCQA	Hybrid/Admin**	Ye
Cancer Prevention Domain Measures				
Breast Cancer Screening*	BCS-E	NCQA	ECDS	Yes
Cervical Cancer Screening	CCS	NCQA	Hybrid/Admin**	Yes
Report Only Measures to DHCS				
Adults' Access to Preventive/Ambulatory Health Services[iv]	AAP	NCQA	Administrative	No
Colorectal Cancer Screening*	COL-E	NCQA	ECDS	No^^
Contraceptive Care – All Women: Most or Moderately Effective Contraception	CCW-MMEC	CMS	Administrative	No
Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	CMS	Administrative	No
Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	ECDS	No^^
Depression Screening and Follow-Up for Adolescents and Adults*	DSF-E	NCQA	ECDS	No^^
Diabetes Screening for People w/Schizophrenia Bipolar Disorder Using Antipsychotic Medications	SSD	NCQA	Administrative	No
Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	NCQA	Administrative	No

MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL[i]
Follow-Up After ED Visit for Substance Use – 7 days[*]	FUA	NCQA	Administrative	No
Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-E-C&M	NCQA	ECDS	No
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-E-Init	NCQA	ECDS	No
Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM-E	NCQA	ECDS	No
Low-Risk Cesarean Delivery[*]	LRCD	CMS	Administrative	No[iii]
Pharmacotherapy for Opioid Use Disorder[*]	POD	NCQA	Administrative	No^^
Plan All-Cause Readmissions[*, iv]	PCR[ii]	NCQA	Administrative	No
Postpartum Depression Screening and Follow Up	PDS-E	NCQA	ECDS	No^^
Prenatal Depression Screening and Follow Up	PND-E	NCQA	ECDS	No^^
Prenatal Immunization Status	PRS-E	NCQA	ECDS	No^^
Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	NCQA	Administrative	No
Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	NCQA	Administrative	No
LTC Report Only to DHCS				
Number of Out-patient ED Visits per 1,000 Long Stay Resident Days[*, iv]	HFS	CMS[***]	Administrative^	No
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization[*, iv]	SNF HAI	CMS[***]	Administrative^	No
Potentially Preventable 30-day Post-Discharge Readmission[*, iv]	PPR	CMS[***]	Administrative^	No

[i] MCPs held to the MPL for the HEDIS© total rates only; the National Committee for Quality Assurance (NCQA) Quality Compass© Medicaid HMO 50th and 90th percentiles represent the MPLs and high-performance levels (HPLs), respectively. MCPs will only be held to the MPL for historically established benchmarks.

[ii] Stratified by Seniors and Persons with Disabilities (SPDs)

[iii] CMS calculated national median is considered the MPL.

[iv] Stratified by Dual eligible Members

ECDS: Electronic Clinical Data Systems (electronic reporting method for certain HEDIS measures)

* Measures must be stratified by race/ethnicity per NCQA categorizations.

** Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates

CMS modified measure to reflect Medi-Cal and dual data sources

^ Measures to be calculated at the facility level for each MCP that can be aggregated to the plan level

^^ Measure will be held to the MPL in MY 2025

For additional information, please visit the HEDIS Resources page on the Alliance provider website.

Provider's Role

The role of the provider is very important in promotion of the health of Alliance members. The Alliance encourages providers to assist in facilitating the HEDIS process by:

1. Providing appropriate care within the designated time frames defined by NCQA, CMS, and DQA;
2. Clearly documenting all care provided in the patient's medical record;
3. Accurately coding all claims (see MY 2024 MCAS Code Set on the HEDIS Resources page);
4. Responding promptly and accurately to medical records requests (within five to seven business days of request); and
5. Providing the Alliance and its HEDIS vendor access to your electronic health record (EHR) system to reduce the impact on your medical records team, as well as accurately reporting your clinic's performance.

HIPAA Statement

All providers are contractually obligated to provide the Alliance with medical records upon request. A patient release form is not necessary. HEDIS data collection and release of information is permitted under HIPAA since the disclosure of records is part of quality assessment and improvement activities. Please be assured that when providing the QI team and the Alliance's HEDIS vendor EHR access that PHI is maintained in accordance with federal and state laws. For more information about HEDIS, please see Policy 401-1607 – Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight.

Continuous Quality Monitoring

The QIHETP uses a variety of mechanisms to identify potential quality of service issues, ensure patient safety, and ensure compliance with standards of care across the care continuum (i.e., preventative health services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services). These mechanisms include, but are not limited to:

1. External quality review using the MCAS measure calculation to annually track and report on a set of quality performance measures and health equity measures as directed by DHCS. These measures

evaluate the quality of care provided to our members and compare against DHCS-established benchmarks.

2. Site reviews of PCP facilities for criteria such as: patient safety, physical accessibility, infection control and quality of medical records.
3. Disease surveillance and reporting to public health authorities, as applicable.
4. Provider contracting, credentialing and recredentialing processes, including peer review activities.
5. Timely access monitoring to ensure the provision of covered services within a timely manner, consistent with External Quality Review Organization (EQRO) network adequacy validation studies.
6. Member satisfaction monitoring including analysis of member satisfaction surveys, grievances and appeals.
7. Provider satisfaction monitoring through annual surveys.
8. Claims encounter monitoring to identify sentinel events, variations in practice and potential fraud, waste and/or abuse.
9. Encounter Data Validation through EQRO.
10. Potential quality issue monitoring, investigation and resolution processes, to ensure that services provided to members meet established standards and address any patient safety concerns. Monitoring of over/under utilization of services to ensure appropriate, high quality, cost-effective utilization of health care resources and that these resources are available to all members.
11. Under/Over-Utilization Monitoring through the UM Program.
12. Population needs assessment to evaluate the health education and cultural and linguistic needs of members to guide the development and implementation of cultural and linguistic health education interventions.
13. Seniors and persons with disabilities activity studies to ensure provision of case management services, coordination, and continuity of care, including ensuring availability and access to care and clinical services.
14. External review of focused clinical and nonclinical topic(s) for quality outcomes and timeliness of, and access to services provided.
15. Stratified data studies to evaluate population(s) as needed.
16. Development and annual review of the Quality Improvement Health Equity Work Plan (QIHE-WP) and Utilization Management Work Plan (UMWP).
17. Behavioral Health Services monitoring.
18. Routine and ad-hoc monitoring of QI activities, behavioral health services, enhanced care management (ECM) monitoring, community support (CS), long term care services, and delegate oversight.

For more information about how the QHIETP maintains continuous quality monitoring, please see Policy 401-1101 – Quality Improvement & Health Equity Transformation Program (QIHETP).

Provider-Preventable Conditions (PPC) Reporting

Federal regulations and state law require that providers report all PPCs to the California Department of Healthcare Services (DHCS). This applies to all providers and facilities contracted with the Alliance.

There are two types of PPCs: health care-acquired conditions (HCAC), which should be reported if these occur in an inpatient acute care hospital, and other provider-preventable conditions (OPPC), which should be reported if these occur in any health care setting, including at long-term care facilities (LTCs).

All PPCs for any Medi-Cal members must be reported to DHCS no later than 5 working days after discovery of the PPC using the DHCS secure online reporting portal. This applies to all PPCs not present on admission (POA), regardless of whether Medi-Cal reimbursement is sought for treatment of the PPC. A copy of the submission must be submitted to the Quality Improvement (QI) department at the Alliance via our secure fax line at 831-430-5688.

Even if an adverse event or a healthcare-associated infection (HAI) was already reported to the California Department of Public Health (CDPH), providers are required to also report PPCs to DHCS as reporting requirements for PPCs are different than those for adverse events and HAIs reported to CDPH.

Please note that the Alliance is required to monitor claims data on a monthly basis and to report all potential PPC diagnoses to DHCS. This does not release providers/facilities from their requirement to report.

- Provider-preventable conditions FAQ
- DHCS secure online reporting portal

Please also refer to Alliance Policy 401-1305 – Provider Preventable Conditions.

Communicating Results of QI Activities

Using a variety of communication methods (e.g., Provider Portal, website posting, newsletters, special mailings, educational sessions, and/or site reviews), QIHETP and Population Needs Assessment (PNA) activities are communicated to Alliance staff, the Alliance Board, oversight and advisory committees, regulatory agencies, providers, delegated subcontractors, downstream fully delegated subcontractors and members. The content of these communications may include:

1. Listings of members who need specific services;
2. Listings of members who need intervention based on pharmacy indicators;
3. Comparison of clinic/practitioner/provider performance to average plan-wide performance;
4. Reports showing clinic/practitioner/provider deviation from a benchmark or threshold;
5. Provider recognition of achievement for high quality performance;
6. Health plan performance for audited MCAS measures or CAHPS performance;
7. Health disparity analysis for quality and equity performance measures;
8. Recommended interventions to improve performance;
9. Barrier analyses and intervention plans/timelines;

10. Plan-sponsored training directed at improving performance;
11. Incentives for improved or above average performance in quality of care or service;
12. Requests for Corrective Action Plans to correct deficiencies

For more information about our QHETP, please see the following policies.

401-1101 – Quality Improvement & Health Equity Transformation Program (QIHETP)

401-1201 – Quality Improvement Health Equity Committee

401-1301 – Potential Quality Issue Review Process

401-1501 – Standards of Care

401-1508 – Facility Site Review Process

401-1510 – Medical Record Review and Requirements

300-1509 – Timely Access to Care

401-1515 – Nurse Midwife: Scope of Practice and Supervision

401-1523 – Non-Physician Medical Practitioner: Scope of Practice and Supervision

401-1306 – Corrective Action Plan for Quality Issues

Section 15
Cultural & Linguistic Services Program

The Alliance is committed to delivering culturally and linguistically appropriate health care services to its diverse membership. The goal of the Cultural & Linguistic Services Program (CLSP) is to ensure that all Alliance members — regardless of race, color, religion, national origin, creed, ancestry, ethnic backgrounds, language, marital status, English proficiency, age, health status, physical and mental disability, gender, sexual orientation or gender identity or identification with any other persons or groups — all have equal access to quality healthcare and that covered services are provided in a culturally and linguistically appropriate manner. The CLSP encompasses language assistance services for members; and cultural competency, sensitivity, and diversity training of staff, providers, and subcontractors. Please see Policy 401-4101 – Cultural and Linguistic Services Program for more information.

Providers shall recognize and integrate members' practices and beliefs about disease causation and prevention into the provision of Covered Services; comply with Plan's Language Assistance Program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04; and cooperate with the Alliance by providing any information necessary to assess compliance.

Language Assistance Program / Interpreter Services

Under federal and state law, all Limited English Proficient (LEP) health plan members are entitled to language assistance at no cost when accessing health care services. In addition, the Americans with Disabilities Act (ADA) requires that persons who are deaf or hard of hearing be offered communication assistance at no cost when accessing healthcare services. The Alliance covers interpreter services for all LEP, deaf or hard of hearing members. The Alliance contracts with pre-approved and qualified agencies to provide these services. Providers and members are strongly encouraged to take advantage of the Alliance's interpreter services at no cost, as the Alliance does not reimburse for services that are not offered by the Alliance.

Telephonic Interpreter Services

- Telephonic interpreter services for LEP members can be accessed by providers for all Alliance-covered services through approved vendors. No prior approval is required.
- Providers may access a telephonic interpreter directly 24 hours a day, 7 days a week.

Face-to-Face Interpreter Services

- Face-to-face interpretation is approved for all covered services for deaf or hard of hearing members and is approved for LEP members only under special circumstances.
- Prior approval and scheduling are required for all face-to-face interpreting services. Providers can request prior approval and schedule these services by submitting the Interpreter Request Form on the Cultural and Linguistic Services page of the Alliance provider website.
- A minimum of 5 business days for all standard (non-urgent) American Sign Language (ASL) requests.

- A minimum of 7 business days for all standard Non-ASL requests (e.g., foreign language).
- Urgent requests can be submitted at any time and will be reviewed immediately upon receipt. A determination will be made within one (1) business day.

For instructions on how to access telephonic and face-to-face interpreter services, including the approved vendors, please review the Interpreter Services Provider Quick Reference Guide. Please see Policy 401-4103 – Interpreter Services for more information.

Summary of Providers Responsibilities and Requirements

1. Due to the complex and sensitive nature of medical care, it is not appropriate to use unqualified bilingual persons as interpreters.
2. The Alliance strongly discourages the use of unqualified interpreters, including bilingual office staff or patients' friends or family members, especially minors.
3. Providers are required to document every patient's preferred language in the medical record and to offer LEP and deaf or hard of hearing patients a qualified interpreter at no cost to the patient.
4. Providers must not require patients to bring their own interpreters or suggest that they use a friend or family member to interpret.
5. Providers are required to document the offer of and patient acceptance or refusal of interpreter services in the medical record.
6. Federal and state laws require medical providers to offer qualified interpreters when needed. Using an untrained interpreter may result in miscommunication of medical information and compromise quality of care.

For a brief summary of federal and state laws related to language assistance, the use of interpreters, and cultural competence, please visit the Cultural and Linguistic Services page on the Alliance provider website.

Section 16
Pharmacy Services

This section describes the Alliance's pharmacy operations for the provision of pharmaceutical services to members. Additional information is available on the Pharmacy Services page of the Alliance provider website and in Policy 403-1101 – Pharmacy Operations Management.

Outpatient Pharmacy Services

Medi-Cal

All pharmacy services billed as a pharmacy claim are a benefit under Medi-Cal Rx, a Medi-Cal Fee-For-Service (FFS) program, including:

- Outpatient drugs (prescription and over the counter)
- Physician-Administered Drugs (PADs)
- Enteral nutritional products
- Medical supplies.

Medi-Cal Rx does not include pharmacy services billed as a medical (professional) or institutional claim. For Physician-Administered Drugs billed as a medical claim, see "Physician-Administered Drugs" below.

Members must obtain their prescribed drugs from a pharmacy that is in the Medi-Cal Rx pharmacy network. A list of pharmacies is available on the Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov or by calling Medi-Cal Rx at 800-977-2273.

Medi-Cal Rx Contract Drugs List and Prior Authorization Requests

The list of covered drugs for Medi-Cal Rx, or Contract Drugs List (CDL), is available on the Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov. Certain pharmacy drugs and medical supplies may require a prior authorization (PA). Prior authorization requests must be submitted to Medi-Cal Rx via the methods listed below. Medi-Cal Rx PA Request Form and additional information are available on Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov or by calling Medi-Cal Rx at 800-977-2273.

- Medi-Cal Rx website
- CoverMyMeds® (CMM)
- Fax: 800-869-4325

- United States (US) Mail

  Medi-Cal Rx Customer Service Center
  ATTN: Provider PA Requests
  P.O. Box 730
  Rancho Cordova, CA 95741-0730

- NCPDP P4 – Request Only

Emergency Dispensing of 14-Day Supply

Dispensing of a 14-day emergency supply of any medication for which delaying the dispensing would withhold a medically necessary service is permitted by Medi-Cal Rx without requirement for a prior authorization. For more information, please refer to Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov or call Medi-Cal Rx at 800-977-2273.

Alliance Care IHSS

The Alliance has partnered with MedImpact, a Pharmacy Benefit Manager (PBM) to process pharmacy claims and prior authorization requests for Alliance Care IHSS members. Members must take their prescriptions to a pharmacy in the MedImpact network. To find a pharmacy, search in the MedImpact Pharmacy Directory. For more information regarding the Alliance Pharmaceutical Services Access, please see Policy 403-1126 – Pharmaceutical Services Access.

Drug Formulary and Prior Authorization Requests

The Alliance Formulary is a list of covered drugs developed and managed by MedImpact. Covered drugs are selected by physician and pharmacist subject matter experts who collaboratively support MedImpact's Pharmacy and Therapeutics (P&T) Committee. To find out if a particular drug is covered, please refer to the Alliance Pharmacy Formulary. A copy of the formulary may be downloaded directly from the Pharmacy Services page on the Alliance provider website.

MedImpact's MedPrescription service provides prescribers with member-specific prescription eligibility, medication history and basic formulary information. Real-Time Prescription Benefits allows prescribers to view member-specific drug coverage, cost and benefit information such as prior authorization requirements or quantity limits, lower-cost therapeutic alternatives and preferred pharmacies. Additional information is available on the MedImpact website or by calling MedImpact at 800-788-2949.

Drugs that are not covered on the formulary, or drugs on the formulary with restrictions such as prior authorization (PA), step therapy, or quantity limits, may require a prior authorization review to determine coverage for medical necessity. For more information, please see Policy 403-1103 – Pharmacy Authorization Request Review Process and Policy 403-1128 – Other Non-Formulary Drugs. When requesting a prior authorization for brand name drugs that have generic equivalents available, please see Policy 403-1112 – Therapeutic Equivalence of Generic Drugs.

Prior authorization requests, including formulary exception and step therapy exception requests, must be submitted to MedImpact, not to the Alliance. If faxed or mailed, prior authorization requests must be submitted on the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (California

Form 61-211). The form is available on the Pharmacy Services page of the Alliance provider website or in the Provider Forms Library. Submissions on other forms will not be accepted.

PA requests must be submitted to MedImpact via the following methods:

- Fax 858-790-7100
- MedImpact Electronic Prior Authorization (ePA) Program
- United States (US) Mail

  MedImpact Healthcare Systems, Inc.
  10181 Scripps Gateway Court
  San Diego, CA 92131

Additional information on ePA Program is available on the MedImpact website or by calling MedImpact at 800-788-2949.

After Hours Access and Emergency Supply

24-hour access is provided by any 24-hour pharmacy that contracts with the Alliance's Pharmacy Benefit Manager (PBM), MedImpact. To find a pharmacy, search in the MedImpact Pharmacy Directory.

MedImpact is authorized to enter an override for a five-day emergency supply of any medication if the pharmacy states that it is for an emergency. The Alliance will receive and retrospectively review a report of all emergency overrides placed by MedImpact. MedImpact can be reached at 800-788-2949.

Physician-Administered Drugs

The pharmaceutical benefit management procedures for Physician/Facility-Administered Drugs (PADs) billed as a medical claim are outlined in Policy 403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee and Policy 403-1141 – Physician/Facility-Administered Drugs Requiring Prior Authorization, and are available online on the Pharmacy Services page of the Alliance provider website. The Alliance Pharmacy and Therapeutics (P&T) Committee meets quarterly to review and update Alliance's Physician-Administered Drug List, clinical criteria, limits and other pharmaceutical benefit management procedures.

Covered PADs, restrictions, prior authorization criteria and any updates are available on the Pharmacy Services page of the Alliance provider website. Providers will be notified via provider newsletter for any negative or restrictive changes. Providers can request to have the information mailed by contacting the Alliance Pharmacy department by calling 831-430-5507 or 800-700-3874, ext. 5507.

Some Physician/Facility-Administered Drugs (PADs) billed as a medical claim may require a prior authorization (PA). Prior Authorization (PA) Criteria are on the recommendations of the Alliance Pharmacy and Therapeutics (P&T) Committee, and is available on the Pharmacy Services page of the Alliance provider website. If a Physician-Administered Drug does not have PA criteria, it will be reviewed for medical necessity based upon Alliance policies as well as nationally recognized standards. Exceptions for PADs not on the Physician-Administered Drug List, not meeting the restrictions or PADs exceeding the limits will require a prior authorization, and will be reviewed for medical necessity. For more information on the authorization review

process for PADs, please see Policy 403-1141 – Physician/Facility-Administered Drugs Requiring Prior Authorization.

The Alliance prefers the use of a Biosimilar over its branded biologic counterpart. For more information, please see Policy 403-1142 – Biosimilars.

For providers who wish to administer Synagis in their office, the Synagis Statement of Medical Necessity form is required to be submitted along with the prior authorization request. The Alliance will cover Synagis for members who meet Conditions of Usage listed in Policy 403-1120 – Synagis (Palivizumab).

Physician-Administered Drugs Carved Out to Fee-For-Service Medi-Cal

For Medi-Cal members, the Alliance does not cover drugs used for treatment of HIV/AIDS/Hepatitis B, alcohol and heroin detoxification and dependency, clotting factor disorder, and antipsychotic drugs listed under "Capitated/Noncapitated Drugs" in the MCP: County Organized Health System (COHS) section in Part 1 of the Medi-Cal Provider Manual. These carved-out or non-capitated drugs should be billed to Fee-For-Service (FFS) Medi-Cal.

Submitting Authorization Requests for Physician-Administered Drugs

Authorization requests for Physician-Administered Drugs billed as a medical claim may be submitted to the Alliance via the methods listed below. Submission of PA requests is preferred through the Alliance Provider Portal. If faxed or mailed, prior authorization requests must be submitted on the Prescription Drug Prior Authorization Request Form for Medi-Cal and Alliance Care IHSS members. Requests submitted on other forms will be voided. The form can be found on the Pharmacy Services page of the Alliance provider website or in the Provider Forms Library.

- Alliance Provider Portal (preferred)
- Fax 831-430-5851
- United States (US) Mail

  Central California Alliance for Health
  Health Services Department – Pharmacy
  PO Box 660012
  Scotts Valley, CA 95067-0012

Questions regarding urgent prior authorization requests may be directed to the Alliance Pharmacy department by calling 831-430-5507 or 800-700-3874, ext. 5507.

To complete a prior authorization request, *all* of the following information must be provided:

1. Member name, ID number and DOB.
2. Requesting provider name and contact information.
3. Description of requested drug or item (must include Healthcare Common Procedure Coding System (HCPCS) code if a physician or facility administered drug is requested).
4. Prescriber name, NPI, address, phone number and fax number.

5. Servicing provider name, NPI, address, phone number and fax number (if different).
6. Diagnosis (or ICD code) that most accurately describes the indication for the medication. Please include all medically relevant diagnoses for review purposes.
7. Quantity requested per administration or per date of service (DOS).
8. Number of administrations or DOS requested.
9. Directions for use.
10. Expected duration of therapy.
11. Documentation of appropriate clinical information that supports the medical necessity of the requested drug or item, including:
    - Other drugs or therapies for this indication that have already been tried and failed. Please include what the outcomes were.
    - Why preferred alternatives cannot be used.
    - Any additional information to support diagnosis and medical justification such as lab results and specialist consults.

Incomplete and/or illegible forms may be denied or voided.

Providers can contact the Alliance Pharmacy department at 800-700-3874, ext. 5507.

For more information on the authorization review process, please see Policy 403-1103 – Pharmacy Authorization Request Review Process.

Continuity of Care for New Members

If new members are being treated with a drug at the time of their enrollment with the plan, the Alliance will work with Alliance providers to ensure that members receive continuity of care with their pharmaceutical services. For more information on continuity of care for new members, please see Policy 403-1114 – Continuing Pharmacy Care for New Members.

Drug Utilization Review (DUR)

The Alliance operates a DUR program to educate physicians and pharmacists to better identify patterns, and reduce the frequency of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care, both among physicians, pharmacists, and patients, and fraud or abuse associated with specific drugs or groups of drugs. For more information on the DUR program, please see Policy 403-1143 – Drug Utilization Review.

The Alliance has developed policies in collaboration with internal and external stakeholders to help ensure the safe and appropriate use of opioid medications. For Alliance Care IHSS members, the Alliance will allow refills for opioid prescriptions when greater-than or equal-to 90% of the days' supply of the prescription is met. The next refill request, for when less than 90% of the days' supply of an opioid prescription has elapsed, will require a prior authorization with medical justification for the early refill. For Medi-Cal members, please refer to the Medi-Cal Rx website. For more information on the Opioid Utilization Review process, please see Policy 403-1139 – Opioid Utilization Review.

Billing and Reimbursement

Billing and Reimbursement for Drugs Carved Out to Fee-For-Service Medi-Cal

For Medi-Cal members, the Alliance does not cover drugs used for treatment of HIV/AIDS/Hepatitis B, alcohol and heroin detoxification and dependency, clotting factor disorder, and antipsychotic drugs listed under "Capitated/Noncapitated Drugs" in the MCP: County Organized Health System (COHS) section in Part 1 of Medi-Cal Provider Manual. These carved-out or non-capitated drugs should be billed to Fee-For-Service (FFS) Medi-Cal. Procedures for Fee-For-Service reimbursement for carved-out drugs can be found on the Medi-Cal Provider Manual.

Drug Waste Reimbursement

For information on billing for drug waste, please see Policy 403-1146 – Drug Waste Reimbursement.

The Alliance 340B Pharmacy Program

For information on billing for drugs purchased under the 340B program, please see Policy 403-1145 – Pharmacy 340B Program.

Drug Recalls

For information on drug recalls, please see Policy 403-1124 – Drug Recall Procedure and the Pharmacy Services page on the Alliance provider website.

Section 17
Resolution of Disputes and Grievances

Alliance members and both contracted and non-contracted providers may access the Alliance Dispute and Grievance Process at any time. To download the necessary forms, go to the Provider Forms Library.

Provider Inquiries and Disputes

The Alliance has a two-level process to resolve Provider disputes. Provider Inquiries investigate and resolve contested claims and/or payment issues. A Dispute may be submitted to contest the processing, payment or non-payment of a previously submitted Provider Inquiry. Providers must complete the Provider Inquiry process prior to submitting a Dispute.

The Alliance scans and reviews all inquiries, disputes and written statements of contested claims or provider dissatisfaction to determine if the request meets criteria for processing as a Provider Inquiry (level 1) or a Dispute (level 2). The Alliance will process written statements and requests according to the criteria stated in the definitions for these processes. Example: If the provider states on their Provider Inquiry Form (PIF) that they are disputing a claim denial, but the contested claim has not yet been reviewed through the level 1 Provider Inquiry process, the Alliance will first process the contested claim as a Provider Inquiry, allowing the provider to further submit a level 2 Dispute if still dissatisfied with the Inquiry decision.

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. Contracted providers must exhaust this dispute resolution process before pursuing other available legal remedies.

Prior to filing an inquiry or dispute, providers should contact the Alliance Claims department to identify whether or not their claim denial issue can be addressed immediately over the phone. Please contact a Claims Customer Service Representative at 831-430-5503, Monday–Friday, 8:30 a.m.–4:30 p.m.

For more information, please see Policy 600-1017 – Provider Inquiry and Dispute Resolution.

Inquiry and Dispute Resolution Process

Provider Inquiries and Disputes must be submitted in writing. You may mail, fax or deliver your hard copy dispute to:

Central California Alliance for Health
ATTN: Provider Inquiries and Disputes
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Fax: 831-430-5569

You may also submit a Provider Inquiry or Dispute electronically using the Provider Inquiry Form located on the Alliance website. Inquiries and disputes may be emailed to CQID@thealliance.health.

Inquiries and disputes must include the following information:

1. Provider name.
2. Provider NPI, Tax ID, or Alliance ID number.
3. Provider contact information.
4. A clear explanation of the issue in question.
5. Your position on the matter.
6. If the inquiry or dispute involves a claim or request for reimbursement of overpayment, you also must include:
7. The contested claim number, and all other claim control numbers if there have been multiple resubmissions of the claim.
8. A clear identification and description of the contested item.
9. The date of service.
10. A clear explanation of why you believe the payment or other action is incorrect.
11. If the inquiry or dispute involves a member, you must include the member's full name and Alliance ID number.

You also may include additional supporting clinical information, if applicable. Please note that if the inquiry or dispute does not include the above information and we cannot readily obtain it, we will return the request to you for more information. Providers have thirty (30) working days to submit an amended dispute to the Alliance.

If you have multiple inquiries or disputes addressing a single issue, you may file a single request using the system described above. Please include a list of each individual issue, along with the original CCN(s) and all other information required for filing multiple disputes.

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 date we receive the request for contracted providers and forty-five (45) business days for non-contracted providers.

For assistance in filing a dispute, or to receive the status update of a dispute, please contact a Dispute Coordinator at 831-430-4105.

FAQs about Provider Disputes

What next steps should I take if a pre-service or prior authorization is denied for lack of information?

Resubmit the authorization request to Health Services with the requested information directly to their Fax number at 831-430-5850.

What if I disagree with the claim's denial for all cases except an unclean claim?

The provider should submit a provider inquiry request to contest the denial within three hundred sixty-five (365) days from the original Remittance Advice (RA) date. Ensure to include all required information listed above such as the original Claims Control Number (CCN), provider information, and a short explanation explaining the provider's position.

What if I noticed a mistake and adjusted the claim? May I still file a dispute?

Please submit a clean claim within the allowable timeframe as a corrected claim or resubmission directly to the Claims department for a complete review. New information should be reviewed by Claims prior to initiating a dispute.

May I balance bill a member when a claim is disputed?

Central California Alliance for Health prohibits Providers from balance billing a member for contested claim denials. The Provider is expected to adjust the balance owed. For more detailed information regarding balance billing, please see Section 10: Claims in this manual.

Member Grievances and Appeals

The Alliance Grievance Process addresses member grievances, also referred to as complaints and appeals. An Alliance member may file a grievance about their experiences with the Plan or with a contracted provider. If a member is filing an appeal about a denial, modification or deferral of services by the Alliance, it must be filed within 60 days of the Notice of Action. While most providers have their own internal mechanisms for resolving patient complaints, we provide complaint forms in English, Spanish and Hmong.

Provider Responsibilities

When a member brings a complaint to your attention, you must investigate and try to resolve the complaint in a fair and equitable manner. Providers may not retaliate against a member for filing a complaint. In addition, providers must cooperate with the Alliance in identifying, processing and resolving all member grievances/complaints and appeals. Cooperation includes but is not limited to:

- Speaking with Alliance representatives to assist in resolving the grievance or appeal in a reasonable manner.
- Having designated staff available to review and respond to grievance and appeal investigations.
- Completing a provider response in writing if requested. Providers may submit a response in writing and often provide written documentation of their requests when filing an appeal on a member's behalf.
- Responding to all information or documentation requests made by the Plan related to a grievance or appeal, such as: medical records request, provider's response to a complaint, scheduling documentation/Phone logs, policies or other supporting documentation to support the review.
- Responding to requests timely (typically within seven (7) business days).
- Taking all reasonable actions suggested by our staff to resolve the members' complaint(s).

Member complaints are also considered by the Peer Review and Credentialing Committee (PRCC) in re-credentialing of providers.

If a member asks to file a complaint, you can access the appropriate forms and instructions on the Member Grievance Form - Medi-Cal page or the Member Grievance Form – IHSS on the Alliance provider website. *Please note that the Member Complaint and Appeal Form must be signed by the member or the Member's Authorized Representative in Step 3 of the form.

Members have the right to express their dissatisfaction with any aspect of the Plan or its providers. Providers can refer members to the following resources to file a grievance or appeal. Providers may only file a grievance or appeal on behalf of a member with the member's written consent. A grievance may be filed by a member or a member's authorized representative:

- In person, by making an appointment to meet with a Member Services Representative at one of our offices.
- By calling a Member Services Representative at:

  Santa Cruz County: 831-430-5500

  Monterey County: 831-755-6000

  Merced County: 209-381-5300
- By calling the TTY line for the hearing and/or speech impaired at 800-735-2929 or the Spanish TTY line at 800-855-3000.
- By faxing to 831-430-5579.
- By calling the Grievance Coordinator at 800-700-3874, ext. 5816.
- By filling out a complaint form or putting the complaint in writing and sending it to the Grievance Coordinator at:

  Central California Alliance for Health
  ATTN: Grievance Coordinator
  1600 Green Hills Road, Suite 101
  Scotts Valley, CA 95066-4981
- Electronically, by visiting the File a Grievance page on the Alliance website.

When the Plan receives a grievance, we will send the member a written acknowledgement letter within five (5) calendar days. The letter will reiterate the issue(s) of concern as we understand it. We will also identify the Grievance Staff contact for the grievance, notify the member of their rights in the Grievance Process, and tell the member that we will send a resolution letter within thirty (30) calendar days from the date the grievance was received.

In some cases, members do not need to use the Alliance Grievance System to resolve their complaint or appeal. Refer to the Alliance Grievance Process linked above, or the Alliance website for information about other options Medi-Cal and IHSS members may take to resolve their grievances.

Member Rights in the Alliance Grievance Process

A member may authorize a friend or family member to act on their behalf in the grievance process.

If the member does not speak English fluently, they have the right to interpreter services.

A member has the right to obtain representation from an advocate or legal counsel to assist them in resolving the grievance.

The State Office of the Ombudsman will help Medi-Cal members who are having problems with the Alliance. Members can call 888-452-8609.

Medi-Cal members have the right to request a State Fair Hearing (SFH) with the Department of Social Services if they have gone through the Alliance appeal process and received a Notice of Appeal Resolution letter, or if the Alliance failed to adhere to appeal timeframes. Members must request a SFH within one hundred and twenty (120) days of receiving their appeal resolution letter.

Members have the right to request continuation of benefits, also known as Aid Paid Pending (APP) during an appeal or SFH.

Alliance Care IHSS members have the right to request a review by the California Department of Managed Health Care if they are unhappy with the Alliance's resolution of their grievance or if a grievance remains unresolved after thirty (30) days.

Alliance Care IHSS members also have the right to request an Independent Medical Review (IMR) if their grievance involves a denial or partial denial of a health care service that was determined not to be medically necessary.

FAQs to Providers for Member Grievances and Member Appeals

What is the Alliance Member Grievance System?

This is the system for resolving member grievances/complaints and appeals about the services a member receives as an Alliance member. Filing a grievance or appeal will not affect a member's health care coverage through the Alliance. Once a member states an expression of dissatisfaction, the Alliance is required to intake this concern.

Why would a member file a grievance or complaint?

A member could file a grievance/complaint if they:

- Encounter delays receiving health care services that the member thinks they need such as medications, medical equipment, referrals to specialists, or doctors' appointments.
- Are unhappy with the services they received from a health care provider.
- Are unhappy with any aspect of their health care.
- Received a bill from a provider.
- Feel a health care provider or the Alliance has not respected their privacy.

- Feel a health care provider or the Alliance failed to give trans-inclusive health care.
- Did not receive gender-affirming care.

Why would a member file an appeal?

Another reason a member might file a grievance is if they received a Notice of Action. A Notice of Action is a formal letter telling the member that a medical service has been denied, deferred, or modified. This type of grievance is also called an appeal. If a member receives a Notice of Action from the Alliance, the member has sixty (60) days from the date on the Notice of Action to file an appeal with the Alliance.

What if the member speaks a language other than English?

The Alliance has staff who speak Spanish and Hmong. The Alliance will also arrange an interpreter for the member through a telephone language line if the member does not speak English, Spanish, or Hmong.

Are there other ways to resolve a member's problem if they are a Medi-Cal member?

If the member has filed an appeal with the Alliance and received an appeal resolution letter, or if the Alliance did not resolve or respond to the member's appeal according to the timelines outlined above, the member can ask for a State Hearing. The member must request the hearing within one hundred and twenty (120) days from the date of receiving the Alliance's appeal resolution letter.

Members may call the California Department of Social Services (DSS) at **800-743-8525** (**TDD: 800-952-8349**) or toll free at 855-795-0634 to request a hearing or can fax their request to DSS to **833-281-0905**.

A member may request a hearing online at www.cdss.ca.gov or email their request to scopeofbenefits@dss.ca.gov.

A member may mail their request to:

California Department of Social Services - State Hearings Division
P.O. Box 944243, Mail Station 9-17-433
Sacramento, CA 94244-2430

A member can also ask for a hearing at their local Human Services county office.

Alliance members also have the right to file a complaint with the Department of Health and Human Services at any time if they feel that their privacy has not been respected. Members can file their complaint by contacting:

U. S. Department of Health and Human Services

Office of Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

What if the member needs help to file their grievance or appeal?

The member can authorize another person such as a family member or a friend to help them. The member can call the State Office of the Ombudsman at **888-452-8609** if the member has Medi-Cal. The member can also call the California Health Consumer Alliance at **888-804-3536** if member needs legal help.

What happens after a member files a grievance or appeal?

The Alliance Grievance staff will send the member a letter within five (5) days after a member files a complaint or appeal. This letter tells the member that the plan received the grievance and explains the member's rights in the grievance process.

How is the grievance or appeal resolved?

Depending on the type of grievance or appeal made, Alliance staff may be able to resolve it very quickly. If this is not possible, we will work with internal Alliance departments and providers to get it resolved.

If we need more information, we will ask for it. For example, if the Chief Medical Officer wants more information, we may ask for medical records from the doctors involved. The Grievance staff will send a *resolution letter directly to the member*.

How long does the member have to wait until they get the *resolution letter*?

The Grievance staff will send the *resolution letter* within thirty (30) days from the day the grievance was received.

What if the grievance or appeal involves a serious threat to their health?

If the member's health problem is urgent, meaning it is a serious threat to their health, the member may ask for an Expedited Review. If the member requests an Expedited Review, then Grievance staff will inform the member within twenty-four (24) hours that the grievance has been received. A resolution will be completed within seventy-two (72) hours. An Expedited Review involves an imminent or serious threat to the member's health, such as severe pain, potential loss of life, limb, or major bodily function.

If the member is an In-Home Supportive Services (IHSS) member, then the following California Department of Managed Health Care statement below applies:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **800-700-3874** or **TTY: 800-735-2929** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website http://www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Section 18
Provider and Member Incentives

This section includes information on the Primary Care Provider (PCP) and Member incentive programs offered by the Alliance in 2025. These programs are evaluated by the Alliance annually to ensure they are achieving their intended outcomes, including improving access, coordination, quality and efficiency of care, and supporting members in making decisions that improve their health outcomes.

Primary Care Physician Incentives and Resources 2025

Care-Based Incentive Program 2025 Overview

The Alliance's Care-Based Incentive (CBI) Program is designed in collaboration with our providers. The CBI program consists of a set of measures to encourage preventive health services and connecting members with their primary care physicians (PCP). The program offers financial incentives, as well as technical assistance to PCPs to support providers in assisting members to self-manage their care and reduce proximal healthcare costs in the following areas:

- Care Coordination
- Quality of Care
- Member Reassignment Measure
- Exploratory
- Fee-For-Service Measures

Although the CBI program evaluates performance on the Alliance's Medi-Cal line of business, the Alliance encourages high-quality, cost-efficient care for all your patients.

For a Provider to participate in the CBI program each year, the Provider and the Alliance must execute an amendment adding an incentive provision to their agreement. The specific details regarding all of the measures within CBI are published on the Alliance's website. The description of the CBI program included in this Provider Manual is intended to provide a general overview of the program.

For more information about the CBI program, please see Policy 401-1705 – Care-Based Incentive Program.

CBI Programmatic Incentives

Under the CBI Programmatic Incentives, Provider's performance during the CBI term is measured against applicable benchmarks or performance targets and then compared to the performance of other CBI Providers to determine Provider's CBI Programmatic Incentive Payment. The CBI Programmatic Incentive contains three categories of measures: (1) Care Coordination Measures, (2) Quality of Care Measures, and (3) Member Reassignment Measure. General information regarding CBI Programmatic Incentive measures is provided below. For more information on the CBI measures, including incentive payment amounts, visit the CBI Resources page on the Alliance website.

Care Coordination (CC) Measures: Care Coordination – Hospital & Outpatient Measures: Under these measures, a provider's performance for Ambulatory Care Sensitive admissions (ACSA) and Preventable Emergency Visits is compared to the performance of providers within the same comparison group (i.e., Family Practice, Internal Medicine or Pediatrics). The Plan All-Cause Readmissions is compared to an Alliance defined standard. To qualify for the Care Coordination – Hospital & Outpatient Measures, providers must have 100 eligible linked members, on average, during the 2025 calendar year or 100 linked members as of December 31, 2025.

Care Coordination – Access Measures: Under these measures, a provider's a provider's performance for the Initial Health Appointment and Post-Discharge Care measures are compared to the performance of providers within the same comparison group (i.e., Family Practice, Internal Medicine or Pediatrics). The Application of Dental Fluoride Varnish, Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents, and Developmental Screening in the First Three Years is based on their rate of achievement under each measure. To qualify for the Care Coordination – Access Measures, providers must have a minimum of 5 eligible linked members at the end of the CBI Term.

Continuous enrollment requirements are applied to all care coordination measures. Visit the CBI Resources page for more information on the criteria per measure.

Quality of Care (QoC) Measures: The Quality of Care (QoC) Measures are calculated using the National Committee for Quality Assurance (NCQA) Medicaid benchmarks, following the Healthcare Effectiveness Data and Information Set (HEDIS) methodology. If there is no NCQA HEDIS benchmark published for a measure, an Alliance defined benchmark is used. For a provider to receive points for a QoC Measure, they must have a minimum of 30 eligible linked members that qualify for the measure based on HEDIS and CMS Core Measure (Child Core Set) specifications. The QoC measures are held to NCQA and Centers for Medicare & Medicaid Services (CMS) continuous enrollment criteria based on the measure steward. The 12 QoC Measures for 2025 are shown below.

1. Breast Cancer Screening.
2. Cervical Cancer Screening.
3. Child and Adolescent Well-Care Visits (3–21 years).
4. Chlamydia Screening in Women.
5. Colorectal Cancer Screening.
6. Depression Screening for Adolescents and Adults.
7. Diabetic Poor Control >9%.
8. Immunizations: Adolescents.
9. Immunizations: Children (Combo 10).
10. Lead Screening in Children.
11. Well-Child Visits in the First 15 Months.
12. Well-Child Visits for Age 15–30 Months.

Exploratory Measure: The Exploratory Measure is a part of the CBI program to monitor performance and is considered for possible inclusion as a paid measure in the 2026 CBI program. This measure does not qualify for payment in 2025. The Explorathjyory Measure is shown below.

- Controlling High Blood Pressure.

Member Reassignment Measure: Member reassignments are challenging and disruptive to the provision of healthcare for our members. The Alliance encourages providers to limit the number of members they reassign in their practice. This measure looks at the number of linked members a PCP reassigns from their practice during a calendar year. The member reassignment threshold is a maximum of one reassignment per 150 linked members. PCPs who exceed one reassignment per year per average 150 linked members are at risk of losing half of their CBI programmatic payments. The PCP must have an average of 100 eligible members during the measurement period or a minimum of 100 eligible members on the last day of the measurement period.

Providers requesting reassignment may not see the reassignment resolution in their membership until later, once the Reassignment Committee has investigated the request. Therefore, reassignment may reflect on the Practice Profile for the following quarter or CBI program year, thus it may affect a different time-period than when the request was made[†].

[†] Should a CBI Provider reassign members at a rate higher than one reassignment per 150 Eligible Members linked to such CBI Provider, based upon the CBI Provider's average linkage throughout the CBI Term (the "Member Reassignment Threshold"), points awarded to the CBI Provider under the CBI Programmatic Incentive will be reduced by fifty percent (50%). The Member Reassignment Threshold is not applied if the CBI Provider has either (i) less than an average of one hundred (100) Eligible Members, as determined by the number of months for which the CBI Provider was contracted during the Measurement Period or (ii) less than one hundred (100) Eligible Members as of December 31, 2025.

CBI Table

Care Coordination Measures						
CBI Programmatic Incentive Measurement Components	**Available Points**	**Member Requirement**	**Benchmark Ranking/ Rate of Achievement**	**Measure-ment Period**	**Measure-ment Data Source**	**Methodology**
All Care Coordination Measures:	***47 total***					
Plan All-Cause Readmissions The number of members 18 years of age and older with acute inpatient and observation stays during the measurement year that was followed by an unplanned acute readmission for any diagnosis within thirty (30) days of discharge.	10.5	100 Eligible Members on average or as of December 31, 2025	Alliance defined ≤25.00% Plan Goal is <15.00%	FY 2025	Claims data	CBI Contract 3.1.4 NCQA HEDIS®
Ambulatory Care Sensitive Admissions The number of ambulatory care sensitive admissions (based upon plan-identified AHRQ specifications) per 1,000 eligible members per year.	7		2.5% Improvement over Comparison Group's 2019 median Measurement Year performance			CBI Contract 3.1.2 AHRQ1
Preventable Emergency Visits The rate of preventable emergency department (ED) visits per 1,000 members per year.	8				Claims	CBI Contract 3.1.3 Medi-Cal State Collaborative adapted definitions from the NYU study[2]

Care Coordination Measures						
Post-Discharge Care Members who receive a post-discharge visit within 14 days of discharge from a hospital inpatient stay by a linked primary care provider (PCP) or specialist. This measure pertains to acute hospital discharges only. Emergency room visits do not qualify.	10.5	≥ 5 Eligible Members linked to Provider			Claims	CBI Contract 3.1.5
Initial Health Appointment New members who receive a comprehensive initial health appointment within 120 days of enrollment with the Alliance.	4			October 1, 2024–December 31, 2025	Claims and Data Submission Tool (DST) data	CBI Contract 3.1.6
Developmental Screening in the First Three Years The percentage of members ages one to three years of age screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on their first, second, or third birthday.	2		2025 Rate of Achievement	FY 2025		CBI Contract 3.1.7 CMS Core Measure Set (Child Core)

Care Coordination Measures						
Application of Dental Fluoride Varnish The percentage of members ages six months to five years (up to or before their sixth birthday) who received at least one topical fluoride application by staff at the PCP office during the measurement year.	2					CBI Contract 3.1.9
Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents The percentage of members ages one to 20 years of age who are screened for Adverse Childhood Experiences (ACEs) annually using a standardized screening tool.	3				Claims data	CBI Contract 3.1.8

Quality of Care Measures *(NCQA HEDIS® and CMS Core Measure Set [Adult Core])*						
CBI Programmatic Incentive Measurement Components	**Available Points**	**Member Requirement**	**Benchmark Ranking/ Rate of Achievement**	**Measurement Period**	**Measurement Data Source**	**Methodology**
All Quality of Care Measures:	***53 total***					
Breast Cancer Screening	CBI Contract 3.2.2	≥ 30 continuously Eligible Members[3]	NCQA HEDIS® Quality Compass National Rankings[4] (Plan Benchmark is the HEDIS national 50th percentile, and Plan Goal is the HEDIS national 90th percentile)	NCQA HEDIS®	Claims in paid or denied status, lab test results, and other NCQA recommended supplemental data sources, DST	CBI Contract 3.2.1 NCQA HEDIS®
Child and Adolescent Well-Care Visits						
Cervical Cancer Screening						
Chlamydia Screening in Women						
Colorectal Cancer Screening						
Diabetic Poor Control >9%						
Immunizations: Children (Combo 10)						
Immunizations for Adolescents						
Lead Screening in Children						
Well-Child Visit in the First 15 Months						
Well-Child Visits for Age 15–30 Months of Life						
Depression Screening for Adolescents and Adults			Alliance defined ≥7.00% Plan Goal is ≥17.00%	NCQA HEDIS®	DST	CBI Contract 3.2.1 NCQA HEDIS®

CBI FFS Incentives			
Measurement Component	**Amount Paid Quarterly**	**Member Requirement**	**Measurement Data Source**
Adverse Childhood Experiences (ACEs) Training and Attestation Payment is available for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying medical practitioners, for completing the Becoming ACEs Aware in California training and attestation form.	$200 one-time payment after receipt of State notification of training and attestation completion.	None	CBI Contract 4.3
Patient Centered Medical Home Recognition Provider to submit documentation substantiating Provider's achievement of NCQA PCMH recognition or TJC certification.	$2,500 one-time payment for PCMH recognition/ certification.	None	CBI Contract 4.1 Documentation from NCQA or TJC
Behavioral Health Integration Provider to submit documentation substantiating behavioral health integration through NCQA Distinction in Behavioral Health.	$1,000 one-time payment for behavioral health integration distinction	None	CBI Contract 4.2 Documentation from NCQA
Diagnostic Accuracy and Completeness Training Payment is available for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying medical practitioners, for completing the Diagnostic Accuracy and Completeness training.	$200 one-time payment after receipt of documentation noting training completion.	None	CBI Contract 4.4
Cognitive Health Assessment Training and Attestation Payment is available for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying medical practitioners, for completing the Cognitive Health Assessment training and attestation.	$200 one-time payment after receipt of State notification of training and attestation completion.	None	CBI Contract 4.5
Social Determinants of Health (SDOH) ICD-10 Z Code Submission Providers are to submit claims using the 25 DHCS priority SDOH ICD-10 Z Codes (All Plan Letter 21-009) to receive quarterly payment of $250 each quarter, but to not exceed $1,000 within the CBI Term.	$250 per quarter for submitting 25 DHCS priority SDOH ICD-10 Z codes, up to $1,000 per CBI year.	None	CBI Contract 4.6
Quality Performance Improvement Projects Offices that are below the minimum performance level (MPL), measured at the 50th percentile for the 2024 CBI Term. CBI Groups will be paid $1,000 after the completion of the project on a quarterly basis.	$1,000 one-time payment for each office that completes an Alliance offered Quality Improvement Project	None	CBI Contract 4.7

[1] https://qualityindicators.ahrq.gov/measures/pqi_resources and https://qualityindicators.ahrq.gov/measures/pdi_resources excluding NQI 03 and PDI 01, 05, 08–12.

[2] The list of preventable emergency department and urgent visit diagnosis that are used to calculate this measure are linked on the Plan's website: https://thealliance.health/for-providers/manage-care/quality-of-care/care-based-incentive/care-based-incentive-resources/preventable-emergency-care-visit-diagnosis-tip-sheet/.

[3] For NCQA HEDIS® measures, the continuously Eligible Members must be qualified per HEDIS specifications.

[4] If no NCQA HEDIS® Quality Compass benchmark is published for a Quality of Care Measure, the calculation of that Quality of Care Measure shall be explained in the Provider Manual.

Note: References to Section numbers in this Attachment 1 are to section numbers of Addendum 3 published on the Alliance website, unless otherwise specified.

CBI Programmatic Measure Benchmarks

The 2025 Programmatic Benchmarks indicate the rate of performance a provider site must achieve in order to receive points for a measure. Total CBI year end payments are dependent on the total number of points a provider site receives. The final programmatic payment amounts are calculated using: 1) total programmatic points received and 2) total number of eligible member months.

In the event a HEDIS benchmark is not published for a Quality of Care Measure, the Alliance will determine a rate of achievement. For additional information on the CBI Benchmarks, visit the Programmatic Measure Benchmarks page on the Alliance website.

CBI Fee-For-Service Incentives

Fee-For-Service Measures Overview

In contrast to CBI Programmatic Incentive, which is paid based on provider's performance as compared to applicable benchmarks or performance targets, CBI Fee-for-Service (FFS) Incentives are single payment incentives to PCP sites and require providers to submit an attestation or certification of achievement to qualify for payment. The Alliance is offering seven CBI FFS Incentives in 2025 for the measures shown below.

1. Adverse Childhood Experiences (ACEs) Training and Attestation.
2. Behavioral Health Integration.
3. Cognitive Health Assessment Training and Attestation.
4. Diagnostic Accuracy and Completeness Training.
5. Patient Centered Medical Home (PCMH) Recognition.
6. Social Determinants of Health (SDOH) ICD-10 Z-Code Submission.
7. Quality Performance Improvement Projects.

For more information on the CBI FFS measures, including incentive payment amounts, visit the CBI Summary page or see the CBI Technical Specifications from the CBI Resources page on the Alliance Website.

CBI Payments

Provider Incentives are paid to qualifying contracted provider sites, including family practice, pediatrics and internal medicine. As noted above, provider incentives are broken into Programmatic and Fee-For-Service

(FFS) measures. Programmatic and FFS measures vary in the frequency which they are paid and the incentive payment calculation methodology.

- Programmatic measures are paid annually based on their rate of performance in each measure.
- Fee-For-Service measures are paid quarterly.

CBI Resources

The CBI Resources page on the Alliance provider website includes the following information and resources for the CBI program:

- What's New for the CBI Program – This page describes recent changes to the CBI program.
- CBI Summary page – The incentive summary provides a brief overview of the CBI program.
- CBI Technical Specifications – This resource is the most comprehensive guide for the CBI program, including measure criteria and calculation method.
- CBI Tip Sheets – The CBI Tip Sheets (on the CBI Resources page) are quick reference guides specific to each CBI measure.

The Alliance's Provider Portal is a resource that offers monthly Quality Reports using applicable claims, laboratory data, immunization registry data (RIDE and CAIR), and Data Submission Tool (DST) data received for specific measures to aid providers in monitoring their patients due for services.

The **Quality Reports** include all eligible linked members, without continuous enrollment criteria, and may include a prospective report design that is different from the CBI measures. The quality reports are updated monthly and can be reconciled with the clinic EHR to use for patient recall or to identify data that needs to be uploaded to the DST.

The **Linked Member Reports** include reports for tracking members who are linked to your clinic for outreach to help them establish care. Reports also provide insight into which members are newly linked and due for an initial health appointment, open referrals, members not seen by a PCP, and members that have been seen in the ED or discharged from the hospital.

The **CBI Reports** are available quarterly and allow providers to view accumulative summaries of both Programmatic and Fee-for-Service measures to monitor their CBI performance.

The **HEDIS (MCAS) Reports** include all eligible linked members with continuous enrollment criteria and provide a retrospective review (i.e., after the child turns two years old in the Childhood Immunization measure). These reports also include clinic performance in the measures in comparison to the NCQA benchmarks, as well as gap analysis to give insight to how many more members are needed to be seen to reach those benchmarks. The CBI Program consists of mostly HEDIS (MCAS) measures and can be used monthly to monitor the clinic's monthly rate performance in the CBI Program.

Note: Claims data is subject to lag and is based upon the Provider's submissions. The measurement of the CBI data is subject to variation, and reasonable statistical and operational error.

The Alliance's **Data Submission Tool (DST)** is available on the Provider Portal to allow providers to upload data for a selection of measures to achieve compliance in CBI. The Data Submission Tool Guide, available on

the Provider Portal, provides step-by-step instructions, required information, and information on how to upload the data. The Alliance is accepting data for the following measures:

- Application of Dental Fluoride Varnish
- Breast Cancer Screening (includes screening and bilateral mastectomy codes)
- Cervical Cancer Screening (includes cervical cytology, high-risk human papillomavirus [hrHPV], and total abdominal hysterectomy codes)
- Child and Adolescent Well-visits (0–21 years)
- Chlamydia Screening in Women
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Developmental Screening in the First 3 Years of Life
- Diabetic Poor Control >9%
- Immunizations for Children and Adolescents
- Initial Health Appointments (IHA)
- Depression Screenings for Adolescents and Adults
- Lead Screening in Children
- Post-Discharge Care (follow-up care provided by a PCP or specialist provider)

If you do not have access to the Data Submission Tool on the Provider Portal or have additional questions, contact your Provider Relations Representative.

For additional CBI resource information, please visit the CBI Resources page on the Alliance provider website or contact your Provider Relations Representative.

Data Sharing Incentive (DSI)

The Alliance's Data Sharing Incentive (DSI) program offers up to $40,000 in financial assistance to Alliance providers (with the exception of hospitals) for participating in active data sharing via Health Information Exchange (HIE).

The incentive aims to support providers to:

- Meet the mandatory California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF) statewide requirements. This requires providers to respond to requests from other health care entities in real time by facilitating HIE connectivity activities.
- Provide timely data submission to their local HIO (specific data elements and target measures differ by provider type).

Data sharing is a key component of the Alliance Strategic Plan and significantly contributes to achieving CalAIM goals and our strategic priorities of health equity and person-centered delivery system transformation.

DSI Eligibility

To be eligible for the incentive, providers must at minimum:

- Be part of a currently eligible provider type.
- Operate in one of the Alliance service areas.
- Use an electronic health records (EHR) system.

DSI Participation Requirements

To participate in the DSI and earn payments, providers will be required to:

- Complete and submit a DSI Interest Form. To do so, email dsi@thealliance.health for a copy of the form and submit the completed form to the same email address.
- After your completed DSI Interest Form has been accepted, Alliance staff will email you a Data Sharing Incentive Agreement (LOA) to review and sign.
- Sign the California Health and Human Services Data Sharing Agreement (DSA). Please check the DSA Signatory List to see if your organization has signed the agreement.
- Sign a participation agreement with the Serving Communities Health Information Organization (SCHIO), the HIE that serves Alliance providers. Once enrolled in the DSI program, incentive payments will be made based on submitting qualifying data directly to SCHIO.

Once all these documents have been signed and accepted, you will have completed Milestone 1. This will trigger your first incentive payment. For additional information on DSI program, please see the DSI page on the Alliance provider website.

Provider Resources and Support

Quality and Process Improvement

Practice Coaching

Consistent with the Alliance's mission of accessible, quality health care guided by local innovation, the Alliance works to identify solutions to produce positive outcomes for our members. As we work to advance our vision of active leadership in achieving healthcare solutions, we want to actively engage with and support individual clinics in Quality Improvement (QI) work. Specifically, we seek to partner with network primary care practices to pursue the "Quadruple Aim": improving the health of populations, enhancing the experience of care for individuals, reducing the cost of health care, and attaining joy in work.

Goals:

- Engage with primary care office managers, administrators, providers, medical assistants, and other staff to organize and prioritize QI activities
- Cultivate collaborative relationships between the Alliance Quality Improvement and Population Health (QIPH) Team and network providers and staff

- Support practice teams in QI project implementation and building/enhancing their QI infrastructure
- Increase the capacity of practices to utilize and make changes based on performance data
- Provide resources and information to disseminate best practices

Expectations of the clinic:

- Leadership will support and encourage engagement with the Alliance QI Team.
- Staff will work collaboratively with the Alliance QIPH Team to identify and prioritize QI needs.
- Involved leaders will make reasonable accommodations to regularly meet with Alliance QIPH Team members and provide information/resources needed to carry out activities.
- Staff and leadership will provide all requested feedback on the engagement.

Benefits to the clinic:

- On-site support from staff trained in QI methods and PCMH-focused primary care change concepts
- Technical assistance to optimize data and EHR utilization
- Hands-on help with advancing QI projects and activities of interest related to workflow development, tracking progress, evaluating PDSAs and other project-related tasks
- Actionable, evidence-based recommendations and feedback tailored to the clinic's specific needs
- Access to QI-related tools and assistance with selecting/adapting resources for the clinic's use
- Enhanced connections with Alliance resources

For additional questions about the practice coaching program please email us at performanceimprovement@thealliance.health

Provider Partnerships

The goal of this program is to improve targeted Managed Care Accountability Set (MCAS) measure compliance rates for low performing CBI sites to reach Minimum Performance Level (MPL) or higher. Quality Improvement Program Advisors are assigned as practice liaisons who build ongoing relationships with key QI stakeholders. This relationship is maintained through monthly practice coaching sessions and quarterly meetings with leadership to provide a deep dive into their practice performance on all MCAS metrics.

Virtual Learning Series: The ABC's of Quality Improvement

The pandemic brought about a lot of changes in primary care and the need to implement meaningful improvement projects with effectiveness and efficiency has never been greater. Therefore, to support our clinics safely, we have created a video learning series on the Basics of Quality Improvement. The videos on topics like SMART Aim Statements, Project Charters and Process Mapping can be accessed on the Practice Transformation Academy page of the Alliance provider website.

Each video introduces key concepts and tools that are integral to an improvement project. The tools we cover in detail are also available for download. If you have any questions about the material covered, or if you need

help starting an improvement project, please email us at performanceimprovement@thealliance.health for assistance.

Learning Collaboratives

Learning Collaboratives are interactive face-to-face in person meetings or virtual via Microsoft Teams with other providers and staff across the network to come together and share best practices on a selected topic. Individuals included in our learning collaboratives include clinics, hospitals, specialists and Alliance staff. During this roundtable, we explore methods to improve CBI scores, as well as discuss techniques to address barriers in healthcare.

Lunch and Learns

The Alliance Lunch and Learn series is meant to highlight a particular area of focus or HEDIS MCAS metrics based on DHCS and NCQA standards of care. The one-hour educational events take place quarterly with information targeted towards providers, nurses, medical assistants, and other support medical staff, as well as administrative staff. Quality Improvement staff collaborates with guest organizations and/or speakers to craft an informational and interactive presentation on the topic of focus.

Member Incentives 2025

Health Rewards Program

The Alliance Health Rewards Program provides member incentives for getting routine health care, managing chronic conditions, and adopting healthy habits. Alliance Medi-Cal members who do not have other health insurance are eligible to participate in member incentive programs. Members need to meet program criteria and must be eligible during the time the service is being provided by their PCP and when becoming active for the incentive.

Health Education and Disease Management Program Incentives

These incentives are provided with the Alliance Health Education and Disease Management programs and are designed to support and encourage members' efforts for engaging in healthy behaviors that improve their health outcomes. The impact of each incentive will be assessed by the Alliance annually. Please visit the Alliance Health Rewards Program page for additional information. Members can earn rewards for participating in the following health education programs:

- **Healthy Moms and Healthy Babies Program**
    - Members who see the doctor within the first 13 weeks of being pregnant or 6 weeks of joining the Alliance, will be entered into a raffle for a chance to win a $50 Target gift card.
    - Members who see their doctor 1 to 12 weeks after having a baby, will be eligible to receive a $25 Target gift card.
- **Healthier Living Program (HLP)**
    - Adult members who attend a 6-week workshop can receive a Target gift card for up to $50.

- **Live Better with Diabetes (LBD) Program**
    - Adult members who attend a 6-week workshop can receive a Target gift card for up to $50.
- **Healthy Weight for Life Program**
    - Parents or guardians of Alliance members ages 2–18 that attend a 10-week workshop can receive a Target gift card of up to $100.

Healthy Start Program Incentives

The Alliance's Healthy Start Program is available for members ages 0–15 months, 15–30 months, 2-year-olds, 13-year-olds and 18 to 21-year-olds for completing check-ups and/or immunizations.

- Immunizations: Adolescents

  Members turning 13 years of age who have received all of the following vaccinations by their 13th birthday and have completed a well care visit in the previous 12 months will be eligible to receive a $50 Target gift card:
    - 1 dose meningococcal conjugate
    - 1 dose tetanus, diphtheria, and pertussis (Tdap)
    - 2 doses of human papillomavirus (HPV)
- Immunizations: Children

  Members turning 2 years of age who have received all of the following vaccinations by their 2nd birthday will be eligible to receive a $100 Target gift card:
    - 4 diphtheria, tetanus, acellular pertussis (DTaP)
    - 3 inactivated polio vaccine (IPV)
    - 1 measles, mumps and rubella (MMR)
    - 3 haemophilus influenza type B (HiB)
    - 3 hepatitis B (HepB)
    - 1 varicella (VZV)
    - 4 pneumococcal conjugate (PCV)
    - 2 or 3 rotavirus (RV)
    - 1 hepatitis A (HepA)
    - 2 influenza (Flu)

- Well-Child Visits First 30 Months of Life

  0–15 Months of Life

  - Members who are 15 months old and have completed **6** or more well-child visits, in alignment with the schedule below, will be eligible to receive a $50 Target gift card:
    - 2–5 days old
    - 1 month old
    - 2 months old
    - 4 months old
    - 6 months old
    - 12 months old
    - 15 months old

  15–30 Months of Life

  - Members who are 30 months old and have completed **2** or more well-child visits, in alignment with the schedule below, will be eligible to receive a $25 Target gift card.
    - 18 months old
    - 24 months old
    - 30 months old

- Well-Care Visits 18–21 year olds
  - Members ages 18–21 years old who complete a well-care visit will be eligible to receive a $25 Target gift card. Members are only eligible to receive one incentive at age:
    - 18 years old
    - 19 years old
    - 20 years old
    - 21 years old

Seasonal Member Incentive

- Immunizations: Childhood Flu
  - Members ages 7 to 24 months who complete their second flu dose between September and May will be entered into a monthly raffle for a $100 Target gift card. Raffles will occur November through July.

Nurse Advice Line Service

The Nurse Advice Line (NAL) offers 24/7 triage support to direct all Alliance members requiring medical attention to the appropriate level of care, in the appropriate time frame, resulting in decreased ED use for avoidable conditions and improved PCP access. Alliance Medi-Cal Members who call the NAL will be entered into a monthly raffle for a chance to win a $50 Target gift card.

Section 19
Forms

Below is a list of forms, along with a brief description for their intended use. To view or download these forms, and for complete instructions on submitting them, please visit the Provider Forms Library.

Claims

Comments/Suggestions for the Claims Department – Providers can use this form to send comments or suggestions to the Alliance Claims Department.

Corrected Claim Form – Providers can use this form to submit corrected claims. The form must be filled out and the claim must be attached. Please do not staple the claim to the form as this delays processing time.

EDI Claims Enrollment Form: All Transaction Types – This form is used by providers to enroll in various ANSI X12 HIPAA-compliant EDI transactions, such as 837 professional and institutional Electronic Claims Submission, and others. Submission of the EDI Claims Enrollment Form begins the electronic claims submission process.

Reimbursement Rates Form – Providers can use this form to request reimbursement rate information from the Alliance.

Credit Balance Report – This form needs to be filled out quarterly and sent to the Alliance.

Provider Identified Overpayment Form – Providers can use this form to report an overpayment made by the Alliance.

Finance

EFT/ACH Authorization Form – Providers can use this form to receive electronic payments via Electronic Fund Transfer/Automated Clearing House.

EFT/ACH Authorization Form Instructions – This document provides instructions on how to complete the Electronic Fund Transfer/Automated Clearing House Authorization Form.

Grievance

Member Complaint Packets (English, Spanish, Hmong) – These files can be printed out and handed to members who are interested in filing a complaint to the Alliance's Grievance Coordinator.

Need Help with Your HMO? (English, Spanish) – Flyers from California Department of Managed Health Care describing how members can get help regarding their health plan.

Health Services

Advance Directive Form (English, Spanish) – These advance directive forms are easy for patients to read and understand.

CPT/Procedure Code Inquiry Form – Providers can use this form to check if a CPT code requires prior authorization.

Provider Change Request (PCR) Form – Providers can use this form to make simple changes to an existing prior authorization.

Authorization Status Request – Providers can use this form to check the status of an authorization request.

Treatment Authorization Request – Providers can use this form to request authorization for outpatient services, out-of-area authorized referrals, and durable medical equipment requests.

Request for Extension of Stay in Hospital – Providers can use this form for an extension of inpatient hospital stays.

Long Term Care Treatment Authorization Request – Providers can use this form to request authorization for long term care.

Community Based Adult Services (CBAS) Inquiry Form – Providers can use this form to inquire about CBAS services for Alliance members.

Consent for Sterilization or Hysterectomy Sample Form – Providers can use this sample form to obtain consent for sterilization or a hysterectomy. Providers are free to duplicate this form and add their letterhead. For additional information, please see Policy 404-1401 – Sterilization Consent Protocol.

Comprehensive Perinatal Services Program (CPSP) – Per Title 22, Section 51348, all contracted providers must perform a comprehensive risk assessment for all pregnant members that is comparable to the American Congress of Obstetricians and Gynecologists (ACOG) and CPSP standards. The Providers can use these forms during an initial prenatal visit, once each trimester thereafter, and at postpartum visits.

Provider-Preventable Conditions (PPC) Reporting Form – Providers are required to report PPCs to DHCS using the DHCS secure online portal within five working days of discovery of a PPC to DHCS. Audit reporting receipt must also be sent to the Alliance Quality Improvement Department via our secure fax line at 831-430-5688. For additional information, please see Policy 401-1305 – Provider Preventable Conditions.

Physician Orders for Life-Sustaining Treatment (POLST) (English, Spanish, Hmong) – This form is designed to support conversations on end-of-life planning occur with seriously ill patients, allowing them to choose the treatments they want and helping ensure that their wishes are honored by medical providers.

Prescription Drug Prior Authorization or Step Therapy Exception Request Form – Providers can use this form to request prior authorization for medications and Physician-Administered Drugs.

Request for Administrative Member Classification – Providers can use this form to request that an Alliance member be made an administrative member.

Synagis Policy **and Medical Necessity Form –** Providers who wish to administer Synagis in their office are required to submit the Statement of Medical Necessity along with the prior authorization request. For more information on Synagis, please see Alliance Policy 403-1120 – Synagis (Palivizumab).

Transportation – Providers can use Physician Certification Statements of Medical Necessity to request Non-Emergency Medical Transportation (NEMT). Providers can use the Transportation Services Request Form to request transportation services.

Operations Management

OHC Referral Form – Providers can use this form to report a member's Other Health Coverage.

Provider Services

Certification Regarding Debarment Suspension, Ineligibility and Voluntary Exclusion – Providers can send this form to the Alliance with their signed Services Agreement.

Certification Regarding Lobbying – Exhibit D (F) Att. 1 and 2 – Providers receiving payments under the Services Agreement of $100,000 or more are required to submit this form to the Alliance.

Locum Tenens Notification Form – Providers can use this form to notify the Alliance of all locum tenens before they render services to Alliance members.

Member Appointment No-Show Notification – Providers can use this form is used to inform the Alliance's Member Services department that an Alliance member did not keep a scheduled appointment.

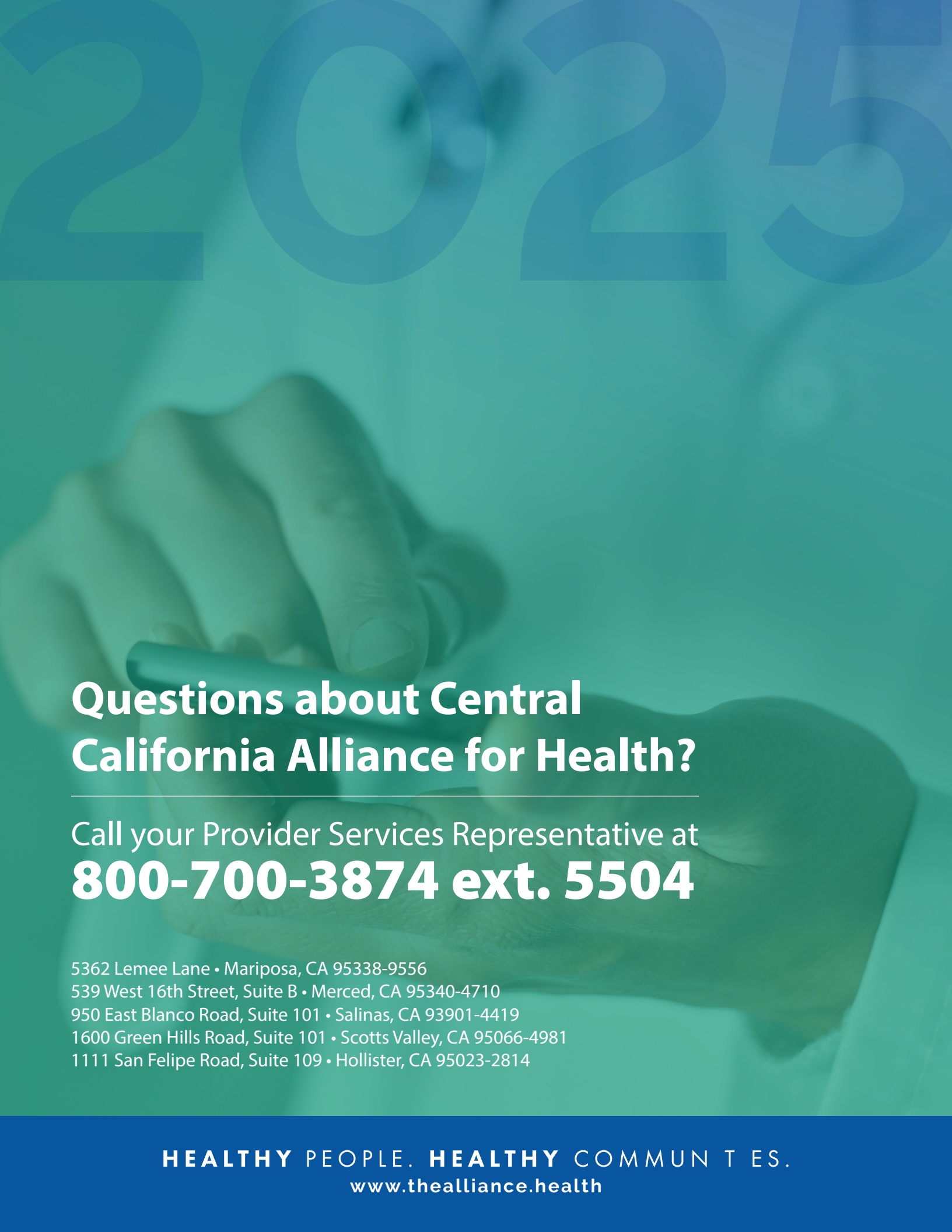
Patient Complaint / Grievance Tracking Log – Providers can use this form to track patient requests for Complaint/Grievance Forms.

Provider Applications – If you are interested in becoming an Alliance provider, visit the Join our Network page on the Alliance provider website.

Provider Dispute Form – Providers can use this form to file a dispute with the Alliance.

Provider Information Change Form – Providers can use this form to update contact and practice information, including provider address, phone number, contact information, payment address, and tax ID number.

Request for Member Reassignment – Forms, procedures, and member notices to be used when requesting member reassignment.



Questions about Central California Alliance for Health?

Call your Provider Services Representative at

800-700-3874 ext. 5504

5362 Lemee Lane • Mariposa, CA 95338-9556
539 West 16th Street, Suite B • Merced, CA 95340-4710
950 East Blanco Road, Suite 101 • Salinas, CA 93901-4419
1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981
1111 San Felipe Road, Suite 109 • Hollister, CA 95023-2814

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