

CONTRA COSTA
HEALTH



Universal Provider Manual 2026

The purpose of the guidelines presented in this Manual is to assist the Providers with information about Contra Costa Health Plan (CCHP) processes. It will assist with referrals for health services, claims processing, member assistance, grievance procedures, and other procedures required by CCHP in the delivery of care to members.

If you need further assistance or clarification regarding any information contained in this manual, please call the CCHP Provider Relations Department at 1-877-800-7423, option 6, e-mail ProviderRelations@cchealth.org, or fax 925-608-9411.

All information contained in this manual can be accessed on our website at <https://www.cchealth.org/health-insurance>.

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Section 1 – Welcome To The Contra Costa Health Plan

How to Read the Manual

This manual contains important information on Contra Costa Health Plan's **Medi-Cal, Care Plus (HMO D-SNP), and Commercial** lines of business. Although our lines of business share many similarities, this manual will clearly distinguish any differences across product lines.

This is an electronic manual that includes hyperlinks directing you to external resources, corresponding sections within the manual, and email addresses to follow up with us if you have questions. Please contact us at providerrelations@cchealth.org if there is anything wrong or if you would like to suggest future changes to help us make this manual better.

Mission Statement

Contra Costa Health Plan's mission is to care for and improve the health of all people in Contra Costa County, with special attention to the most vulnerable. They actively stand against racism, prejudice, and systemic discrimination. CCHP is the primary managed-care provider for Medi-Cal beneficiaries in Contra Costa, and they manage smaller plans for county employees and IHSS homecare workers.

About CCHP

CCHP is accredited for our Medi-Cal product by the National Committee for Quality Assurance (NCQA). As a Federally Qualified Health Maintenance Organization (HMO), CCHP enrolls Contra Costa County employees, In-Home Support Services (IHSS), and Medi-Cal members that include Seniors and Persons with Disabilities and Chronic Conditions, Medi-Cal Expansion, Families, Low-Income Children's Programs and Care Plus (HMO D-SNP) CCHP's commitment to serving the County's most vulnerable populations is reflected in the composition of its membership. Above all, CCHP is committed to our motto: "A Culture of Caring"

Organizational Structure

The elected five-member County Board of Supervisors represents CCHP's Board of Directors. The Board of Supervisors establishes the mission and goals of CCHP; the Chief Executive Officer of Contra Costa Health Services has the responsibility for meeting these goals. The HMO Chief Executive Officer, who reports to the Chief Executive Officer of Contra Costa Health Services and to the Board of Supervisors, is responsible for the overall administration and management of CCHP; the Chief Medical Officer is a Board-Certified Physician who is responsible for the overall clinical operations of CCHP.

CCHP is a division of the Contra Costa County Health Services Department. The organizational structure of the Department allows CCHP to work closely with the Regional Medical Center Network and its ten Ambulatory Care Centers, Behavioral Health Services,

Public Health, Emergency Medical Services, Environmental Health, Hazardous Materials, Health, Housing & Homeless Services, Information Technology, and Finance Divisions to provide comprehensive health care services to members.

Health Care Delivery System

CCHP uses a primary care model in delivering comprehensive health care services to members. The goals of this model are:

- to provide convenient and timely access to health care services
- to ensure the provision of preventive healthcare
- to maintain the health of its members
- to coordinate referral and access to specialty care services including inpatient care.

Services provided to members vary depending on the member's specific group benefit package. However, all plans include, but are not limited to, the following services:

- Physician Services – Primary and Specialty Care
- Preventive Health Care
- Consultation and Referral Services
- Diagnostic Services
- Durable Medical Equipment (DME) Services and Supplies
- Emergency/Urgent Care Services
- Inpatient Hospital Services
- Laboratory Services
- Outpatient Hospital Services

Depending on the benefit package, members choose or are assigned to one of two Networks:

- Regional Medical Center (RMC) Network. The RMC Network is comprised of Contra Costa Health Services medical staff; physicians, specialists, nurse practitioners, nurses, and ancillary providers providing care at the ten county health centers and the Contra Costa Regional Medical Center.
- Community Provider Network (CPN). The CPN is comprised of local physicians, nurse practitioner mid-levels, physician assistants, specialists, and ancillary providers providing care in their private offices in the community and at our contracted community hospitals.

Members receive care from the providers within the network they have chosen or been assigned. However, there may be a case when a member will be authorized to receive care outside of their network. CCHP providers contract for all product lines applicable to the service they provide, and they may serve members enrolled in CCHP Managed Care Medi-Cal, Seniors and Persons with Disabilities and Chronic Conditions (SPDs) members, County Employees, and Care Plus (HMO D-SNP).

Section 2 – Provider Relations

Provider Relations is responsible for the centralization of the following services for Providers:

- Enrollment and Screening
- Credentialing and Re-credentialing
- Contract Management
- New Provider Health Plan Orientation
- On-line Provider Directory
- Provider Complaints (Non-Clinical)

Additionally, Provider Relations staff function as key liaisons to providers covering the following types of issues and concerns:

- Authorization and referral guidelines
- Claims submittal and payment
- Contractual requirements
- Member discharge from practice
- Provider recruitment and retention

Provider Enrollment

The Department of Healthcare Services (DHCS) mandates all contracted providers or any new provider joining the Contra Costa Health Plan (CCHP) be enrolled through either the DHCS Fee-For-Service (FFS) Medi-Cal program or the Centers for Medicare & Medicaid Services (CMS) program.

The required disclosure and enrollment options are as follows:

Managed Care providers have three options for enrolling with the Medi-Cal Program. Providers may enroll through:

- Department of Health Care Services (DHCS) Provider Enrollment Division (PED)
- Centers for Medicare & Medicaid Services (CMS)
- Medi-Cal Managed Care plan (MCP)

If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with CCHP for Managed Care Medi-Cal services. Providers are not required to see Medi-Cal FFS beneficiaries even though they are enrolled.

Generally, State and Federal laws and regulations that apply to FFS providers will also apply to the enrollment process for Managed Care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the “CCHP Provider Agreement” and the “DHCS Provider Enrollment Agreement or CMS Enrollment Agreement.”

The CCHP Provider Agreement is the contract between CCHP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

1. Enrollment through DHCS
 - The provider will use DHCS' standardized application form(s) through their PAVE Provider Portal when applying for participation in the Medi-Cal program. Applications can be found at the provided link:
<https://pave.dhcs.ca.gov/sso/login.do>
 - State and Federal laws and regulations that apply to FFS providers will apply to the enrollment process for Managed Care providers.
 - Upon successful enrollment through DHCS, the provider will be eligible to contract with CCHP and provide services to FFS beneficiaries, if desired.
2. Enrollment through CMS
 - The provider will use CMS' standardized application form(s) through their PECOS Provider Portal when applying for participation in the Medicare & Medicaid program. Applications can be found at the provided link:
 - <https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers>
 - State and Federal laws and regulations that apply to Medicare & Medicaid providers will apply to the enrollment process for Managed Care providers.
 - Upon successful enrollment through CMS, the provider will be eligible to contract with CCHP and provide services to Medicare and Medicaid beneficiaries, if desired.
3. Enrollment through a Managed Care Plan other than CCHP
 - Submit Verification of Enrollment to CCHP. CCHP will accept this verification as proof of enrollment.
4. Enrollment through CCHP - The following provides an overview of the CCHP enrollment process:
 - The provider will submit the same approved DHCS enrollment application to CCHP.
 - As part of the application process, the provider will be required to agree that DHCS and CCHP may share information relating to a provider's application and eligibility, including, but not limited to, issues related to program integrity.
 - CCHP will be responsible for gathering all necessary documents and information associated with the Provider's application.
 - The provider should direct any questions regarding their application to CCHP by e-mailing ProviderRelations@cchealth.org.

- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with CCHP.
- While CCHP's enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment application may differ. In addition, CCHP will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal CCHP's decision to cease the enrollment process.
- CCHP will complete the enrollment process within 120 days of the provider's submission of their complete application. During this time, the provider may participate in CCHP's network for up to 120 days, pending approval from the CCHP, if all other Contracts and Credentialing processes are complete.
- Once CCHP places a provider on the Enrolled Provider List, the provider is eligible to contract with all Managed Care Plans (MCPs). However, an MCP is not required to contract with an enrolled provider. Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if CCHP receives any information that impacts the provider's enrollment, CCHP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- For a provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

Provider Credentialing and Recredentialing

CCHP follows Department of Health Care Services (DHCS), Department of Managed Care (DMHC), National Committee for Quality Assurance (NCQA) guidelines and standards for initial Provider credentialing and re-credentialing. The purpose of the credentialing process is to exercise reasonable care in the selection of providers delivering care to CCHP members. The credentialing cycle is generally every three years and includes a comprehensive Facility Site Review for all Primary Care, and Organizational Providers such as a stand-alone surgery center or skilled nursing facility that is not accredited or has a current CMS survey (within three years of credentialing date). All providers must be qualified in accordance with

current applicable legal, professional, and technical standards, appropriately licensed, certified, or registered and must have a good standing in the Medi-Cal and Medicare programs. Providers that have been suspended or excluded from participation in either Medi-Cal/Medicare program are ineligible to participate in the CCHP network. Network Providers/Subcontractors may be suspended or excluded from participation in the Medi-Cal program when an individual or entity has:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reason; or
- Lost or surrendered a license, certificate, or approval to provide health care.

CCHP may contract with a Network Provider and/or Subcontractor that has been suspended or excluded from participation in the Medi-Cal program when the suspension and/or exclusion has been lifted.

CCHP is required to check the following databases to verify the identity and determine the exclusion and/or enrollment status of all providers:

- Social Security Administration's Death Master File.
- National Plan and Provider Enumeration System (NPPES).
- List of Excluded Individuals/Entities (LEIE).
- System for Award Management (SAM).
- CMS' Medicare Exclusion Database (MED).
- DHCS' Suspended and Ineligible Provider List.
- Restricted Provider Database (RPD).

The following actions are taken if a provider or vendor appears on an exclusionary database or list.

Exclusionary Database/List	Criteria	MCP Action
Suspended and Ineligible Provider List	Medi-Cal providers suspended from participation in the Medi-Cal program.	Terminate contract and submit appropriate documentation as outlined in APL 21-003.
<u>Restricted Provider Database</u>	<i>Payment Suspension:</i> Providers are placed under a payment suspension while under investigation based upon a credible allegation of fraud.	CCHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services will be withheld. Providers subject to only a payment suspension will show a comment of "Payment Suspension Only" on the Restricted Provider Database. If CCHP chooses to terminate the contract, they must submit appropriate documentation as outlined in APL 21-003

	<i>Temporary Suspension:</i> Providers placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.	Terminate contract and submit appropriate documentation as outlined in APL 16-001. The Restricted Provider Database will not reflect any comments for providers subject to a temporary suspension.
List of Excluded Individuals/Entities	Individuals and entities that are excluded from federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud.	Terminate contract and submit appropriate documentation as outlined in APL 21-003.
Procedure/Drug Code Limitation List	Providers placed under a procedure or drug code limitation sanction.	CCHP may continue to contract with providers placed on a procedure/drug code limitation, however, the MCP will not be paid for services provided by a restricted provider or receive reimbursement for those services under restriction. Providers who fill orders for lab tests, drugs, medical supplies, or any other restricted services prescribed or ordered by a provider under restriction will not be reimbursed. If CCHP chooses to terminate the contract, they must submit appropriate documentation as outlined in APL 21-003.

Upon discovery that a Network Provider/Subcontractor has been excluded or suspended from the Medi-Cal program, CCHP must take the following steps:

1. Immediately, or within 10 calendar days of learning of a Network Provider/Subcontractor’s exclusionary status, provide DHCS with written notice of the termination and submit a Member Transition Plan, and Network Review Documents;
2. Immediately, or within 10 calendar days of learning of a Network Provider/Subcontractor’s exclusionary status, suspend payment to the excluded Network Provider/Subcontractor for all Medi-Cal services provided after the effective date of the exclusion;
3. Immediately, or within 10 calendar days of learning of a Network Provider/Subcontractor’s exclusionary status, notify all affected directly contracted providers, as applicable;
4. Provide notice to all impacted members;
5. Coordinate care for impacted members as required by federal and state law, and CCHP’s contract with DHCS; and
6. Report to DHCS program integrity information related to fraud, waste and abuse allegations, including any contract terminations.

All providers, including non-physician medical practitioners and organizational

providers, applying to the CCHP network must be credentialed and approved by the CCHP Peer Review and Credentialing Committee (PRCC) and have an executed contract prior to the provision of services to CCHP members. The PRCC, facilitated by the Chief Medical Officer, or designee, makes the decision to accept, retain, deny, or terminate a provider's participation in the CCHP network. The PRCC determines that the practitioner should either be:

Recommended for full credentialing: - three-year period, or for a shorter period review cycle.

1. Deferred for further information and/or clarification.
2. Recommended for denial. In the case of a denial, the practitioner is notified in writing within sixty (60) calendar days of the PRCC committee's recommendation.

The practitioner has the right to appeal the denial, and the appeal process is included in the denial letter. Should a practitioner be denied participation he/she may reapply one year after the date of the denial notification.

1. If a practitioner is recommended for denial of credentialing, the PRCC will review the reasons for denial to determine if the denial constitutes a mandatory 805 report to the Medical Board.
2. When a practitioner's recommendation for approval has been ratified by the PRCC, a letter will be sent to the practitioner within sixty (60) calendar days from the date of the committee decision indicating that their request for participation has been approved.

The PRCC does not make credentialing or recredentialing decisions based on an applicant's age, gender, race, ethnic/national identity, sexual orientation, or types of procedures performed by the applicant.

Providers will be notified by e-mail, phone or mail when the documents in the credential file such as licensure, certifications and liability coverage have expired. A request will be sent for a current copy of the document. Failure to send in renewal documents within thirty days of expiration may result in suspension or termination from the CCHP network.

For questions concerning credentialing, contact the Credentialing Unit:

- 1-877-800-7423, option 6
- E-mail: CCHPCredentialing@cchealth.org

Credentialing Criteria and Basic Qualifications to apply for participation or continued participation with CCHP. Participating practitioners who no longer meet these requirements will be terminated from the network and are not eligible to appeal.

The following criteria is reviewed and current at time of initial credentialing.	
Medi-Cal Certification (if applicable)	If the applicant is a current Medi-Cal practitioner in accordance with DHCS requirements, the CCHP will refer to reports received directly from the Department of Health Care Services to ensure that the practitioner is certified and in good standing as a participant in the Medi-Cal program. Refer to CCHP Screening and Enrollment policy.
Physician (MD or DO) including Mental Health and Substance Use Disorder Criteria and Licensure	Be a graduate of an accredited medical or osteopathic school located in the United States, its territories, or Canada or be a graduate of a medical school approved by the state licensing board. Have successfully completed an accredited residency program in the specialty in which (s)he is seeking participation. Criteria may be waived if the practitioner is Board Certified in the specialty in which he or she is seeking participation without being required to complete a residency program. An applicant must maintain a current, unrestricted license to practice medicine or osteopathy. Should practitioners also maintain out-of-state licenses, the status of these licenses may be verified.
Dentists (DDS) Criteria and Licensure	Be a graduate from a dental school accredited by the American Dental Association Commission on Accreditation or a dental school accepted by the licensing board. Have successfully completed an accredited residency program in the specialty in which (s)he is seeking participation. Those specialties which require completion of a residency include: Endodontics, Oral and Maxillofacial Surgery, Orthodontics and Dentofacial Orthopedics, Pediatric Dentistry, Periodontics, and Prosthodontics. Have a valid, current, unrestricted license.
Podiatrists (DPM) Criteria and Licensure	Be a graduate of a school of podiatric medicine that is accredited by the Council on Podiatric Medical Education. Have successfully completed an accredited residency program in the specialty in which (s)he is seeking participation. Criteria may be waived if the practitioner is Board Certified in the specialty in which he or she is seeking participation without being required to complete a residency program.
Chiropractors (DC) Criteria and Licensure	Be a graduate of a college of chiropractic medicine that is accredited by the Council on Chiropractic Education. Have a valid, current, unrestricted license.
Certified Nurse Midwives (CNM), Certified Nurse Practitioners (NP or FNP) Criteria and Licensure)	Be a graduate of an accredited college of nurse midwifery or other advanced nursing practice program and be certified by a national certification organization acceptable to the state licensing board. Have a valid, current, unrestricted license and prescribing privileges. Have a practice agreement (protocol) with a CCHP participating

	supervising physician.
Licensed Midwives (LM)	Have completed a three-year postsecondary education program in an accredited midwifery school approved by the Medical Board of California and clinical experience in midwifery or met the challenge requirements and must pass the North American Registry of Midwives' (NARM) comprehensive examination. Have a valid license to practice midwifery by the Medical Board of California.
Doulas	<p>Not a licensed provider and no supervision required.</p> <p>Provide health, education, advocacy and physical, emotional and non-medical support for pregnant and postpartum people before, during and after childbirth, including support during miscarriage, still birth and abortion with the goal of preventing perinatal complications and improving health outcomes for birthing parents and infants. Services can only be provided during pregnancy; labor and delivery including stillbirth; miscarriage; abortion and within one year of the end of a Member’s pregnancy. Services require a written recommendation by a physician or other licensed practitioners (who don’t need to be enrolled in Medi-Cal or be a Network Provider within CCHP) of the healing arts within their scope of practice under state law</p> <p>Must be enrolled as a Medi-Cal provider and have a National Provider Identifier (NPI) number. Must be at least 18 years old at the time the application is submitted; Provide proof of an adult and infant cardiopulmonary resuscitation (CPR) certification from the American Red Cross or American Heart Association. Attest they completed basic Health Insurance Portability and Accountability Act (HIPAA) training. Complete three hours of continuing education in maternal, perinatal, and/or infant care every three years. Doulas must maintain evidence of completed training to be made available to DHCS upon request.</p> <p>Meet qualifications either through the Training Pathway or Experience Pathway:</p> <p>Training Pathway • Certificate of Completion for a minimum of 16 hours of training in which includes all of the following topics: Lactation support, Childbirth education, Foundations on the anatomy of pregnancy and childbirth, Nonmedical comfort measures, prenatal support, and labor support techniques, Developing a community resource list, Attest they have provided support at a minimum of three (3) births.</p>

	<p>Experience Pathway • Attest that they have provided services in the capacity of doula either a paid or volunteer capacity for at least five years. The five years of experience in the capacity as a Doula must have occurred within the last seven (7) years. Three (3) written client testimonial letters, or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven (7) years. One (1) letter must be from either a licensed provider, a community-based organization, or an enrolled doula. “Enrolled doula” means a doula enrolled either through DHCS or through an MCP consistent with APL 22-013 Provider Credentialing /ReCredentialing and Screening/Enrollment or subsequent updates within CCHP of the healing arts within their scope of practice under state law.</p>
Physician Assistants (PA) Criteria and Licensure	<p>Be a graduate of a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessors. May have current certification by the National Commission on Certification of Physician Assistants. Have a valid, current, unrestricted license. Have a practice agreement (protocol) with a CCHP participating supervising physician.</p>
Optometrists (OD) Criteria and Licensure	<p>Be a graduate of optometry that is accredited by the Council on Optometric Education of the American Optometric Association. Have a valid, current, unrestricted license.</p>

Non-Physician Medical Practitioner Criteria and Licensure	<p>All non-physician medical practitioners must have a valid, current, unrestricted license.</p>
Non-Physician Medical Practitioner Protocol	<p>Practitioners employing non-physician medical practitioners must submit protocols on the supervision in accordance with state and federal regulations.</p>
Hospital Admitting Privileges	<p>An applicant must maintain current, unrestricted hospital staff membership, clinical privileges, and admitting privileges with a CCHP-participating hospital (if applicable). Applicants without privileges may be waived of this requirement if approved by the PRCC. Applicants may be required to provide written attestation of admitting arrangements. PCPs are not required to have hospital privileges.</p>
DEA or CDS Certification	<p>An applicant must maintain a current Drug Enforcement Administration (DEA) certification, with a California practice address listed for the practitioner, if applicable to applicant's scope of practice.</p>
Specialty Board Certification	<p>Primary Care and Specialty Care practitioners must be board certified by the American Board of Medical</p>

	<p>Specialties in the specialty and subspecialty or practice, American Medical Association, American Osteopathic Association, American Board of Podiatric Surgery, American Board of Podiatric Orthopedics and Primary Podiatric Medicine, American Board of Lower Extremity Surgery, if applicable Specialty Dental Boards:</p> <p>Dental Specialty Boards Recognized by the American Dental Association Counsel on Dental Education and Licensure (CDEL)</p> <p>CCHP does not require existing practitioners (as of January 2000) to be board certified unless they completed residency after January 1, 1996. This exception would be “grandfathering.” New practitioners must become board certified within 5 years of completing residency. In accordance with ABMS guidelines recertification in the specialty is not required to obtain certification in the subspecialty. CCHP expects all practitioners to maintain board certification.</p>
Board Certification for Mid-levels	Nurse Practitioners and Physician Assistants who indicate on their application they are board certified, must have verification of the certification from Nursing Boards or National Commission on Certification of PA’s (NCCPA).
Patient Age Ranges for Specialists	Age ranges for specialty physician are specific to the specialty.
HIV/AIDS Specialists	Practitioners who wish to be identified as an HIV/AIDS specialist must meet the definition of an HIV/AIDS specialist according to California state regulations. All HIV/AIDS specialists will be surveyed annually with form 2168 to determine if they continue to meet regulations
Primary Care Providers (PCPs)	<p>PCPs being reviewed for credentialing must meet one of the following criteria:</p> <ul style="list-style-type: none"> • Pediatric board certification • Family Medicine board certification • Internal Medicine board certification • OB/GYN board certification
Patient Age Ranges for PCP’s	<ul style="list-style-type: none"> • Pediatric age: 0 - 21 maximum • Family Medicine: all ages • Internal Medicine: age 14 and above • OB/GYN: age 14 and above, restricted to females • General Practice all age ranges if evidence of pediatric training, experience and/or CME is present • Age ranges for non-physician medical practitioners are the same as stated above based on PCP specialty
Primary Care Criteria Form	PCPs and OB/GYN (PCPs) being reviewed for credentialing must complete the Primary Care Criteria form. PCPs that

	are unable to meet the criteria are unable to join the network. Exception: An OB/GYN is not required to be a PCP unless OB/GYN requests and agrees to meet PCP criteria. Refer to CCHP Policies MS 8.050, UM 15.032, UM 15.064
National Practitioner Data Bank (NPDB)	CCHP runs an NPDB report on all practitioners applying to participate in the network. Derogatory information is reviewed by the Peer Review and Credentialing Committee (PRCC). All practitioners must maintain satisfactory standing with the National Practitioner Data Bank. CCHP participating practitioners are enrolled in NPDB Continuous Query. When issues are identified, those issues are reviewed at the next scheduled PRCC.
Professional Liability Claims History	Malpractice history is verified through the NPDB. Practitioners with a history of malpractice suits or decisions of three or more claims in any five-year period, multiple settled or negative verdicts in excess of \$100,000 and/or multiple claims in a similar area, require full discussion and review by PRCC prior to making a credentialing decision.
Sanction Information	Practitioners with Medi-Cal, Medicaid, or Medicare certification must be clear of sanctions imposed, suspension from, or termination from these programs. CCHP does not contract or credential practitioners who opt out of Medicare or are excluded from Medi-Cal.
Fraud, Waste, and Abuse	Practitioners, Organizational Providers or Vendors must not appear on the Office of Inspector General (OIG) exclusion list. CCHP does not contract or credential practitioners, providers or vendors who are on the OIG exclusion list.
Professional Liability Insurance	Participating practitioners must maintain professional liability insurance (malpractice) with limits of liability of at least \$1,000,000 per occurrence and \$3,000,000 aggregate all times. Each practitioner must notify the insurance company holding the policy to provide the CCHP with copies of the updated policy upon each renewal.
DHCS or ORP Enrollment if Pathway to enroll	Prospective and current network providers must be enrolled as a Medi-Cal provider if a pathway to enroll exists. (Medi-Cal providers only)
Street Medicine	Street Medicine Providers are credentialed using the process and criteria outlined in the policy to ensure meeting standards of participation in the network. The providers are not required to be a PCP to contract.

Delegated Credentialing

CCHP follows CMS, DHCS, DMHC and NCQA guidelines and standards for delegated credentialing and is responsible for oversight of the delegated activity. CCHP delegates credentialing to Independent Physician Associates (IPA’s), Physician groups, hospitals and other entities that provide services to our members. CCHP is ultimately responsible and does ensure that all delegated

entities and subcontractors comply with all applicable State and Federal laws and regulations, contract requirements, reporting requirements, and other DHCS guidance including but not limited to All Plan Letters.

Before delegation is granted, the entity must submit written policies and procedures related to credentialing activities of potential network providers. The written policies and procedures must meet CCHP requirements for credentialing and recredentialing.

Delegated entities are required to sign a delegated credentialing agreement and contract with CCHP. In addition, delegated entities must submit quarterly or semi-annual reports that include network changes. Delegated entities credentialing files and Policies and Procedures are audited annually by the Provider Relations credentialing staff or through the Health Industry Collaboration Effort (HICE) shared audit unless the entity is NCQA accredited.

CCHP designated staff, Chief Medical Officer (or designee), and the PRCC have the responsibility to perform oversight of any delegated entity's credentialing and recredentialing activities to ensure compliance with CCHP policies and to make recommendations for improvement. If the delegated entity fails to meet its obligations, CCHP has the right to terminate the delegation.

Organizational Providers

An organizational provider is a provider contracted with CCHP to provide inpatient or outpatient services. CCHP directs members to organizational providers to receive health care services rather than to an individual practitioner.

Organizational providers include:

- Dialysis Infusion Centers
- Home Health Agencies
- Hospice
- Hospitals
- Mental Health Facilities/Chemical Dependency Facilities
- Skilled Nursing Facilities/Long Term Care Facilities/ICF-DD Homes
- Free Standing Surgery/Surgical Centers

All organizational providers requesting participation with CCHP must complete an application for participation, which is designed to perform a review of the organizational provider's credentials and ability to provide services, and complete required contract documents. CCHP's Peer Review and Credentialing Committee (PRCC) will review the assessment of each organizational provider prior to approval to participate in the CCHP provider network. Organizations accredited by an

approved accrediting body will be deemed as meeting the required standards and will not be further reviewed by CCHP. An on-site quality assessment will be conducted if the organization is not accredited.

In lieu of an on-site quality visit, for a non-accredited organization, CCHP will accept a CMS or state review provided the review is not greater than three (3) years old at the time of verification. Prior to providing services, organizational providers must be approved by the PRCC and have an executed contract in place.

CCHP assesses organizational providers at a minimum of every three (3) years, with the exception of ICF-DD Homes, which are recertified every two (2) years in accordance with CMS, DHCS, DMHC and NCQA standards and guidelines in order to ensure that providers continue to be in good standing with state and regulatory bodies and meet health and safety standards required by the health plan. Organizational providers must maintain Medicare certification (if applicable). Providers will be notified periodically of expired licensure, certification and liability coverage and requested to send in the renewal copy of the documents. Failure to send in renewal documents within thirty days of expiration and notification may result in termination from the CCHP network.

The California Department of Public Health (CDPH) is responsible for decertifying or suspending licensed Long-Term Care (LTC) facilities. Upon discovery of an LTC facility decertification or suspension, CCHP must terminate its contract with the facility, and take the following steps outlined below:

1. Immediately notify DHCS of the contract termination with the LTC facility due to decertification or suspension;
2. Within five business days of receiving a final notification of an LTC facility decertification, submit a Transition Plan and Network Review Documents;
3. Immediately suspend payment to the decertified or suspended LTC facility for all Medi-Cal services provided after the effective date of the exclusion;
4. Immediately notify all affected directly contracted providers of the decertified or suspended LTC facility;
5. Provide notice to all impacted members; and
6. Coordinate care for impacted members as required by federal and state law, and the MCP's contract with DHCS.

Specialty Care

CCHP has a large Specialty Care Provider network to meet a wide range of member needs. All contracted providers are listed on the CCHP online Provider Directory located at www.cchealth.org/healthplan. Searches will provide you with the names

of providers, specialties, board certifications, hospital affiliations, directions, languages spoken, office hours, telephone numbers and more.

Telehealth

CCHP follows all applicable State and Federal laws in the use of Telemedicine services to provide consultation, access and quality of care to members. CCHP's guidance on providing essential services by Telehealth:

- Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or member home or other setting.
- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment.
- The member has provided verbal or written consent, and it is documented in the medical record.
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service.
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a member's right to the member's own medical information.
- The member is not precluded from receiving in-person health care services after agreeing to receive telehealth services.

CCHP providers must use the appropriate modifiers and CPT-4 or HCPCS codes when billing for services delivered via telehealth and document the Place of Service code on the claim.

POS 02: Telehealth Provided Other than in Member's Home

Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. Member is not located in their home when receiving health services or health related services through telecommunication technology.

POS 10: Telehealth Provided in Member's Home

Descriptor: The location where health services and health related services are provided or received through telecommunication technology. Member is located in their home (which is a location other than a hospital or other facility where the member receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Use modifier 95 for synchronous rendering of services or GQ for asynchronous.

Provider Contracts

CCHP contracts with physicians, hospitals, ancillary, organizational providers, and

vendors for healthcare services and supplies that meet the participation requirements and are fully credentialed in accordance with CCHP's Credentialing and Recredentialing policies. For medically necessary services not available in our network, CCHP may negotiate single member Letters of Agreement (LOA) with non-credentialed, non-contracted providers or vendors as necessary to meet member's needs and in the event a member resides in a zip code CCHP has DHCS or DMHC approved Alternative Access Standards. CCHP is required by the Department of Healthcare Services (DHCS) to have all contracted entities complete and return the form indicating ownership status of all entities we contract with. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information described in Title 42, CFR, Section 455.104.

Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

In addition, all providers must complete a County Registration and Certification form, a signed W-9 dated within the same year and be registered with the Secretary of State to conduct business in California. The Secretary of State website is located at [California Secretary of State](#).

All contracts are signed through DocuSign. Contractors are expected to promptly notify the Health Plan should information change at any time during the contract term. Contract renewals begin three-six months in advance of the term expiration date. Providers will be notified and required to update their contract information. Signed copies are required to be promptly returned to the County by Contractors to continue timely payments.

For subcontractors and delegated entities, CCHP is ultimately responsible and does ensure that they comply with all applicable State and Federal laws and regulations, contract requirements, reporting requirements, and other DHCS guidance including but not limited to All Plan Letters.

For questions regarding contracting, contact the Contract Management Unit:
Provider Relations Contract Management Unit
1-877-800-7423, option 6
E-mail: CCHPcontracts@cchealth.org

Provider Roles and Responsibilities – New Provider Orientation

The Provider Relations Department is mandated by regulatory bodies to orient new providers to the health plan within ten (10) business days of being placed as active in the CCHP Network. The Provider Manual and Provider Orientation PowerPoint (Appendix R) are available on our website at www.cchealth.org/healthplan. The

Provider Manual is updated with new materials as changes occur.

Orientation materials are e-mailed to each provider. The provider or entity is required to review the material and return the attestation acknowledgment form. Providers who fail to return the attestation acknowledgment form within the ten-day timeframe may be placed as inactive in the CCHP network until the form is returned.

Delegated entities receive their orientation materials during the onboarding process with the entity. CCHP has provided the orientation materials to each delegated entity. Until the onboarding process is completed, the provider is not allowed to see CCHP members.

Orientation materials cover the following areas:

- PCP and Specialty Provider Roles and Responsibilities
- Managed Care and Special Needs Plans
- Seniors and Persons with Disabilities (SPD's) Cultural Awareness and Sensitivity Training (Refer to Appendix K)
- Case Management Services
- Access to Health Plan Programs
- Advanced Health Care Directives
- Providers must document execution of an Advanced Health Care Directive and place in a prominent area in the medical record, or if not executed, documentation that it was offered to the member (Refer to Appendix B)
- Model of Care for Care Plus (HMO D-SNP)
- Advice Nurse Services
- Behavioral Health Services-Mild to Moderate, Substance Use Disorders, Alcohol Misuse Screening and Behavioral Counseling, Autism Spectrum Disorders, Dyadic Care Services, Family Therapy, SABIRT (Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment) to members ages 11 years and older, including pregnant women, referrals for Applied Behavior Analysis, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for Members under 21 years of age.
- California Children Services-CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Plan's network, and only from the date of referral
- Claims Filing Process
- Clinical Protocols
- Communicating to the member about health status, medical care or treatment options (including alternative treatments that may be self-administered), including sufficient information to provide the member

with an opportunity to decide among all relevant treatment options. Information on the risks, benefits, and consequences of treatment or non-treatment providing members with the opportunity to refuse treatment and to express preferences about future treatment decisions

- Confidentiality/Unlawful PHI Disclosure
- Cultural Competency Training
- Diversity, Equity and Inclusion Training within 90 days
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for Members under 21 years of age using the Provider Training Program developed by DHCS; Medi-Cal for Kids and Teens effective January 1, 2024
- Facility Site Review (if applicable)
- Formulary
- Fraud, Waste and Abuse (Refer to Appendix E)
- Grievance, Complaints and Appeal Procedures and forms
- HIPAA Training (Initial and annually)
- Independent Medical Review (IMR)
- Initial Comprehensive Health Appointment (IHA)
 - Documentation of IHA's or the reason an IHA was not completed. Timelines for performing IHA's. Procedures to assure that visits for the IHA's are scheduled and members are contacted about missed IHAs.
- Interpreter Services
- Member Access to Care
- Member Accessible Clinical Telephone Triage
- Member Assignment Process
- Member Benefits, this includes, but is not limited to, the following:
 - How to identify Care Plus (HMO D-SNP) and Medi-Cal covered benefits by accessing the appropriate plan or state agency materials. Visit Contra Costa Health Plan's website at: <https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/health-benefits>
 - How to access Medi-Cal carved-out services, including waiver services such as Long-Term Support Services (LTSS), In-Home Support Services (IHSS), or Behavioral Health Services.
- Member Discharge Process from Provider Pane
- Member Eligibility Verification
 - Provider must check eligibility (on-line or by phone) on the date of service. If a member is retroactively terminated after provider verifies eligibility and if authorization was required, and Provider received authorization to provide services, provider will be compensated at their contracted rates.
- Member Rights
- Non-Physician Medical Practitioner Supervisor Ratios
 - Physician Supervisor to Non-Physician Medical Practitioner
A full-time physician supervisor is required to supervise non-physician medical

practitioners. The ratio must not exceed the following:

- Nurse Practitioners 1:4
- Physician Assistants 1:4

Four (4) non-physician medical practitioners in any combination that does not include more than three (3) Nurse Midwives or four (4) Physician Assistants

- Provision of Health Services - Consistent with professionally recognized standards of care, Clinical protocols and evidence-based practice PCPs must follow the most current US Preventive Health Task Force (USPSTF) guidelines for preventive health services. Providers must follow all USPSTF A and B level recommendations, which are listed here: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>. Preventive Services require no co-payment by the Member. CCHP's preventive guidelines can be found at <https://www.cchealth.org/health-insurance/information-for-providers/clinical-guidelines>.
- Provider hours of operation that are no less than the hours of operation offered to other members or comparable to Medi-Cal Fee-For-Service
- Provider Acceptance of Members: Providers are required to notify Provider Relations by phone, e-mail, or fax when there is a change in accepting Members for services, panel status open or closed. Provider Relations will update the panel status in PMIS to accurately reflect the Provider status within five days of being notified of the change. When a Provider whose panel is closed is contacted by a Member or potential Member, Provider or office staff will direct caller to contact CCHP Member services for assistance in identifying a Provider who is accepting Members and to DMHC to report any inaccuracy with the plan's directories. (Section 1367.27 (j) (2) Health and Safety Code)
- Re-credentialing
- Referral and Authorization Processes
- Reporting of any disease or condition to Public Health Authorities. CCHP will report diseases or conditions within the timeframe indicated on the Confidential Morbidity Report (PM-110) pursuant to the relevant disease or condition. CCHP's Medical Director will be responsible for reporting to Public Health authorities.
- WIC (Refer to Appendix L)
 1. Identifying and referring members to the Women, Infants and Children (WIC) program. Those eligible include pregnant, postpartum, and breastfeeding members and infants and children under five years of age, including foster children and those members determined to be at nutritional risk. Two major types of nutritional risk are recognized:
 - a. Medically based risks such as anemia, underweight, overweight, history of pregnancy complications, or poor pregnancy outcomes.
 - b. Dietary risks, such as failure to meet the dietary guidelines or inappropriate nutrition practices. Providing current hemoglobin or hematocrit laboratory values to the WIC program with proper documentation of such values in the member's medical record.

2. Including nutrition and health education assessments and interventions as part of prenatal care and include breastfeeding counseling and support after delivery. Assessment of breastfeeding support needs is part of the first newborn visit after delivery.

Regulatory Requirements

- CCHP may not prohibit providers from providing advice to members based upon cost of care or any other factors.
- Providers may freely communicate to the member about their health status, medical care or treatment options regardless of benefit coverage limitations.
- Providers may not engage in marketing CCHP or any of its products to members.
- Providers are prohibited from billing CCHP members for any services covered by CCHP, except for co-payments and deductibles.
- Providers are prohibited from charging members to complete medically necessary forms.
- Providers that have “opted out” of the Medicare program or appear on the Medi-Cal Exclusions list are prohibited from credentialing and/or contracting with CCHP.
 - Providers that “opt out” of the Medicare program or appear on the Medi-Cal exclusions list after being credentialed, recertified or contracted will be issued a thirty (30) day notice to terminate participation in the CCHP networks.

Providers will update CCHP within five (5) business days if: (i) provider is not accepting new members; or (ii) if provider had not previously accepted new members, but provider is currently accepting new members. If Provider is not accepting new members, provider will direct a member or potential member to both the CCHP Member Services for additional assistance in finding a provider and to the Department of Managed Health Care to report any potential directory inaccuracy.

Provider Changes

Prior to implementing material changes to terms of payment, credentialing and other rules of participation, CCHP will issue written notice by fax, e-mail or mail to providers within thirty (30) days of the change.

When a provider changes or adds a new office location, changes tax identification information or adds or terminates a provider within the practice, notification in writing must be made to CCHP at least ninety (90) days prior to the effective date of

the change. Providers are also required to notify CCHP within thirty (30) days of any change in status such as licensure, malpractice claims settlement and hospital privileges.

When a Primary Care or Obstetrics and Gynecology Provider acting as a Primary Care Provider adds an office location or changes to a new location, the new location must undergo a Facility Site Review (FSR) at least thirty days prior to services being rendered at that new site. If a provider notifies CCHP after the move, existing members can continue to receive services, but no new members can be assigned until the FSR is complete. The FSR must be completed within sixty (60) days of the move.

When a contracting provider or CCHP decides to terminate a contract without cause, the provider and/or CCHP, must provide written notice at least ninety (90) days in advance of the requested date of termination. In addition, CCHP requests specialty providers send a list of members to whom they are providing services, for CCHP to redirect the member's care to another contracted specialist. CCHP's Provider Relations Unit, in collaboration with Member Services and Utilization Management Units, will notify affected members within thirty (30) days of the Provider termination date.

Provider Termination – Coordination and Continuity of Care

In some instances, if a provider leaves the CCHP network, the member's medical condition may require coordination and continuity of care to ensure that needed medical services are uninterrupted. CCHP will negotiate terms and conditions for continuity of care with the provider when a termination is requested. In addition, CCHP requests specialty providers send a list of members they are providing services to, for CCHP to redirect the member's care to another contracted specialist. Primary Care Providers are requested to inform CCHP where the Member's medical records will be stored for retrieval as needed for a ten-year period after leaving the plan or closing their practice.

Provider Complaints

CCHP is committed to the delivery of excellent customer service. If you have received less than excellent service, there is a process to have your complaints evaluated and resolved in a timely manner. Complaints you would likely submit may include member discharge from your practice, member behavior at your practice, facility site reviews, contractual concerns, interactions with CCHP staff or concerns regarding CCHP policies and procedures.

All Provider Complaints are required to be submitted on the Provider Complaint

Form that can be downloaded from the CCHP website (Appendix J) . The Provider Complaint Form must be submitted no more than ninety (90) days from the action or inaction precipitating the complaint. Provider Relations will acknowledge receipt of your complaint within fifteen (15) business days and will send a written resolution within thirty (30) business days. Non-medically related complaints will be evaluated and resolved by the Director of Provider Relations or Network Management Team. Medically related complaints will be referred to the Quality Management Unit for evaluation and resolution.

If a complaint is referred to professional peer review, all parties will be given written notification that a referral has been made, and a final determination will require up to sixty (60) days from the acknowledgement of receipt of grievance or complaint.

Submit the completed Provider Complaint Form by mail, e-mail, or faxing it to:
Contra Costa Health Plan Attn: Provider Relations
595 Center Avenue, Suite 100, Martinez, California 94553
Fax: 925-608-9411
E-mail: ProviderRelations@cchealth.org

If you have any questions, contact Provider Relations by e-mail above or phone 877-800-7423, option 6.

Provider Disputes are complaints expressed in writing requesting a review of a denied service or claims denial. See Section 7 Provider Dispute Resolution for guidance on appeal submission.

Member Discharge from Practice

Providers may not discriminate against CCHP members based on health status. Members may be discharged from a provider's practice for non-compliance, more than two missed appointments within one year or disruptive and/or threatening behavior, but not for health status or diagnosis.

Missed appointments require documentation that the provider office has contacted the member, documented the reason missed, and offered an opportunity to reschedule the appointment.

Missing the second appointment within a six-month period may be grounds to discharge the member from the panel depending on the provider's specific office policy.

If the provider is discharging the member for abusive or threatening behavior, a detailed account of the interaction with words used by the member, the number of times/dates of the offense, and if the behavior threatened office staff of the

provider or concerned other members in the office at the time of the occurrence, needs to be detailed on the Provider Complaint Form. Include the specific reason(s) for the request and any pertinent documentation, CCHP uses this information in a letter to the member to explain the reason of reassignment and address their unacceptable behavior.

It also necessary for CCHP to know if the member is undergoing any active care that will require review and intervention, upcoming appointments that need to be cancelled and/or if the member has any medically necessary prescriptions that will need to be renewed within the next thirty (30) days. Depending on the reason for the discharge, the provider may need to continue emergency care and refill prescriptions up to thirty (30) days post discharge. If this is not reasonable, then the discharging provider will need to assist the plan's member services staff with ongoing clinical information that will be needed by the newly assigned PCP.

To discharge a member from a provider's practice, the request must be made in writing, using the Provider Complaint Form (located on our website <http://www.cchealth.org/healthplan> under the topic Forms and Resources or in Appendix O) and include the reason for the request and any pertinent documentation. The form can be e-mailed to the Provider Relations Department at ProviderRelations@cchealth.org.

Provider should notify the member in writing they are being discharged from the practice and to notify CCHP Member Services if they have any questions including information on how to contact CCHP Member Services. A copy of the discharge letter should be sent to CCHP Provider Relations.

Provider Network Update

On a quarterly basis, CCHP is contractually required by the Department of Health Care Services (DHCS) and Centers for Medicaid and Medicare Services (CMS) to verify the information listed in our database and directories for your practice or facility. Information verified includes, but is not limited to, all practice locations, phone and fax numbers, office e-mail, languages spoken, providers practicing at each location and whether a provider is accepting new members. Annually we are required to verify hospital affiliations and if your staff knows your practice is contracted with the health plan for all product lines. This information is used on our electronic Provider Directory at [Provider Directory | Contra Costa Health](#), and in printed directories distributed to our health plan members.

The Provider Network Update (PNU) Survey link is e-mailed to provider or designated staff quarterly and is completed and updated electronically. PNUs may be faxed if the electronic process is not functional. We request that providers or

designated staff complete and submit the PNU link within two weeks of receipt. However, providers are given thirty (30) business days to acknowledge receipt of the PNU or access the link, complete and submit the PNU confirming the information listed in the provider directory is current and accurate or update the information required to be in directories, including accepting new members. If not returned within the first fifteen (15) business days, a reminder is sent allowing another fifteen (15) business days to complete and submit the form. Providers who do not return the form after the second attempt will receive a verification call from Provider Relations staff within fifteen (15) business days. All information in the database will be queried, and Provider Relations staff will review submitted electronic or hard copy PNU for changes. If providers are non-complaint, we will notify providers by fax, e-mail or mail that within ten (10) business days of the date of the notification that the provider's information will be removed from provider directories. If providers respond prior to the ten (10) business days, the provider's information will remain in the directories.

Electronic submissions will be received by Provider Relations staff, and any changes will be reviewed and updated in our database. Our goal is to ensure all practice information is accurate. We appreciate your assistance and time in keeping the provider database and directories accurate.

Facilities will be notified by e-mail quarterly regarding the required information to confirm and may send rosters with the information.

Provider Directories

Contra Costa Health Plan (CCHP) is required by the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) to ensure all provider information listed in our Provider Directories is accurate. All credentialed and contracted providers are listed in our printed member and online Provider Directory. The online Provider Directory can be accessed 24 hours a day, seven days a week at the following internet address: [Provider Directory | Contra Costa Health](#). If incorrect data is displayed, updates can be made by clicking on "Report an Error in the Provider Directory" on the left side menu. This allows a provider to list the correct information which is automatically sent directly to CCHP for correction. CCHP reviews and makes the appropriate corrections.

In addition, please notify us immediately about upcoming changes to your practice, such as a new address or suite number, phone, fax, tax identification number* (TIN), ownership or group name change*, provider additions or deletions, or any new practice limitations through e-mail, fax or mail:

Contra Costa Health Plan
Provider Relations

595 Center Ave., Ste. 100
Martinez, CA 94553
Fax: 925-608-9411
E-mail: ProviderRelations@cchealth.org

*Submit a current signed W-9 with the new information.

The online Provider Directory provides maps, directions, languages spoken, office hours, telephone numbers, physical accessibility and more. A user can enter the database by clicking “begin your search here”. This brings the user to an area to search by PCP, Specialist or Facility.

In the PCP or Specialty area, a user can search by name, hospital affiliation, medical group, specialty, location, network, gender, language, physical accessibility, CA license number, NPI and accepting members by entering the requested information and clicking on “begin search”. The requested information will be displayed and can be printed or saved in a PDF file.

In the Facility area, a user can search by type of facility, name, location or physical accessibility. The hospital accreditation is displayed in the search results. The requested information will be displayed and can be printed or saved in a PDF file.

[ccLink Provider Portal](#)

The ccLink Provider Portal is an on-line communication tool between the Community Provider Network (CPN), Contra Costa Health Plan (CCHP), and the Specialty Care Providers and Primary Care Providers at Contra Costa Regional Medical Center (CCRMC) and Health Centers. The ccLink Provider Portal is based on best practices from other medical centers and health plans. CCHP is not requiring our CPN doctors to utilize the ccLink (Epic) electronic records for our members.

ccLink Provider Portal allows on-line access to CCHP member information and provides real-time eligibility inquiries about CCHP members. If the provider is the member’s primary care provider or the “referred to specialist”, the provider will be able to access a list of members that are assigned to them. It allows a provider to submit and check the status of any required referral or authorization and to attach documentation to a referral being sent to CCHP for evaluation of an authorization. Providers can also check the status of a submitted claim, facilitate communication, and streamline member care across locations and disciplines.

For Primary Care Providers, the Provider Portal is the only way to access your assigned patient panel. Provider groups should designate specific individuals at their practice that should have access to provider reporting. Designated individuals

will receive:

- **Downloadable Reports:** Your assigned patient panel is available for download in Excel format, making it easy to integrate into your practice management systems or use for population health and quality outreach activities.
- **Daily Updates:** Reports, including patient rosters and quality reports, are updated daily to provide you with the most current information.

For Regional Medical Center members that are referred to a Community Provider Specialist, reports and notes about consultations can be received and included in the CCRMC and Health Centers' member electronic health record by faxing this information to 925-370-5275.

If providers are not already signed up for access to ccLink Provider Portal, providers must complete and return an [access user agreement](#) to be assigned a username and password. As requested, CCHP can set up a provider group Administrator profile that allows the Administrator to grant and remove staff access to the ccLink Provider Portal without having to go through CCHP. The documents can be downloaded from the CCHP website located at [Information for CCHP Providers | Contra Costa Health](#) or requested by e-mailing CCHPportalsupport@cchealth.org.

Section 3 – Utilization Management

CCHP's Utilization Management (UM) Department provides oversight and monitoring of services provided to members. UM decisions are based only on appropriateness of care and service and the member's benefit package. The UM staff is neither compensated or rewarded for issuing denials or approvals of coverage or financially encouraged to make decisions that result in underutilization or overutilization.

Normal business hours for the Utilization Management (UM) Department are Monday through Friday from 8:00am to 5:00pm, excluding holidays. Staff is available for inbound and outbound communications regarding UM processes. When making outbound or returning calls, staff identifies themselves by their name, title and organization. Providers can reach the UM Department by calling the Provider Call Center at 1-877-800-7423, option 3 or e-mail CCHPauthorizations@cchealth.org. Please ensure any Protected Health Information (PHI) is encrypted.

After hours and during weekends, callers have two options:

1. For non-urgent matters, the caller can leave a message at the above number. Messages are addressed the next business day.
2. For urgent matters, the caller can stay on the line and be automatically transferred to the Advice Nurse Unit, which operates 24/7. The Advice Nurse (AN) Unit can reach an on-call UM staff member for assistance as appropriate. This includes the UM Manager, UM Director, Chief Medical Officer, and/or Medical Director as needed.

A toll-free number, TDD/TTY for hearing impaired, and language assistance are available and accessible to members and providers. Providers can utilize the Health Plan's language services to assist our members who are hearing impaired or need language translation services. Please refer to Section 12 - Cultural and Linguistic Services for detailed information. Language services information is also available at our website [Interpreter Services | Contra Costa Health](#).

Providers may access a list of current clinical guidelines from CCHP's website at <https://www.cchealth.org/health-insurance/information-for-providers/clinical-guidelines> and search on clinical guidelines. Providers can request, free of charge, copies of clinical criteria or guidelines used for decision-making by contacting CCHP's Utilization Management Department at 1-877-800-7423, option 3 or fax 1-925-313-6458 or by email CCHPauthorizations@cchealth.org and type Attn: Internal Audit/Charge Nurse. When requested services are denied or modified, providers can discuss the UM decision via Peer-to-Peer discussions. Providers are

notified (via Notice of Action, Notice of Non-Coverage, etc.) on how to contact and when the reviewer is available to discuss the decision.

Clarification On Provider Networks + Different Insurance Programs

CCHP offers different types of insurance (e.g., Medi-Cal, Care Plus (HMO D-SNP), Commercial A, Commercial A2, Commercial IHSS Plan A2, etc.) with different provider networks (e.g., CCRMC Network, CPN Network). Traditionally, this has caused confusion for providers in our provider network. Given CCHP's different insurances with different coverages, clarification is provided here. All members can only receive PCP services from their assigned PCP.

In summary:

- Medi-Cal Members PCP assignment to either CCRMC (RMC) or to CPN Network = Specialist network = CCRMC (RMC) and CPN.
 - Detailed explanation: for Medi-Cal members in both the CCRMC (RMC) or CPN Network, the member can receive non-PCP services and see contracted specialists in either the RMC or CPN network. Please note that prior authorization may be required depending on the service requested – please utilize CPT Code Search Tool (see below) if that service does not require prior authorization. Also, of note, any services performed, or specialists seen at a non-contracted provider or at a tertiary care center require prior authorization as these are not considered part of the RMC or CPN network.
- Care Plus (HMO D-SNP) Members PCP assignment to either CCRMC (RMC) or to CPN Network
 - Detailed explanation: for Care Plus (HMO D-SNP) members in both the CCRMC (RMC) or CPN Network, the member can receive non-PCP services and see contracted specialists in either the RMC or CPN network. Please note that prior authorization may be required depending on the service requested – please utilize CPT Code Search Tool (see below) if that service does not require prior authorization. Also, of note, any services performed, or specialists seen at a non-contracted provider or at a tertiary care center require prior authorization as these are not considered part of the RMC or CPN network.
- Commercial A/Commercial A2/Commercial IHSS Plan A2: Network = Specialist network = CCRMC (RMC) Only
 - Detailed explanation: For Commercial A/Commercial A2/Commercial IHSS Plan A2, whose network is only CCRMC, any referral to a specialist outside of CCRMC or any service provided outside of CCRMC requires prior authorization.
- Commercial B: Network = Specialist network CCRMC (RMC) + CPN

- Detailed explanation: For Commercial B, the member can receive non-PCP services and see contracted specialists in either the CPN or RMC network. Please note that prior authorization may be required depending on the service requested – please utilize CPT Code Search Tool (see below). Also, of note, any services performed, or specialists seen at a non-contracted provider or at a tertiary care center require prior authorization as these are not considered part of the CCRMC or CPN network.

Different networks affect member's eligibility for services that do not require prior authorization (see below).

Levels Of Authorization Required

For services provided in network for the member, there are types/levels of service available to the member. These are:

1. No prior authorization required
2. Prior authorization required

Referred-to providers may expect referring-providers to offer verification of a referral (along with relevant clinical documentation) to schedule patients. These requests are according to the accepting providers discretion and best-practice and are independent of any authorization requirements from CCHP.

*Reminder: All services out-of-network (including both non-contracted and tertiary providers) require prior authorization. Guidance on authorization requirements do not apply to non-contracted providers.

Submission Of Requests

All referrals and prior authorization requests submitted to CCHP must be complete. Incomplete referrals will be sent back to the provider for additional information. If additional information is not provided in a timely manner, the request will be denied. Information required to be submitted with each referral include the service requested, associated CPT code(s), relevant diagnosis(es), clinical reason why this service is medically necessary, and any supporting clinical documentation.

CCRMC Providers:

CCRMC Providers can submit prior authorization requests to CCHP via ccLink.

CPN Providers:

CPN Providers can submit prior authorization requests via the ccLink Provider Portal. Access to the Provider Portal is outlined in the Provider Relations section above.

For noncontracted providers and out-of-area hospitals fax to: 1-925-313-6645.

Services that Require/Do Not Require Prior Authorization

CCHP offers a web-based tool to support identification of services that require CCHP authorization.

Please visit the Utilization Management page on the CCHP website ([Utilization Management: Authorization and Referrals | Contra Costa Health](#)) to access the CPT Search Code Tool. The CPT Code Search tool is regularly maintained by CCHP Auth/UM staff. As such, CCHP welcomes feedback regarding authorization requirements or codes not presently listed in the tool.

As per above, for some services, referrals may be required by certain referred-to providers. This referral requirement is independent of CCHP guidance on services that require authorization.

Following completed evaluation (regardless of authorization requirements) specialists responsible for faxing all clinical documentation back to the referring provider. For CCRMC Providers, please send to medical records at Fax 925-370-5239. For CPN providers please check with the individual provider for the best way to communicate this information.

Services Requiring Health Plan Prior Authorization

CCHP has certain services that require prior authorization to determine medical necessity.

For those services requiring prior authorization, a prior authorization request must be submitted electronically to CCHP. If the referral is approved, CCHP will mail a copy of the authorization to the provider submitting the request (PCP or another provider), the member, and the specialist referred-to provider. The provider submitting the request (PCP or other provider) should then provide additional clinical information to the specialist and the member can then call the specialist for an appointment (CPN specialist) or the specialist will contact the member with an appointment (CCRMC specialist).

To determine if a service requires prior authorization, please refer to CCHP's CPT Code Search

Tool. Please visit the Utilization Managements page on the CCHP website ([Utilization Management: Authorization and Referrals | Contra Costa Health](#)) for the most updated version of this tool.

For all services requiring Prior Authorization, the specialist is responsible for faxing all clinical documentation back to the referring provider. For CCRMC Providers, please send to medical records at Fax 1-925-370-5239. For CPN providers please check with the individual provider for the best way to communicate this information.

Services Requiring Health Plan Retrospective Authorization

CCHP will require retrospective review and authorization for certain services. Other services that require prior authorization may, in addition to prior authorization, be reviewed via retrospective authorization instead. Retrospective authorization requests must be received by CCHP within 180 days of date of service unless there is a good cause for late submission. This includes, but is not limited to the services listed below:

- All services that require prior authorization (above) that is provided by an in-network provider for the member.
- Please note out-of-network providers and tertiary care providers for the Member will NOT be granted retrospective authorization if CCHP determines that the service could have been rendered by an in-plan provider instead except for genetic/biomarker testing for advanced or metastatic stage 3 or stage 4 cancer that is associated with a FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer.

Continuity of Care for Care Plus (HMO D-SNP) Primary and Specialty Providers

Under the Department of Health Care Services' (DHCS) CalAIM D-SNP Policy Guide, upon Member request, or request by other authorized representative as noted below, and as required by applicable Laws, rules, and guidance, CCHP Care Plus (HMO D-SNP) must offer continuity of care with out-of-network Medicare providers to all Members if all of the following circumstances exist:

- A Member has an existing relationship with a primary or specialty care provider. An existing relationship means the Member has seen an out-of-network PCP or a Specialty Care Provider, at least once, during the 12 months prior to the date of their initial enrollment in D-SNP for a non-emergency visit;
- The out-of-network provider is willing to accept, at a minimum, payment from
- CCHP based on the current Medicare fee schedule, as applicable; and

- The out-of-network provider does not have any documented quality of care concerns that would cause CCHP to exclude the provider from its network
- Each continuity of care request must be completed within:
 - Thirty (30) calendar days from the date CCHP receives the request;
 - Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
 - Three (3) calendar days if there is risk of harm to the Member

For more information on Continuity of Care requirements please refer to the CalAIM D- SNP Policy Guide at [CALAIM DUAL ELIGIBLE SPECIAL NEEDS PLAN POLICY GUIDE – CONTRACT YEAR 2026](#).

Second Opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request a second opinion from another Provider at no cost to the Member. Members or Providers on behalf of the Member should call Member/Provider Services line to find out how to get a second opinion. Second opinions may require prior authorization.

Inpatient Admission and Hospitalization

Non-emergent, planned hospitalizations require prior authorization by CCHP and should follow the referral and prior authorization process above.

Emergent hospitalization requires CCHP notification within 24 hours of hospitalization via the CCHP Provider Portal. Late notification may result in nonpayment. Emergent hospitalization is subject to concurrent review and authorization on up to a daily basis. Clinical notes and other relevant clinical information must be sent from the previous 24 hours the next day to CCHP via the Provider Portal or fax. If a member does not meet Medical Necessity criteria for the level of care clinically, CCHP will send the facility a facility notice that denies authorization starting the date the member no longer meets clinical criteria. Late provision of clinical records may result in nonpayment.

Skilled Nursing Facility Admission and Ongoing Stay

Skilled nursing facility admissions for skilled or subacute level of care require CCHP approval and are subject to ongoing concurrent review. Clinical notes and other relevant clinical information must be sent no less than weekly to CCHP via the Provider Portal. Late provision of clinical records may result in nonpayment.

SNF or Subacute Long-Term Care (AKA Custodial Care) Requests (Continuation of Care)

A new prior authorization is required for Long-Term Care (LTC) admissions with long-term dispositions that exceed the month of admission and month after. To request prior authorization for continued SNF or Subacute care services, please submit a referral to the CCHP Utilization Management Department via the online ccLink Provider Portal (CPN Providers) or ccLink (CCRMC providers). Clinical notes to support your request, such as recent notes on the member's health history and progress, prescriptions, physical exams, MDS and MC 171 are required. Please direct any questions you may have about this process to the Long-Term Care team at CCHPCaAIM@cchealth.org.

Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

Authorization responsibility is shared between CCHP and the Regional Center. The Regional Center is responsible for conducting medical necessity placement reviews for eligible members. CCHP is responsible for providing administrative authorization, a notice of determination, and claim payment (for approved services). Authorization requests are initiated by the ICF/DD facility. Prior to requesting authorization from CCHP, the Regional Center must render a placement decision and complete the Certification for Special Treatment Program Services form (HS 231). The ICF/DD Authorization Request and HS 231 Forms are required for CCHP authorization.

Submission of Prior and Retrospective Authorization Requests

Prior and Retrospective Authorizations should be submitted to the CCHP Utilization Management Department via the online ccLink Provider Portal (CPN providers) or ccLink (CCRMC providers). Always indicate whether the authorization request is URGENT or ROUTINE. Retrospective requests are never categorized as urgent.

Definition of Emergent, Urgent, Routine, and Retrospective Referrals

Emergent Referral

A request is considered emergent when the member faces an “imminent and serious threat” to his or her health and thus waiting the timeframe of 72 hours for urgent UM review:

- Would cause loss of or serious detriment to the enrollee's life, limb, vision, or health

These requests do not require prior authorization and will be reviewed on a retroactive basis. If there are concerns, please call the UM department

immediately.

Urgent Referral (processed within 72 hours of receiving all required information)

A request is considered urgent when the member must see a provider within 7 days or would otherwise face an “imminent and serious threat” to his or her health and thus waiting the standard timeframe of 5 business days for UM review:

- Would be detrimental to the enrollee’s life, limb, vision, or health or
- Could jeopardize the enrollee’s ability to regain maximum function.

Routine Referral (processed within 5 business days of receiving all required information)

All requests not meeting the definition of urgent are considered routine referrals.

- Circumstances that are not considered emergent/urgent include:
 - Late request for scheduled visit/service (e.g., appointment scheduled for the next day)
 - Routine follow-up/annual appointment
 - Ongoing continued care of an existing member
 - Retro authorization request

Retrospective Referral (processed within 30 days of receiving all required information)

All requests that require prior or retrospective authorization that are submitted after rendering of the date of service are considered retrospective authorization requests.

- These must be submitted within 180 days of date of service unless there is good cause.
- Services that could have been rendered by an in-network provider for the member will be denied for non-contracted or tertiary care providers (except for Stage 3/Stage 4 genetic testing as noted above).

Please note that Urgent Requests may take up to 72 hours to process.

If a request for an urgent referral does not meet the above guidelines but is still considered urgent, please document the reason that it does not meet the guidelines in the text notes. Urgent Requests will be reviewed for “Urgency” - those that do not meet urgent criteria and do not include documentation for why they require urgent processing will be processed as routine.

Review Of Prior and Retrospective Authorization Requests

Utilization Management clinical staff review the request for medical necessity based on established and/or licensed clinical guidelines and appropriateness of services, which includes but not limited to:

- Availability of service/procedure within assigned provider network
- Diagnosis (ICD-10 code) and requested CPT/HCPCS codes
- History and physical and pertinent clinical findings
- Procedure
- Purpose of the referral
- Requested services
- Symptoms and significant physical findings
- Test, procedures, and lab results already performed
- Specialist findings, recommendations, and treatments

Non-Network, Non-Contracted and Tertiary Care Specialty Services

Non-emergent out-of-network, out-of-plan, tertiary care center, or seldom used/unusual specialty service referrals require prior authorization by CCHP. The request is reviewed by the UM department to determine medical necessity and availability of services within the Health Plan provider network or with a non-contracted preferred provider. Services that are seldom used or unusual may require internet literature research or an external medical review to evaluate the latest evidence-based clinical practice standards prior to making a determination on the request. Refer to CCHP Policy UM15.010- New Technology for details.

Referrals to and arrangements with a tertiary care center may be necessary and requires prior authorization to accommodate the unusual medical need of the member. An approval must be obtained from the CCHP Utilization Management Department prior to rendering non-emergent services.

The Chief Medical Officer, Medical Director, Assistant Medical Directors, or a Utilization Management physician will review all out-of-network, out-of-plan or unusual specialty referrals not meeting criteria to:

1. Assess medical appropriateness
2. If necessary, consult with specialist to determine medical justification of referral
3. Identify potential fraudulent or abusive practices, and
4. Provide a mechanism which enable members to explore other treatment options

If a specialty service is authorized, the Utilization Management Department will issue an approval letter to the member and the referred to provider. The letter indicates the name of the specialist and their contact information. For detailed

information, refer to UM 15.018 Timeliness of the Utilization Review Decision and Communication. If a member is referred to a specialist or tertiary care center and s/he is unable to navigate through the provider or institution's healthcare system, staff is available to assist the member with making arrangements.

Out-Of-Network Care Coordination

Upon approval of care to a non-contracted provider, a written approval notice is issued to the member and copied to the referring provider and referred to provider. The notice includes provider instructions on where to submit consult, procedure and test reports. The referring provider, as appropriate will coordinate care with the referred to provider. When necessary, the member may be referred to Case Management for care coordination activities.

Waiver Programs

Waiver Programs are specific to our Medi-Cal product line. If a Medi-Cal member is accepted into a State Waiver Program, such as the AIDS Waiver Program, Model Waiver Program, or In-Home Medical Care Waiver Program the member would be disenrolled from CCHP to obtain necessary FFS benefits under the waiver program. The California Department of Health Care Services administers these services under FFS Medi-Cal. Contact the Member Services department for information and disenrollment assistance.

Palliative Care Services for Medi-Cal Members

Palliative Care Services is a covered benefit for Medi-Cal members. Palliative care consists of member- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care does not require the member to have a life expectancy of six months or less and may be provided concurrently with curative care. This is different than hospice care which is a Medi-Cal benefit that serves terminally ill members. A member with a serious illness who is receiving Palliative Care services may choose to transition to Hospice care if they meet the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in Hospice and Palliative Care.

Care Plus (HMO D-SNP) members who qualify for palliative care are considered a vulnerable sub-population. Palliative care should be delivered in a coordinated manner for members enrolled in Care Plus (HMO D-SNP) and members of the palliative care team should be included in the member's care team meetings.

A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care. Under the Patient Protection and

Affordable Care Act (ACA) Section 2302 and the provisions of California Children's Services (CCS). Additionally, members who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services may receive services to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services, whether such services are covered under the California State Plan.

- Members of any age are eligible to receive palliative care services if they meet all the criteria in Section 1 below and at least one of the four requirements outlined in Section 2.
- Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section I.C. below, consistent with the provision of EPSDT services. (APL 18-020).

General Eligibility

- a. The member is likely to or has started to use the hospital or emergency department to manage his/her advanced disease. This refers to unanticipated decompensation and does not include elective procedures.
- b. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
- c. The member's death within a year would not be unexpected based on clinical status.
- d. The member has either received appropriate patient-desired medical therapy or is a member for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation.
- e. The member and, if applicable, the family/patient-designated support person, agrees to:
 - i. Attempt as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/Palliative Care instead of first going to the emergency department; and
 - ii. Participate in Advanced Care Planning discussion.

Disease Specific Eligibility Criteria

- a. Congestive Heart Failure (CHF):
 - I. Member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association (NYHA) heart failure classification III or higher; and
 - II. Member has an Ejection Fraction of less than 30 percent for systolic failure or significant co- morbidities.

- b. Chronic Obstructive Pulmonary Disease (COPD):
 - i. Member has a Forced Expiratory Volume (FEV) 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
 - ii. Member needs a 24-hour oxygen requirement of greater than or equal to three liters per minute
- c. Advanced Cancer:
 - i. Member has a stage III or IV solid organ cancer, lymphomas, or leukemia: and
 - ii. Member has a Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
- d. Liver Disease:
 - i. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
 - ii. Member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
 - iii. Member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.
- e. In addition to the disease conditions authorized above which are defined by the requirements of SB 1004 and described in APL 18-020, CCHP will authorize palliative care for other disease conditions for which the member would be eligible to receive hospice services if less than 6-month life expectancy and may benefit from earlier palliative care services, including, but not limited to:
 - i. Neurologic disease
 - ii. Cerebrovascular accident (Stroke)
 - iii. Neurodegenerative disease (i.e. ALS, Huntington's)
 - iv. Parkinson's disease
 - v. Dementia
 - vi. Multiple sclerosis
 - 1. The member has functional decline from irreversible progression of the neurologic disease resulting in:
 - a. Inability to ambulate without assistance; OR
 - b. Inability to dress without assistance; OR
 - c. Inability to bathe without assistance; OR
 - d. Lack of consistently meaningful verbal communication; OR
 - e. Inability to maintain sufficient fluid and calorie intake with 10% weight loss over preceding 6 months or serum albumin <2.5 gm/dl.
 - ii. Renal failure
 - i. The member is not seeking dialysis or renal transplantation or is discontinuing dialysis.

- f. Pulmonary disease
 - i. Severe chronic lung disease (including, but not limited to, pulmonary fibrosis, chronic lung infections, cor pulmonale) with dyspnea at rest and persistent progression of end stage disease (increasing emergency department visits and hospitalizations for respiratory failure), and the member is not seeking lung transplantation.
- g. Acquired Immune Deficiency Syndrome (HIV/AIDS)
 - i. CD4+ Count <25 cell/mcl or persistent viral load >100,000 copies/ml; OR
 - ii. Any of the following:
 - 1. CNS lymphoma
 - 2. Untreated or persistent wasting (loss of at least 10% lean body mass)
 - 3. Mycobacterium avium complex (MAC) bacteremia
 - 4. Progressive multifocal leukoencephalopathy
 - 5. Systemic lymphoma with advanced HIV disease
 - 6. Visceral Kaposi's sarcoma
 - 7. Renal failure
 - 8. Cryptosporidium infection
 - 9. Toxoplasmosis, unresponsive to therapy
 - 10. Advanced AIDS dementia complex
 - 11. Absence of or resistance to effective antiretroviral, chemotherapeutic, and prophylactic drug therapy related to HIV disease
 - iii. Refractory severe autoimmune disease (i.e. systemic lupus erythematosus, rheumatoid arthritis)
 - iv. Physiologic impairment of functional status including dependence on assistance for two or more activities of daily living:
 - 1. Ambulation
 - 2. Continence
 - 3. Transfer
 - 4. Dressing
 - 5. Feeding
 - 6. Bathing
 - v. Absence of or resistance to effective therapeutic, and prophylactic drug therapy related to specific autoimmune disease

Pediatric Palliative Care Eligibility Criteria

- a. Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
- b. The family and/or legal guardian agree to the provision of pediatric palliative care services; and

- c. There is documentation of life-threatening diagnosis. This can include but is not limited to:
- I. Conditions for which curative treatment is possible, but may fail, (e.g. advanced or progressive cancer or complex and severe congenital or acquired heart disease): or
 - II. Conditions requiring intensive long-term treatment aimed at maintaining quality of life, (e.g. human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
 - III. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g. progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
 - IV. Conditions involving severe, non-progressive disability or causing extreme vulnerability to health complications, (e.g. extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection of difficult-to-control symptoms), (APL 18-020).

If a member continues to meet the above minimum eligibility criteria, he or she may continue to access both Palliative Care and curative care until the condition improves, stabilizes or results in death.

For Children who have an approved CCS-Eligible condition, CCS will remain responsible for medical treatment for the CCS-eligible condition, and CCHP will be responsible for the provision of palliative care services related to the CCS-eligible condition, (APL 18- 020)

CCHP's provider contracting will ensure an adequate network of palliative care providers to meet the needs of the members. CCHP may authorize palliative care to be provided in a variety of settings, including inpatient, outpatient, or community-based settings. CCHP's hospital and facility network includes Acute Care facilities, Long Term Care, Outpatient Clinics. CCHP will ensure that appropriate newly contracted facilities have Palliative Care services that are certified by DHCS.

Palliative care providers must have licensed clinical staff with experience and/or training in palliative care. Providers must comply with existing Medi-Cal contracts and policy. Palliative care provided in a member's home must comply with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans. All CCHP subcontractors will abide by all CCHP quality standards. Palliative care providers will meet all CCHP credentialing quality standards.

Provider Network

- a. CCHP has 2 distinct primary care networks the Community Physicians Network and CCRMC physicians.
 - I. The CCRMC network physicians will refer exclusively to the Palliative Care Clinic within the CCRMC Network that is housed within the Health Services Division
 - II. The CPN network will refer to the community network to the exclusive Palliative Care provider networks.
 - III. One exception to the referral process for the CCRMC providers they will access the Chaplain Services through the community network. Chaplain services are not billable under the program; therefore, coordination with CCHP will require a listing of Chaplain Services is made available to CCRMC Palliative Care Clinic.
 - IV. CCHP's network will meet the access standards for Palliative Care as a specialty provider.
 - V. CCHP's Health Education Department will ensure health education resources on Palliative Care are available to providers.
 - VI. CCHP will include a section under Palliative Care Providers so that the PCPs can easily identify those contracted services.
 - VII. CCHP will keep PC providers educated on the program to include enhancements or updates as directed by DHCS
- b. CCHP is responsible for ensuring that their delegates and subcontractors comply with all applicable state and federal laws and regulations, contract requirements and other DHCS guidelines. (APL 18-020).

Referral Process for Palliative Care Services

CCHP members can be referred to palliative care services by:

- a. **Self-referral:** When a member self-refers to the program, typically through care management, their PCP will be informed to confirm their condition based on their medical history.
- b. **Primary care provider referral** to appropriate network providers as described above.
- c. **Referral by a family member** (if they have power of attorney and can represent the member). Documentation must be on file with this authorization from the member.
- d. **Referral by other Health Services Division departments** who are providing services to the member

Other Medi-Cal Excluded Services Not Requiring Member Disenrollment

California Children Services (CCS) Eligible Medical Conditions

Members under the age of 21 may have a health condition that is covered under

CCS. Providers and the Health Plan may refer a member to CCS. Once eligibility for the CCS program is established, the Health Plan will continue to provide all medically necessary covered services that are not related to the CCS eligible condition(s). PCPs are responsible for ongoing medically necessary diagnostic, preventive treatment and services not covered by CCS.

Dental Services

Dental services are covered by Denti-Cal. CCHP will cover medically necessary services that are covered benefits not covered by Denti-Cal.

Specialty Mental Health Services

For Medi-Cal members, Specialty Mental Health Services (SMHS – for moderate to severe acuity) are carved out to County Behavioral Health (the Mental Health Plan in Contra Costa County). CCHP will coordinate with County Behavioral Health to ensure coverage for all medically necessary services that are covered benefits. See Behavioral Health Section below.

Referrals

With the exception of Emergency Services, a referral may be necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice, or if it is necessary to consult or obtain services from other in-network specialty health professionals. Information is to be exchanged between the PCP and specialist to coordinate Member care. Providers need to document referrals that are made in the Member's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers that are contracted with CCHP. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, urgent care and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization may be required from CCHP except in the case of urgent and Emergency Services.

Prior Authorizations

Prior authorization ensures services are based on medical necessity, are a covered benefit, and are provided by appropriate Providers. Providers are responsible for verifying eligibility and ensuring the appropriate prior authorization review has been conducted by CCHP for elective non-emergency and scheduled services, before

providing those services.

Prior authorization is required for all elective and out-of-network services with the exception of emergency room or urgent care visits.

Utilization Management Contacts

Normal business hours for the Utilization Management (UM) Department are Monday through Friday from 8:00am to 5:00pm, excluding holidays. Staff is available for inbound and outbound communications regarding UM processes. When making outbound or returning calls, staff identifies themselves by their name, title and organization. Providers can reach the UM Department by calling the Provider Call Center at 1-877-800-7423, option 3 or e-mail CCHPauthorizations@cchealth.org. Please ensure any Protected Health Information (PHI) is encrypted.

After hours and during weekends, callers have two options:

1. For non-urgent matters, the caller can leave a message at the above number. Messages are addressed the next business day.
2. For urgent matters, the caller can stay on the line and be automatically transferred to the Advice Nurse Unit, which operates 24/7. The Advice Nurse (AN) Unit can reach an on-call UM staff member for assistance as appropriate. This includes the UM Manager, UM Director, Chief Medical Officer, and/or Medical Director as needed.

A toll-free number, TDD/TTY for hearing impaired, and language assistance are available and accessible to members and providers. Providers can utilize the Health Plan's language services to assist our members who are hearing impaired or need language translation services. Please refer to Section 12 - Cultural and Linguistic Services for detailed information. Language services information is also available at our website [Interpreter Services | Contra Costa Health](#).

Emergency Services

CCHP covers Emergency Services as well as Urgently Needed Services and Post-Stabilization Care for Members in accordance with applicable federal and state law.

Medicare law defines Emergency Services as covered services provided to evaluate or treat an Emergency Medical Condition. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant

- woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

The attending physician treating Members for Emergency Services will determine when the Member is stabilized and deemed ready for discharge out of an Emergency setting or transfer to another care setting.

Urgently Needed Services

Covered services:

- Are not Emergency Services, but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
- Are provided when (a) the Member is temporarily absent from the CCHP service area and therefore cannot obtain the needed service from a network Provider; or (b) when the Member is in CCHP's service area, but the network is temporarily unavailable or inaccessible; and
- Given the circumstances, it was not reasonable for the Member to wait to obtain the needed services from the Member's regular plan Provider after returning to the service area, or the network becomes available

Emergency Services and Urgently Needed Services do not require pre-authorization, although contracted Provider notification requirements may apply. See Emergency Inpatient Admissions below.

Post-Stabilization Care Services

Covered Services:

- Related to an Emergency Medical Condition;
- Provided after the Member is stabilized; and
- Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the Member's condition

Inpatient Admission Notification and Management

CCHP requires contracted PCPs, hospitals and Skilled Nursing Facilities (SNF) to provide timely electronic notifications of any admissions in the hospital or SNF of all Members in accordance with federal, state, and contractual requirements in order to coordinate appropriate care.

Elective Inpatient Admissions

CCHP requires prior authorization for all elective/scheduled inpatient admissions and procedures to any inpatient facility (i.e., including hospitals, Skilled Nursing

Facilities (SNF), and other inpatient settings). Contracted SNFs, long-term acute care hospitals (LTACH), and acute inpatient rehabilitation (AIR) facilities/units must obtain prior authorization before admitting the Member.

Inpatient facilities are also required to notify CCHP of the admission within twenty-four (24) hours, by the following business day, or as otherwise specified in the relevant Provider Agreement. Inpatient notifications may be submitted by fax. Contact telephone numbers and fax numbers are provided in the Requesting Prior Authorization section of the Universal Provider Manual.

Continued inpatient stay must be supported by clinical documentation supporting the level of care. Failure to obtain prior authorization, to provide timely notice of admission, or to support the level of care may result in denial with Provider liability. Members cannot be held liable for failure of a contracted Provider to follow the terms of the relevant Provider Agreement and Provider Manuals. Additional information can be found in the Claims and Payment section of Universal Provider Manual.

Inpatient at Time of Termination of Coverage

Members hospitalized on the day CCHP coverage terminates are usually covered through discharge. Specific plan rules and Provider Agreement provisions may apply.

NOTICE Act

Under the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals (including critical access hospitals) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including a Medicare Advantage enrollee) who receives observation services as an outpatient for more than 24 hours. The MOON is issued to inform the Member that they are an outpatient receiving observation services and not a hospital inpatient. The Member is informed that the Member's services are covered under Medicare Part B. Additional information is provided to the Member with regard to how an observation stay may affect the Member's eligibility for a SNF level of care and that Medicare Part B does not cover self-administered drugs.

Readmissions

Readmission review is important to ensure that Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within twenty-four (24) hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the subsequent readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

Out-of-Network (OON) Providers and Services

CCHP is responsible for ensuring Members obtain Medically Necessary Covered Services from an OON Provider if the services cannot be provided by an in-Network Provider in accordance with contractual requirements, including timely access requirements. CCHP must authorize and arrange for OON access when a Member is unable to receive an appointment with timely access standards, unless CCHP determines the delay will not have a detrimental impact on the health of the Member. CCHP must inform Members of their right to obtain Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) services to access OON services and provide NEMT or NMT at no cost to the Member.

Termination of Inpatient Hospital Services

Hospitals are required by CMS regulations to deliver the Important Message (IM) from Medicare (IM, Form CMS-10065) to all Medicare beneficiaries (including Medicare Advantage enrollees) who are hospital inpatients within two calendar days of admission. This requirement is applicable to all hospitals regardless of payment type or specialty. Delivery must be made to the Member or the Member's authorized representative in accordance with CMS guidelines. A follow-up copy of the IM is delivered no more than two calendar days before the planned discharge date.

The IM informs beneficiaries of their rights as a hospital inpatient, including their right to appeal the decision to discharge. Hospitals must deliver the IM in accordance with CMS guidelines and must obtain the signature of the beneficiary or the beneficiary's representative and provide a copy at that time. When the Member is no longer meeting criteria for continued inpatient stay, and the hospital has not initiated discharge planning, CCHP may require that the hospital issue a follow-up copy of the IM and notify the Member of the Member's discharge date, or provide additional clinical information supporting an inpatient level of care. Failure to do so may result in the denial of continued hospital services with Provider liability. The Member cannot be held liable for any continued care (aside from any applicable deductibles or co-payments) without proper notification that includes the

Member's appeal rights located within the IM, and if the Member exercises appeal rights, not until noon of the day after the quality improvement organization (QIO) notifies the Member of an adverse determination to the Member.

When the Member exercises appeal rights with the QIO, the hospital is required to properly complete and deliver the Detailed Notice of Discharge (DND, Form CMS-10066) to the QIO and the Member as soon as possible and no later than noon following the day of the QIO's notification to the hospital of the appeal. The hospital is also required to provide all information that the QIO requires to make its determination. At the Member's request, the hospital must provide to the Member a copy of all information provided to the QIO, including written records of any information provided by telephone. This documentation must be provided to the Member no later than close of business of the first day that the Member makes the request.

The exhaustion of a Member's covered Part A hospital days is not considered to be a discharge for purposes of issuing the IM.

Termination of SNF, CORF, and HHA Services

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Medicare beneficiaries to inform them of the termination of ongoing services (discharge) by a Skilled Nursing Facility (SNF) (including hospital swing beds providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHA). The NOMNC also provides the beneficiary with appeal rights for the termination of services. The NOMNC must be delivered to the Member or the Member's authorized representative in accordance with CMS guidelines and at least two days prior to discharge (or the next to the last time services are furnished in the case of CORF or HHA services).

When CCHP makes a determination that the Member's continued services are no longer skilled level and discharge is appropriate, a valid NOMNC is sent to the contracted Provider (SNF, CORF, or HHA) for delivery with a designation of the last covered day. Contracted Providers are responsible for delivering the NOMNC on behalf of CCHP to the Member or Member representative and for obtaining signature(s) in accordance with CMS guidelines. The contracted Provider must provide CCHP with a copy of the signed NOMNC. If the Member appeals the discharge to the QIO, the contracted Provider must also provide the QIO with a signed copy of the NOMNC and all relevant clinical information. The Member cannot be held liable for any care (aside from any applicable deductibles or co-payments) without proper notification that includes the Member's appeal rights located in the NOMNC, and if the Member exercises appeal rights, not before the appeal process with the QIO is complete. If the QIO's decision is favorable to the Member, the Member cannot be held liable until a proper NOMNC is issued, and

the Member is given the Member's appeal rights again. Failure of the contracted Provider to complete the notification timely and in accordance with CMS guidelines, or to provide information timely to the QIO, may result in the assignment of Provider liability. Members cannot be held responsible for the contracted Provider's failure to follow the terms of the relevant Provider Agreement or the Provider Manual.

A NOMNC is not issued in the following instances:

- When services are reduced (e.g., when a Member is receiving physical therapy and occupational therapy from a home health agency and only the occupational therapy is terminated);
- When the Member moves to a higher level of care (e.g., from home health to SNF);
- When the Member exhausts the Member's Medicare benefit;
- When the Member terminates services on the Member's own initiative;
- When the Member transfers to another Provider at the same level of care (e.g., a move from one SNF to another while remaining in a Medicare-covered stay); or
- When the Provider terminates services for business reasons (e.g., the Member is receiving home health services, but has a dangerous animal on the premises)

Quality of Care Review

The Provider agreement between CCHP and the provider states that upon five (5) business day prior notice, or as otherwise required by the applicable law and or regulatory agency, and subject to applicable state and federal confidentiality or privacy laws, Provider shall make all books, records and papers relating to Provider Services provided to Members available during normal business hours for inspection by CCHP, Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) and other applicable state or federal regulatory agencies.

Provider will make and provide copies of such records as may be reasonably requested by CCHP or applicable regulatory agencies. If such records are maintained by Provider's management company, then Provider shall be responsible for ensuring that the records and information requested are provided within the specified time.

Section 4 – Case Management and Care Coordination

The purpose of the Case Management (CM) Programs at CCHP is to ensure that medically necessary care is delivered to our members in the most efficient and effective setting and those social determinants of health are addressed quickly to minimize their negative impact. Case Management programs include:

- CCHP Case Management and Care Coordination Programs
 - Complex Case Management
 - Care Coordination
 - Transitional Care Services
- Other Case Management and Care Coordination Supports under CalAIM
 - Enhanced Care Management (ECM)
 - Community Supports
 - Community Health Workers

CCHP Case Management Programs

Case Management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Case Managers coordinates individual services for members whose needs include ongoing assistance with coordinating health care services. The Case Managers work collaboratively with all members of the healthcare team, including the Primary Care Provider, Specialist Providers, and Discharge Planners at the affiliated hospitals and Utilization Management staff at the Health Plan.

The primary goal of case management is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner.

Other goals include:

- Enhance the quality of life of the client
- Provide support and advocacy to member and provider
- Decrease fragmentation of care
- Promote cost-effectiveness
- Improve client and provider satisfaction
- Meet regulatory and accreditation requirements

Complex Case Management (CCM)

Complex Case management includes a comprehensive assessment of the member's condition, available benefits and resources (including Community

Supports), and development and implementation of a case management plan, monitoring and follow-up. This is a voluntary program, and Members have the right to decline services. CCM also includes services and interventions including:

- Care coordination, including focus on longer-term chronic conditions
- Interventions of episodic, temporary member needs
- Disease-specific management that include self-management support and health education
- Coordination of and referral to services and support.
- Transitional Care Services

CCM Eligibility includes:

- Member must have at least one of the following:
 - Poorly controlled disease states as evidenced by:
 - 2 or more hospitalizations within the last 12 months with at least one related to a chronic condition
 - 3 ED visits within the last 6 months with at least one related to a chronic condition
 - Taking 15 or more prescribed medications
 - Transplant candidate or recipient

Care Coordination

Care Coordination is for Members who do not qualify for CCM but may still benefit from case management support. This is a voluntary program, and Members have the right to decline services. Care Coordination includes:

- Assistance with navigation of health care system, including, but not limited to making appointments and reminders, finding needed service providers, and coordination of health care services and social services affecting health.
- Support with connection to available community resources that impacts health, including public benefit programs.
- Referrals to appropriate services and support programs
- Coordination of episodic care needs
- Transitional Care Services

Transitional Care Services (TCS)

Transitional Care Services (TCS) support members as they move between different care settings or levels of care. This includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (such as Sobering Centers, Recuperative Care, and Short-Term Post-Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

For high-risk members (as defined by DHCS on PHM Policy Guide May 2024), experiencing a transitional event who are not currently assigned to an Enhanced Care Management (ECM), Complex Case Management (CCM), or Care Coordination case manager, a CCHP Case Manager is assigned under Transitional Care Services. Low-risk members receive information about available case management support and guidance on how to request services at discharge.

For members already enrolled in ECM, CCM, or Care Coordination, the lead case manager is responsible for providing transitional care services.

Transitional Care Services include:

- Coordinating with the discharging facility to ensure member engagement, information sharing and seamless care transition.
- Post-discharge services and follow-ups, including:
 - Outreach to the member.
 - Ensuring timely post-discharge services and follow-ups, including scheduling provider appointments within 7 days post-discharge, coordinating with a primary care provider (PCP), and arranging transportation.
 - Supporting the initiation or continuation of substance use disorder (SUD) and mental health treatment for members with identified needs.
 - Ensure completion of medication reconciliation.
 - Referrals to social service organizations and at-home care services as needed.
 - Connection to community supports as needed to enhance recovery and stability.
- Care coordination for members transitioning to or from nursing facilities, including:
 - Ensure outpatient appointments are scheduled prior to discharge.
 - Verify that Members arrive safely and have their medical needs met.
 - Follow-up support to confirm all transitional care needs are addressed.

How to refer to CCHP Case Management:

- Submit a CCHP Case Management referral via ccLink
 - For RMC providers: Enter a CCHP Case Management referral on ccLink
 - For CPN providers: Enter a CCHP Case Management referral on ccLink Provider Portal - [ccLink Provider Portal Login](#) by following these instructions:

- [Case Management Programs | website for Contra Costa Health](#)
- If you do not have access to the ccLink Provider Portal, please download and complete the ccLink Provider Agreement posted on our website:
<https://www.cchealth.org/home/showpublisheddocument/7813/638354844779694259> and e-mail it to CCHPPortalSupport@cchealth.org.
- Submit a CCHP Case Management referral via fax at 925-252-2609
- Referral form: [CCHP Case Management Referral Form](#)
- Call CCHP Case Management at 1-925-313-6887 to request CM services

If you have any questions, please contact the Case Management Unit at 925-313-6887.

Enhanced Care Management Program Description

CCHP will take a whole-person approach to offering Enhanced Care Management (ECM), ensuring that ECM addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management in distinct Populations of Focus, and that ECM is community-based, interdisciplinary, high-touch, and person-centered. CCHP will also ensure that services are not duplicated. ECM is a Medi-Cal benefit.

Organizations that provide ECM services are contracted with CCHP, and the member must meet the criteria listed and also requires CCHP to authorize. Please refer to the Utilization Management Section for the Prior Authorization process.

Populations of Focus

Adult Populations of Focus:

- Experiencing Homelessness
- At Risk for Avoidable Hospital or ED Utilization (5 or more ED visits or 3 or more hospital and skilled nursing facility (SNF) admissions in the last 6 months)
- Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Transitioning from Incarceration in the last 12 months
- Adults Living in the Community and At Risk for LTC Institutionalization
- Nursing Facility Residents Transitioning to the Community
- Birth Equity (Pregnant or postpartum women who are subject to racial and ethnic health disparities)

Children/Youth (up to Age 21) Populations of Focus:

- Experiencing Homelessness
- At Risk for Avoidable Hospital or ED Utilization (3 or more ED visits or 2 or more hospital and skilled nursing facility (SNF) admissions in the last 6 months)
- Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition
- Children and Youth Involved in Child Welfare (Including former Foster Youth up to Age 26)
- Transitioning from Incarceration in the last 12 months
- Birth Equity (Pregnant or postpartum women who are subject to racial and ethnic health disparities)

CCHP will ensure all members receive all ECM core service components described below:

- Outreach and Engagement
- Comprehensive Assessment and Care Management Plan
- Enhanced Coordination of Care
- Health Promotion

Transitional Care Services

- Member and Family Supports

For additional ECM criteria, go to: [CalAIM Programs | Contra Costa Health](#)

Community Support (CS) Services

Organizations that provide CS services are contracted with CCHP, and the member must meet the criteria listed and also requires CCHP to authorize. Please refer to the UM Section for the Prior Authorization process. Referrals for CalAIM can be made for any Medi-Cal member in ccLink (CCRMC providers), via the CCHP ccLink Provider Portal (CPN providers), or by calling member services (members, their friends and family).

Referrals for CalAIM Community Supports are open to all CCHP Medi-Cal members.

For service overviews and eligibility and exclusion criteria for the following programs, go to: [CalAIM Programs | Contra Costa Health](#)

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)

- Respite Services • Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers (CCHP is not currently offering this CS)
- Asthma Remediation

Community Health Worker Services

Community Health Workers (CHWs) are skilled and trained health educators who you can employ to work directly with members who may have difficulty understanding and/or interacting with providers due to cultural and/or language barriers. CHWs tend to be members of the community they are serving and a larger component to linking health and social services for members with an overall improvement in quality of services delivered. They can assist those individuals by helping them to navigate the relationship with their health care providers, assist them in accessing health care services, and provide key linkages with other similar and related community-based resources. They can also encourage early detection of disease through health education about appropriate screening, and promote effective, timely management of chronic conditions, which helps people avoid unnecessary care and complications that lead to costly emergency room visits.

CHW services may address issues that include, but are not limited to:

- control and prevention of chronic conditions or infectious diseases
- mental health conditions and substance use disorders
- need for preventive services
- perinatal health conditions
- sexual and reproductive health
- environmental and climate-sensitive health issues
- child health and development
- oral health
- aging
- injury
- domestic violence
- violence prevention

Referrals for CHW services will be auto authorize the first 12 units. Providers can enter the written referral via Epic or portal which will be auto authorized for the first 12 units. Providers can refer to the list of contracted CHWs on the provider directory.

Section 5– Transportation Services

Contra Costa Health Plan (CCHP) provides Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) benefits to eligible Medi-Cal and Care Plus (HMO D-SNP) members. These services ensure members can access covered medical appointments and pharmacy pick-ups when transportation would otherwise be a barrier to care.

Transportation benefits are not available to Commercial line of business members.

This section outlines provider-facing guidelines for both NMT and NEMT, including clinical certification requirements, scheduling procedures, service limitations, and claim submission considerations.

Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (NEMT) is a covered benefit for eligible Medi-Cal and Care Plus (HMO D-SNP) members. NEMT is available when a member’s medical or physical condition prevents them from using public or private transportation safely and independently to access covered services. Providers play a key role in determining medical necessity and initiating authorization for these services.

Covered Services and Use Cases

NEMT may be used when transportation is needed to obtain:

- Covered medical services (e.g., appointments, diagnostics, procedures)
- Pharmacy pick-ups when medically necessary and prescribed by a Medi-Cal or Care Plus (HMO D-SNP) provider
- Services related to organ transplants (recipient or living donor)

NEMT must be medically necessary and prescribed by a licensed provider. The mode of transportation authorized will be the lowest cost option that appropriately meets the member’s clinical needs.

Eligible Modes of NEMT Transport

Mode	Typical Use Case
Ambulance	Member requires continuous medical monitoring or oxygen; transfers between acute settings
Gurney (Litter Van)	Member must lie flat and cannot sit; requires specialized safety

	equipment
Wheelchair Van	Member cannot walk or safely sit in a standard vehicle; requires door-to-door assistance
Air Transport	Only when ground transport is medically inappropriate or infeasible (must be physician-substantiated)

Transportation Authorization Requirements

A Physician Certification Statement (PCS) is required for most NEMT requests. The PCS must include:

- The member’s physical or medical limitations
- Dates of service (up to 12 months)
- Mode of transport required
- Certification statement of medical necessity
- A completed PCS form is required prior to service unless:
 - The service is urgent, and the request is submitted within 72 hours
 - The member is being transferred from an acute hospital to another licensed inpatient facility (e.g., SNF, psychiatric hospital)
 - The member is being transferred from an ER to inpatient care

For these exceptions, preliminary authorization may be granted without the PCS. However, a completed PCS must still be submitted within 30 days post-service, or the claim may be denied.

A DHCS-approved PCS form is available here: [Physician Certification Statement \(PCS\)](#).

Time-Sensitive Transfer Requirements

When a member is being discharged from an acute hospital to a licensed inpatient facility (e.g., SNF, psychiatric health facility), NEMT must be arranged and completed within 3 hours of the provider or member’s request. If not, the hospital may coordinate an out-of-network NEMT vendor, and CCHP will reimburse the service.

Minors and NEMT

Unless otherwise permitted by law, minors (under 18) must be accompanied by a parent or guardian. If unaccompanied, a signed Minor Consent Form must be on file. The form can be found in Appendix H or at: [Unaccompanied Minor Consent Form](#).

Transportation Provider Role and Contact Information

- Submit PCS and authorization requests via secure email: CCHPauthorizations@cchealth.org
- For authorization questions: 1-877-800-7423, option 3
- To schedule NEMT services: Call 1-855-222-1218 (members or providers)
 - Required to schedule at least 7–10 business days in advance
 - Same-day or urgent needs should be communicated as early as possible

Providers are responsible for initiating appropriate NEMT authorizations, ensuring member safety during transport, and adhering to all DHCS and CMS guidelines.

Non-Medical Transportation (NMT)

Non-Medical Transportation (NMT) is a covered benefit for all Medi-Cal and Contra Costa Health Care Plus (Care Plus) members who need assistance getting to and from covered medical services, including:

- Appointments for Medi-Cal or Medicare-covered care
- Ancillary services such as medical supply pick-up or pharmacy visits (when mail delivery is not appropriate)
- Services carved out of managed care (e.g., dental, specialty mental health, alcohol and drug services)
- NMT is not available to Commercial members.

Transportation Modes

CCHP authorizes the lowest-cost, most appropriate mode of transport for the member's needs. This may include:

- Public transit (e.g., bus or BART)
- Paratransit
- Private vehicle (with paid driver, e.g., taxi or rideshare)
- Transportation broker dispatch

Self-transport with reimbursement is not permitted. Members may not drive themselves and request payment.

Limitations

NMT may be denied or modified under the following circumstances:

- The member has not reasonably exhausted other available resources (e.g., family, friends, community transport programs)
- The requested destination is outside Contra Costa County and the service is available locally
- The destination pharmacy is not the nearest location for the prescribed

medication, or the medication can be mailed

- The requested provider is not contracted or does not have a valid referral from a contracted provider
- The service requires prior authorization that has not been secured
- The request is for transport into Contra Costa County from an out-of-county location, and no continuity of care or approved referral applies

Scheduling NMT

Transportation must be scheduled in advance. Members, or providers on their behalf, should call:

- CCHP Transportation Line: 1-855-222-1218 (TTY 711)
- Hours: 24 hours-per-day, 7 days-per-week

Requests must be made 5 to 7 business days before the appointment when possible, or as soon as possible for urgent care needs. Members will need:

- Their Member ID number
- Full appointment details (date, time, provider/facility name and address)

Unaccompanied Minors

Minors must be accompanied by a parent or guardian unless one of the following applies:

- A signed Minor Consent Form is on file allowing the child to travel unaccompanied
- The minor is accessing a service for which state or federal law does not require parental consent (e.g., sensitive services)

The Minor Consent Form is available in the Appendices (see Appendix H) or on the CCHP website:

- [Unaccompanied Minor Consent Form](#)

Section 6 – Pharmacy Services

Medi-Cal and Commercial Members

CCHP manages the utilization of pharmacy services and ensures quality, appropriate and timely services for its members by utilizing established written clinical criteria approved by the CCHP Pharmacy and Therapeutics Committee (P&T). Please note that, as of January 1, 2022, CCHP Medi-Cal members will receive their retail prescription benefits through Medi-Cal Rx. CCHP will continue to manage the physician administered drug medical benefit for CCHP Medi-Cal members.

For CCHP Commercial members, CCHP uses a preferred drug list/formulary (PDL) that is designed to promote cost-effective medication use based on published medical literature and community standards of care. The PDL is subject to revision, on a quarterly basis, as necessary to keep pace with continuous advances in pharmaceutical treatments and the needs of the members served by CCHP. There are a few ways to access the Preferred Drug List:

- A printable PDL is available online at <https://www.cchealth.org/health-insurance/information-for-providers/preferred-drug-list>
- Epocrates also hosts the CCHP formulary (available on all mobile devices).
- An online searchable formulary can be found at <https://client.formularynavigator.com>

CCHP's Commercial Plan pharmacy network consists of most national pharmacy chains, including Walgreens, CVS, Costco, Walmart and Safeway, as well as many independently owned pharmacies in Contra Costa County. If you need help finding a pharmacy for your members, use the search engine available at the above website or call CCHP Pharmacy services for assistance.

Hours Of Operation

- The CCHP Pharmacy Authorization Unit is available to answer questions from providers and members from 8:00 a.m. – 5:00 p.m., Monday through Friday.
- Our Pharmacy Benefits Manager, PerformRx, also handles provider calls. They are available 24 hours per day, 7 days per week to answer questions related to the CCHP Commercial formulary or prior authorization status. They can be reached at 877-234-4269. Note: for contract related questions, the PerformRx Network Management unit can be reached at 1-800-555-5690.
- After hours – CCHP Pharmacy Unit personnel are available to process prior authorization requests 7 days per week (Mon-Sun). Requests for drugs requiring prior authorization received outside of CCHP's prior authorization processing hours will not be processed until the next business day.

- If an urgently needed medication that requires prior authorization is needed; an emergency fill procedure may be utilized. The retail pharmacy will need to enter a special code to allow for a temporary five (5) day supply of medication to process while the provider submits an authorization request. The pharmacy may call the claims processor, PerformRx, to receive this code. Please note, that this does not eliminate the need for a prior authorization.
- For pharmacy specific processing instructions, contact CCHP pharmacy services during normal business hours or the Advice Nurse line after normal business hours.

Pharmacy Phone: 1-877-800-7423, option 2

Advice Nurse Phone: 1-877-661-6230, option 1

Perform RX: 1-877-234-4269

Prior Authorization

Providers must submit Medication Prior Authorization via phone, fax or portal to request a non-preferred drug or for an amount above our plan's quantity limits. CCHP requires prior authorization for non-preferred medications before the provision of a prescription of such medication to the member. Providing samples of a non-preferred drug for use is highly discouraged by the plan and is not considered continuation of therapy for authorization review purposes.

Prior authorizations are usually approved for a period of 12 months for maintenance medications unless the prescriber submitting the prior authorization requests a shorter duration. Prescribers who want to know the status of a prior authorization or wish to know when a prior authorization will end can call CCHP Pharmacy services for help at the number listed above.

- Drugs requiring a prior authorization may include but not limited to:
- Drugs with a high potential for adverse reactions
- Drugs that are frequently prescribed inappropriately
- Drugs with a high potential for abuse
- High-cost drugs with therapeutically equivalent alternatives
- Second-line agents that frequently are used as first-line treatments

Response Time

All CCHP Commercial Plan prior authorization requests will be evaluated by the CCHP pharmacy unit as quickly as possible. Per regulatory guidance, decisions will be sent to the appropriate provider and member (via fax, electronic communication and/or mail) within 72 hours of receipt of a valid non-urgent prior authorization request and within 24 hours of receipt of a valid urgent prior authorization request. All CCHP Medi-Cal physician administered drug prior authorization requests will be evaluated by the CCHP pharmacy unit as quickly as possible. Per regulatory guidance, decisions will be sent to the

appropriate provider and member (via fax, electronic communication and/or mail) within 24 hours of receipt of a valid prior authorization request.

Medication Appeals

Medication appeals are made directly to CCHP by contacting the Member Services Department. There are appeals processes and time standards for CCHP Medi-Cal and Commercial members. For questions regarding the appeals process call:

CCHP Member Services: 1-877-800-7423, option 7

Formulary Changes

Providers may request changes to the CCHP PDL that will be reviewed by the Pharmacy and Therapeutics (P&T) Committee, which meets at least four (4) times per year. Providers who submit a formulary change will be notified after the P&T committee has reviewed the request. To request a change in the formulary, use the Request for Formulary Review form (Located in the appendices Appendix F).

Care Plus (HMO D-SNP)

Members may be required to pay a co-pay for covered prescription drugs. Co-pays vary depending on:

- Member’s benefit plan
- Coverage stage the Member is in
- Medication’s formulary tier
- Member’s low-income subsidy level

Members who reach \$2,100 yearly out-of-pocket drug costs enter the Catastrophic Coverage Stage; at this stage, Care Plus (HMO D-SNP) pays all of the costs for the Member’s Medicare drugs.

Co-pays for Members in the Initial Coverage Stage (Members with Part D drug out-of- pocket costs from \$0 - \$2,100) are identified by the tiers listed below.

Tier	Co-pay for a one month (30 day supply) per prescription filled at a network pharmacy
Tier 1 - Preferred Generic Medications	The co-pay will be \$0.
Tier 2 – Generic Medications	The co-pay will be from \$0 to \$5.10 or 25% coinsurance, depending on the Member’s level of extra help (low-income subsidy).
Tier 3 - Preferred Brand Medications	The co-pay will be from \$0 to \$12.65 or 25% coinsurance, depending on the Member’s level of extra help (low-income subsidy).

Tier 4 - Non-Preferred Medications	The co-pay will be from \$0 to \$12.65 or 25% coinsurance, depending on the Member’s level of extra help (low-income subsidy).
Tier 5 - Specialty Medications	The co-pay will be from \$0 to \$12.55 or 25% coinsurance, depending on the Member’s level of extra help (low-income subsidy).
Tier 6 – Select Care Medications	The co-pay will be \$0.

Coverage and Limitations

Contra Costa Health Plan has a formulary that lists all covered drugs. Certain prescription drugs have additional requirements for coverage or limits. The formulary is updated monthly, and the current formulary list can be found on the Contra Costa Health Plan website at <https://www.cchealth.org/careplus>.

Medi-Cal Rx may pay for certain medically necessary drugs and items not covered under Medicare Part D.

Drugs commonly covered under Medi-Cal Rx may include, but are not limited to, the following:

1. Cough/cold medications
2. Over-the-counter medications
3. Prescription vitamins and minerals
4. Certain medical supplies (except for medical supplies associated with the delivery of insulin, syringes which are covered by Medicare Part D)

For any questions regarding coverage of drugs not covered under Care Plus (HMO D-SNP) Medicare Part D, please contact Medi-Cal Rx:

Medi-Cal Rx – Prime Therapeutics
 Phone: 1.800.977.2273
 Website: <https://medi-calrx.dhcs.ca.gov/home/>

Medicare Part D Pharmacy Network

A large number of network pharmacies (including retail, mail order and long-term care pharmacies) are available to members both inside and outside of Contra Costa County. The retail pharmacy network includes most major chain drug stores as well as independent community pharmacies. Members should fill prescriptions at network pharmacies. The pharmacy list is updated monthly.

How do Members Get Their Part D Prescription Filled

Members must obtain their prescriptions from a network pharmacy. A Pharmacy Directory can be provided to members upon request. A copy of the Pharmacy Directory can be found

on the Contra Costa Health Plan Medicare Member Materials website:
<https://www.cchealth.org/careplus>

Mail Order Pharmacy Services

Members can obtain their prescribed medications, taken on a regular basis for a chronic or long-term medical condition, through the network mail order pharmacy service.

Contra Costa Health Plan offers members the option of getting up to a 100-day supply of select maintenance medications mailed to their home or alternate address through our prescription mail order program.

A member is not required to use the mail order service in order to get an extended supply. Network pharmacies can also provide extended supplies. Many medications listed on Contra Costa Health Plan's formulary are available through the mail order pharmacy service.

Providers can call, mail, e-prescribe, or fax prescriptions to Walgreens Mail Service Pharmacy. Prescriptions should be delivered to member within 14 days from when the request was processed.

Walgreens Mail Service Pharmacy #3397
8350 S. River Pkwy
Tempe, AZ 85284
Phone: 877-787-3047

Medication Therapy Management (MTM) Programs

Care Plus (HMO D-SNP) offers a Medication Therapy Management (MTM) Program via the PerformRx to eligible members as part of the Medicare Part D benefit. This program aims to optimize therapeutic outcomes by promoting safe and effective medication use, improving adherence, and identifying potential medication-related issues. The MTM Program is available at no additional cost to eligible members.

Eligibility Criteria

Members may qualify for the MTM Program if they meet all CMS-defined minimum targeting criteria, which include:

- Having at least two chronic conditions from the following core chronic diseases: diabetes, asthma, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, heart failure, Alzheimer's disease or other dementias, HIV/AIDS, mental health conditions (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions), bone disease-arthritis (including osteoporosis, osteoarthritis, and

- rheumatoid arthritis), and respiratory disease (including asthma, COPD, and other chronic lung disorders).
- Taking multiple Part D medications, including all Part D maintenance drugs (minimum of eight medications).
 - Meeting annual expected Part D drug cost thresholds calculated using CMS methodology based on the average annual cost of eight generic drugs, as updated annually for coverage year 2026.

Program Components

The MTM Program encompasses comprehensive medication reviews, targeted medication reviews, medication action plans, and collaboration with healthcare providers to optimize medication therapy and identify potential drug-related issues. MTM pharmacists may contact prescribers to suggest clinically appropriate interventions or adjustments. These communications may involve phone calls or faxes to the prescriber's office, providing information and recommendations regarding a member's drug therapy regimen.

Dual-Eligible Member Coordination

While the MTM Program is a Medicare Part D service, Contra Costa Health Plan collaborates with Medi-Cal programs and providers to offer integrated support for dual-eligible members. This coordination ensures comprehensive care management that addresses both Medicare Part D and Medi-Cal covered services. Recommendations from MTM reviews may include follow-up with the member's primary care provider, behavioral health provider, or other specialists as needed to ensure continuity of care across both Medicare and Medi-Cal benefits.

Provider Role and Referral

Providers are encouraged to refer eligible members who may benefit from MTM services, particularly those experiencing polypharmacy, frequent hospitalizations, or medication non-adherence. Program participation does not affect coverage or benefits. The member's primary care provider plays a crucial role in the provision and coordination of quality care for MTM participants. After a member completes a medication review with a pharmacist, a letter with recommendations will be sent to the member's primary care provider to ensure optimal medication management and continuity of care.

MTM program qualification criteria are updated annually. For more up-to-date information, please visit: <https://www.cchealth.org/careplus> or call the Contra Costa Health Plan PBM (PerformRx) at 1-855-287-9128.

Opioid Overutilization

Contra Costa Health Plan has an opioid overutilization program (also known as a Drug Management Program, or DMP, for Medicare D-SNP) that can help members safely use their prescription opioid medications or other medications that are frequently abused.

Opioid utilization is monitored by Contra Costa Health Plan and PerformRx to reduce potentially inappropriate and unsafe use of opioids. Member specific reports are generated when pre-established overutilization criteria are met during a defined time period, and the reports are supplied to the appropriate providers. The information is shared with providers to increase awareness and facilitate next steps to address opioid overutilization. The monitoring program also improved Drug Utilization Review (DUR) controls at the point-of-sale, formulary management, case management and overall utilization reviews.

Please refer to the Controlled Substance Utilization Review and Evaluation System (CURES) before prescribing opioids.

If the member uses opioid medications from several providers or pharmacies, we may talk to you and other providers to make sure the use is appropriate and medically necessary. If Contra Costa Health Plan decides that the member is at risk for misusing or abusing the opioid or benzodiazepine medications, we may limit how the member can get those medications.

Limitations may include the following:

- Requiring the member to get all prescriptions for those medications from one pharmacy and/or from one provider
- Limiting the amount of those medications Contra Costa Health Plan will cover for the member

If Contra Costa Health Plan decides that one or more limitations should apply to the member, a letter will be sent in advance to the member. The letter will explain the limitations that should apply. The member will have a chance to tell us which providers or pharmacies they prefer to use. If a provider thinks Contra Costa Health Plan made a mistake, disagrees that the member is at risk for prescription drug abuse or disagrees with the limitation, providers and the member can file an appeal.

For more up-to-date information, please visit: <https://www.cchealth.org/careplus> or call the Contra Costa Health Plan PBM, PerformRx at 1-855-287-9128.

Part D Prescription Drug Prior Authorizations (PA)

Certain formulary medications and all non-formulary medications require a prior authorization (PA) request to be submitted by the prescribing provider for Contra Costa Health Plan members. Each PA request will be reviewed based on the individual member's medical need and determination will be based on documentation of meeting prior authorization criteria. The PA criteria and the length of PA

approval follow CMS requirements.

Instructions on how to submit PA requests are located on the Prescription Drug Prior Authorization forms, which can be found at: <https://www.cchealth.org/careplus>

Prescribers may also access additional information regarding the formulary and the specific PA criteria on the coverage determination process from Contra Costa Health Plan's contracted Pharmacy Benefit Manager (PBM).

Below is the PBM vendor that handles the processing of Care Plus (HMO D-SNP) pharmacy benefits and PA:

[PerformRx](#)

Phone: 1-855-287-9128

Part D Coverage Determinations

A Medicare Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a formulary exception request, a decision on the amount of cost sharing for a drug, or whether a member has or has not satisfied a prior authorization or other UM requirement.

Coverage determinations are either standard or expedited depending on the urgency of the request.

Initiating a Part D Coverage Determination Request

PerformRx will accept requests from providers or a member's appointed representative on the behalf of the member. The request may be communicated through the standardized Contra Costa Health Plan Medication Prior Authorization Request Form, the electronic portal, through telephone or via fax. All requests will be determined and communicated to the member and the member's prescribing provider with an approval or denial decision within 72 hours days after PerformRx receives the completed request.

PerformRx may request submission of additional information if a request is deemed incomplete for a determination decision. Review criteria will be made available at the request of the member or their prescribing provider.

Denial decisions are only given to the member or member's representative by a PerformRx pharmacist. The written denial notice to the member (and the prescriber involved) includes the specific rationale for denial, the explanation of both the standard and expedited appeals process, and an explanation of a member's right to, and conditions for, obtaining an expedited appeal.

If PerformRx denies coverage of the prescribed medication, PerformRx will give the

member a written notice within seventy-two (72) hours explaining the reason for the denial and how to initiate the appeals process.

If a coverage determination is expedited, PerformRx will notify the member of the coverage determination decision within the twenty-four (24) hour timeframe by telephone and mail the member a written Expedited Coverage Determination within 72 hours of the oral notification.

Appeals/Redeterminations

When a member's request for a coverage determination is denied, members may choose someone (including an attorney, provider, or other authorized representative) to serve as their personal representative to act on their behalf. After the date of the denial, a member has up to 60 calendar days to request a redetermination. This is the first level of appeal for Medicare Part D adverse decisions.

The redetermination request will be responded to within 7 calendar days. If an expedited appeal is required for an emergent situation, then the decision will be made within 72 hours of the request.

At any time during the appeal process, the member or personal representative may submit written comments, papers or other data about the appeal. If the appeal/reconsideration is denied, the member has the right to send the appeal to the Independent Review Entity (IRE) within 60 days of receipt of the appeal. The IRE has 7 days to make a decision for a standard appeal/reconsideration and 72 hours for an expedited request. The IRE will notify Contra Costa Health Plan and the member of the decision. When an expedited review is requested, the IRE will make a decision within 72 hours.

If the IRE upholds Contra Costa Health Plan's denial, they will inform the member of their right to additional appeal levels including Office of Medicare Hearings and Appeals, Medicare Appeals Council and a Judicial Review.

To file a redetermination/appeal, please contact Contra Costa Health Plan via phone, fax, mail or visit the CCHP website. For additional information on how to file a redetermination/appeal, please see the Medicare Member Grievances and Appeals section of this Provider Manual.

Part D Prescription Drug Policy

The Pharmacy and Therapeutics (P&T) Committee meets to review Contra Costa Health Plan's Part D policies which include the following:

- **Formulary** – A formulary is a list of medications selected by Contra Costa Health Plan in consultation with a team of health care providers, which

represents the prescription therapies are believed to be a necessary part of a quality treatment program. Contra Costa Health Plan will generally cover the drugs listed on our formulary as long as the prescription is filled at a network pharmacy and other plan rules are followed.

Formularies are updated annually. Current formularies may be downloaded from our website at: <https://www.cchealth.org/careplus>

- **Restrictions on Contra Costa Health Plan’s Medicare Drug Coverage –**
Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
 - **Prior Authorization:** Contra Costa Health Plan requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, Contra Costa Health Plan may not cover the drug
 - **Quantity Limits:** For certain drugs, Contra Costa Health Plan limits the amount of the drug that it will cover
 - **Step Therapy:** In some cases, Contra Costa Health Plan requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Contra Costa Health Plan may not cover drug B unless drug A is tried first
 - **Part B Medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. Newly FDA approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the P&T Committee
 - Non-Covered Contra Costa Health Plan Medicare Part D Drugs:
 - Agents, when used for anorexia, weight loss, or weight gain (no mention of medically necessary)
 - Agents, when used to promote fertility
 - Agents used for cosmetic purposes or hair growth
 - Agents used for symptomatic relief of cough or colds
 - Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations
 - Non-prescription and over-the-counter (OTC) drugs
 - Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
 - Prescriptions that are not being used for a medically accepted indication (i.e., prescriptions must either be FDA-approved or Medicare-approved compendia supported for the diagnosis for

which they are being used)

Part D Transition Fills

To minimize disruption in therapy, new and returning members may receive a temporary supply of a non-formulary drug or a drug requiring prior authorization within the first 90 days of enrollment. This period allows time for clinical assessment and the completion of prior authorization or transition to a covered alternative.

Section 7 – Claims

This section provides guidance on submitting clean medical claims to Contra Costa Health Plan (CCHP) for prompt reimbursement. The Claims team ensures timely payment of clean claims and is responsible for:

- Claims processing
- Responding to claims inquiries
- Returning claims to providers when information is missing

Balance Billing for Medi-Cal and Care Plus (HMO D-SNP)

Providers **cannot balance bill Medi-Cal or Care Plus (HMO D-SNP) members** for **any** portion of the cost of a covered service. Balance billing is strictly prohibited in the following cases, including but not limited to:

- Coinsurance, co-pays and deductibles. CCHP is not responsible for member co-pays.
- Differences between the billed amount and the applicable fee schedule
- Denied claims due to late submission, lack of authorization, or medical necessity determinations
- Pended claims under CCHP review
- No-show fees
- Fees for transferring or copying medical records

Billing Requirements Before Submitting Claims to CCHP

Electronic Data Interchange (EDI) & Paper Claims

CCHP requires contracted providers to submit claims electronically via Availity, which serves as CCHP's clearinghouse. However, providers are free to submit through their own clearinghouse if preferred.

- Register for Availity: [Availity Registration](#)
- CCHP Payer ID: CCHS
- Paper claims (only if electronic submission is unavailable) must be typed and mailed to:
P.O. Box 5122, Lake Forest, CA 92609
- Availity Support: [Availity Customer Support](#)
 - Availity support is available for all clearinghouse-related issues, including registration, claim submission, rejected claims, and file exchange.

Accepted Claims Formats

- Claims must be submitted using UB-04, CMS-1500, or other pre-approved formats.
- Clean claims include all necessary details and supporting documents.

- Adhering to the billing guidelines below will reduce chances of claims rejection or denial:
 - [UB-04 Billing Guidelines](#)
 - [CMS-1500 Billing Guidelines](#)
- For EDI inquiries, email EDIsupport@cchealth.org.

Reimbursement and Payment Processing

Electronic Funds Transfer (EFT)

Providers are encouraged to enroll in EFT for faster payments. Email edisupport@cchealth.org to request setup.

Provider Portal Access

Providers must use the [ccLink Provider Portal](#) to check claim status and submit claims.

- Register: [ccLink Provider Portal Registration](#)
- Support: CCHPportalsupport@cchealth.org

General Billing Instructions

- Claims with services requiring authorization must include valid authorization numbers in Box 23 of the CMS 1500 or Box 63A of the UB-04.
- Medi-Cal claims must adhere to Medi-Cal Provider Manual billing guidelines.
- When CCHP is the secondary payer, providers must include with their claim submission an Explanation of Benefits (EOB) or other supporting documents as required.
- Providers must submit clean claims or corrected claims within 180 days from the service date or EOB.
- Only original claim forms are accepted; copies and handwritten claims will be rejected.
- *Use the most recent AMA CPT and ICD-10 coding guidelines.*

National Provider Identifier (NPI) Requirements

Providers must include their NPI on all claims:

- CMS-1500: Box 24J (Rendering) & Box 32a (Facility)
- UB-04: Box 56 (Billing) & Box 76 (Attending)
- NPIs must be registered with Medi-Cal before billing CCHP.
- Claims missing NPIs will be rejected.

National Drug Codes (NDC) Requirements

For physician-administered drugs, claims must include:

- 11-digit NDC number
- Metric quantity
- Unit of measure
- Claims missing this information will be rejected or denied.

Provider Dispute Resolution

Providers may dispute claim denials, underpayments, or other reimbursement issues within **365 days** of the claim decision. Dispute avenues to consider following include:

- For five (5) or fewer claims: Submit disputes via [ccLink Provider Portal](#).
 - A single claim can be submitted per dispute or inquiry by navigating to "In Basket," selecting "New Msg," choosing "CCHP CPN Portal Communication" as the Topic, and "Claim Dispute" or other applicable as the Subtopic.
- For more than five (5) claims: Email claimstatus@cchealth.org with a description of the issue in the body of the email and a spreadsheet attached including affected claim numbers.
- Mail disputes to:
 - Contra Costa Health Plan
 - Attn: Claims Department – Provider Disputes
 - 595 Center Avenue, Suite 100, Martinez, CA 94553
- Each dispute must reference only one claim.
- Second-level disputes must be submitted to DMC.

Claims Processing and Payment Timelines

- **General Claims:** Processed within 30 calendar days unless contested. Late payments include interest.
- **Medi-Cal/Commercial Claims:** Processed within 30 calendar days.
 - Interest on Late Payments accrues at the greater of applicable regulation or:
 - Non-emergency claims: 15% per year
 - Emergency claims: the greater of \$15 per year or 15% per year
 - Interest begins after 30 calendar days.
- **Care Plus (HMO D-SNP) Claims:** Processed within 30 calendar days.
 - Interest on Late Payments accrues at the applicable Treasury rate, currently
 - Annual Rate: 4.625% (as of Jul–Dec 2025)
 - Interest = (Payment Amount × Annual Interest Rate × Number of Days Late) ÷ 365
 - Interest begins after 30 calendar days.

Corrected Claim Submission

Providers must submit corrected claims when a prior claim was denied, incorrect, or incomplete.

- **Electronic Corrected Claims:**
 - 837P/837I Claims: Use Claim Frequency Type Code "7".

- Include original claim number (REF*F8 segment) exactly as it appeared.
- **Paper Corrected Claims:**
 - CMS-1500: Code "7" in Box 22
 - UB-04: Type of Bill ending in "7" in Box 4 and original claim number in Box 64
 - Mail to:

Contra Costa Health Plan
ATTN: Claims Unit
595 Center Ave, Suite 100
Martinez, CA 94553
- Must be submitted within **180 days** of service or EOP.
- Prior payment from the “original” claim will **be recouped via a “reversal” claim and a new payment will be issued based on corrections via an “adjustment” claim.**

Crossover Claims (Medicare, Medi-Cal, Other Health Coverage)

- **Primary vs. Secondary Payer:** CCHP is the payer of last resort. Providers must bill other insurance carriers first and include primary documents with their secondary claims submission to CCHP.
- **Medi-Cal Payment Limits:** Combined payments from Medicare and Medi-Cal cannot exceed Medi-Cal’s allowed amount.

Frequently Asked Questions (FAQ)

How do I check the status of my claim?

Providers can check claim status via the [ccLink Provider Portal](#).

What should I do if my claim is denied?

Review the denial reason in the [ccLink Provider Portal](#). If incorrect, submit a corrected claim or initiate a dispute within 365 days from date of denial notice.

Care Plus (HMO D-SNP) Claims

In order to ensure timely processing and payment for all claims which CCHP is responsible for, Providers must complete all the required information outlined below.

CCHP requires contracted providers to submit claims electronically via Availity, which serves as CCHP’s clearinghouse. However, providers are free to submit through their own clearinghouse if preferred.

- Register for Availity: [Availity Registration](#)
- CCHP Payer ID: **CCHS**
- **Paper claims** (only if electronic submission is unavailable) **must be typed** and mailed to:

P.O. Box 5122, Lake Forest, CA 92609
- **Availity Support:** [Availity Customer Support](#)

- Availability support is available for all clearinghouse-related issues, including registration, claim submission, rejected claims, and file exchange.

Misdirected Claims

Misdirected is defined as claims erroneously submitted to an entity for which does not have financial responsibility.

- Claims erroneously submitted to CCHP – Misdirected claims received by CCHP will be forwarded to the appropriate Delegated Entity within ten (10) working days. For claims forwarded to a Delegated Entity, the entity's date of receipt shall be the working day when the claim is first delivered to the delegate as the party responsible to adjudicate and pay the claim. The exception is for Medicare / D-SNP, where the date of receipt date stamped on the claim by CCHP.
- Claims erroneously submitted to a Delegated Entity – misdirected claims should be submitted to CCHP within ten (10) working days via U.S. mail or electronic submission. The Provider should include a written confirmation of the original claim and the date it had knowledge of the misdirection.

If the Provider is contracted with a Delegated Entity and claims do not involve emergency services or care, CCHP will perform one of the following within ten (10) working days of receipt:

- Send the claimant a notice of denial with instructions to bill the Delegated Entity, or
- Forwards the claim to the appropriate Delegated Entity

If the Provider is not contracted with a Delegated Entity and claims does not involve emergency services or care, CCHP will forward the misdirected claim to the appropriate Delegated Entity within ten (10) working days of receipt. Providers have two (2) options to submit misdirected claims:

1. By Mail:
Contra Costa Health Plan
ATTN: Claims Unit
595 Center Ave, Suite 100
Martinez, CA 94553
2. By Electronic Submission:

CCHP requires contracted providers to submit claims electronically via Availity, which serves as CCHP's clearinghouse. However, providers are free to submit through their own clearinghouse if preferred.

- Register for Availity: [Availity Registration](#)
- CCHP Payer ID: **CCHS**
- **Paper claims** (only if electronic submission is unavailable) **must** be typed and mailed to:
P.O. Box 5122, Lake Forest, CA 92609
- **Availity Support:** [Availity Customer Support](#)
 - Availity support is available for all clearinghouse-related issues, including registration, claim submission, rejected claims, and file exchange.

Appeals Involving Provider Liability

The claim denial appeal rights are only applicable to non-participating providers. Disputes between CCHP and a contracted Provider are subject to the claims disputes provisions of this Provider Manual Chapter. Parts C & D Member grievances, prior authorization request processing, and appeals guidance of the Medicare Managed Care Manual specifically states that contracted Providers do not have appeal rights on their own behalf under the Medicare Member appeals process. Contracted Provider disputes involving plan payment denials are governed by the appeals and dispute resolution provisions of the relevant Provider agreement. When CCHP determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement or Provider Manual, either administratively or by not providing the clinical information needed to substantiate the services requested, the contracted Provider is prohibited from billing the Member for the services.

For Contracted Provider Disputes: Providers should mail or fax their written dispute to Contra Costa Health Plan at:

Contra Costa Health Plan Provider Relations
595 Center Ave., Ste. 100 Martinez, CA 94553
Fax: 925-608-9411
E-mail: ProviderRelations@cchealth.org

Coordination of Benefits (COB) and Third Party Liability (TPL)

In accordance with requirements of the Balanced Budget Act of 1997, CCHP's Medi-Cal, as a secondary payer, will pay deductibles and or coinsurance and co-pays for Medi-Cal covered services as long as the total cost for all services, deductible and coinsurance does not exceed the Medi-Cal Fee-For-Service rate.

California law limits Medi-Cal's reimbursements for a crossover claim to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum allowed for similar services (Welfare and Institutions Code, Section 14109.5).

For coordination of Medicare and Medi-Cal claims payments, CCHP or its delegated entity will process claims under Medicare as primary. If there are any applicable Medicare cost share, Medi-Cal crossover claims will be created and processed by CCHP for any applicable Medicare cost share amounts.

There are certain benefits that will not be covered by the CCHP Medi-Cal program but may be covered by Medi-Cal fee-for-service. In this case, the Provider should bill Medi-Cal with a copy of the CCHP Medicare remittance advice, and the associated state agency will process the claim accordingly.

Balance Billing Protections

Federal law prohibits balance billing of beneficiaries eligible for Medicare and Medi-Cal, including CCHP's Care Plus (HMO D-SNP) Members. Balance billing is the practice of billing a Member for the difference between what is reimbursed for a covered service and what a Provider feels should have been paid. It includes asking a Member to enter into a private payment agreement or waive their balance billing protection and charging deductibles, coinsurance, co-pays, or other administrative fees.

If you have questions regarding Balance Billing, please contact our Provider Relations Department at ProviderRelations@cchealth.org

Maximum Out-of-Pocket

Federal law requires Medicare Advantage plans to track individual Member's Medicare covered Part A and Part B cost share amounts. Annual limits are set by CMS annually. If met, the following will apply for the remainder of the calendar year:

- Member will have no out-of-pocket responsibility
- Providers will receive 100% of their Medicare payment

Member Grievances and Appeals

Contra Costa Health Care Plus responds promptly to complaints from either a provider or a member. Two types of formal complaints may be submitted by or on behalf of member: a grievance or an appeal.

Definition of Key Terms used in Medicare Member Grievances and Appeals Process

Grievance is any written or oral expression of dissatisfaction, regarding the plan and/or provider, including quality of care concerns, and rudeness of a provider or

office staff. A complaint is the same as a grievance. A grievance can be filed at any time regardless of the date of the occurrence or issue.

Appeal is a formal request for Care Plus to reconsider an adverse benefit determination (e.g., denial, deferral, or modification of a decision about health care coverage) that a member believes they are entitled to receive.

Integrated Organization Determination

Any determination (an approval or denial) made by CCHP for both Medicare and Medi-Cal. CCHP must adopt and implement a process for enrollees to request that the plan make an integrated organization determination. The process for requesting that CCHP make an integrated organization determination must be the same for all covered benefits.

Medicare Member Appeal

Medicare defines an Appeal as the procedures that deal with the review of adverse initial determinations made by the Plan regarding health care services or benefits under Medicare Part C or Medicare Part D that the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the Member's health) or regarding any amounts the Member must pay for a service or drug. These appeal procedures include a Plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

Integrated Appeal

The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and Medi-Cal rules the Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service. Integrated Appeals do not include Appeals related to Part D benefits.

Provider Disputes for Denied UM Authorization

The claim denial appeal rights are only applicable to non-contracted providers. Disputes between CCHP and a contracted Provider are subject to the claims disputes provisions of this Provider Manual Chapter. Parts C & D Member

grievances, prior authorization request processing, and appeals guidance of the Medicare Managed Care Manual specifically states that contracted Providers do not have appeal rights on their own behalf under the Medicare Member appeals process. Contracted Provider disputes involving plan payment denials are governed by the appeals and dispute resolution provisions of the relevant Provider agreement. When CCHP determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement or Provider Manual, either administratively or by not providing the clinical information needed to substantiate the services requested, the contracted Provider is prohibited from billing the Member for the services. Additional information regarding Provider Dispute Resolution can be found in the Claims and Payment section of the Universal Provider Manual.

How to File an Appeal

An appeal is a request for CCHP to review and change a decision we made about your services. If CCHP sent a Notice of Action (NOA) letter telling the member or provider that we are denying delaying, changing, or ending a service, and you do not agree with our decision, you can ask us for an appeal. A member's authorized representative or provider can also ask us for an appeal with your permission from the member. An appeal must be requested within 65 days from the date on the NOA you got from CCHP. If we decided to reduce, suspend, or stop a service you are getting now, you can continue getting that service while you wait for your appeal to be decided. This is called Aid Paid Pending. To get Aid Paid Pending, you must ask us for an appeal within 10 days from the date on the NOA or before the date we said your service will stop, whichever is later. When you request an appeal under these circumstances, your service will continue while you wait for your appeal decision. You can file an appeal by phone, in writing by mail, or online:

- By phone: Call CCHP at 1-877-661-6230 (Option 2) (TTY 711) between Monday – Friday, 8:00 a.m – 5:00 p.m. Give member name, health plan member ID number, and the service being appealed.
- By mail: Call CCHP at 1-877-661-6230 (Option 2) (TTY 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number, and the service you are appealing. Mail the form to: Contra Costa Health Plan Member Appeals / Grievance Unit 595 Center Ave, Suite 100 Martinez, CA 94553 Your doctor's office will have appeal forms available.
- Online: Visit the CCHP website. Go to www.ContraCostaHealthPlan.org.

If you need help asking for an appeal or with Aid Paid Pending, we can help you. We can give you free language services. Call 1-877-661-6230 (Option 2) (TTY 711). Within 5 days of getting your appeal, CCHP will send you a letter telling you we got

it. Within 30 days, we will tell you our appeal decision and send you a Notice of Appeal Resolution (NAR) letter. If we do not give you our appeal decision within 30 days, you can request a State Hearing from the California Department of Social Services (CDSS) and an Independent Medical Review (IMR) with DMHC. But if you ask for a State Hearing first, and the hearing to address your specific issues has already happened, you cannot ask for an IMR with DMHC on the same issues. In this case, the State Hearing has the final say. But you may still file a complaint with DMHC if your issues do not qualify for an IMR, even if the State Hearing has already happened. If you or your doctor wants us to make a fast decision because the time it takes to decide your appeal would put your life, health, or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call 1-877-661-6230 (Option 2) (TTY 711). We will decide within 72 hours of receiving your appeal.

What to Include with Appeal Requests

Members or Authorized Representative should include their full legal name, contact information, Member ID number, reason for appealing, and any evidence the Member wishes to attach. Members or Authorized Representative may send in supporting medical records, documentation or other information that explains why CCHP should provide or pay for the item or service.

Appeal Timeframes

Appeal decisions are made as expeditiously as the Member’s health condition requires and within regulatory timeframes.

Expedited Pre-Service Non-Part B, Non-Part D drug	72 hours
Expedited Pre-Service Part B drug	72 hours
Expedited Pre-Service Part D drug	72 hours
Standard Pre-Service Non-Part B, Non- Part D drug	30 calendar days
Standard Pre-Service Part B drug	7 calendar days
Standard Pre-Service Part D drug	7 calendar days
Standard Post-Service Part C	60 calendar days
Standard Post-Service Part D drug	14 calendar days

Extensions may be allowed under specific conditions (with the exception of requests involving a Part B or Part D drug).

Expedited request can be filed if it’s made or supported by a physician, prescribing physician, or other prescriber who indicates applying the standard timeframe could seriously jeopardize the life or health of the Member or the Member’s ability to

regain maximum function.

Continuation of Benefits (aka Aid Continuing)

Members may be entitled to continue benefits pending Appeal if authorization for services is terminated, suspended or reduced prior to the expiration of the authorization period. This typically occurs with Medi-Cal covered services such as personal care services but can be applicable to other Medicare or Medi-Cal services not authorized for a limited, defined benefit period when the services are terminated, suspended, or reduced prior to the expiration of the authorization period. The right to continue benefits is subject to the filing of the Appeal and/or providing a written request for continuation of benefits within 10 calendar days of the date of the notice of suspension, termination, reduction or the expiration of the authorization, whichever is later. The right to request continuation of benefits typically resides with the Member. When Providers are allowed to request continuation of benefits under applicable Federal and State regulations, they may be required to have the written consent of the Member to file the Appeal.

If the Member's Appeal is upheld by CCHP, their notice of the Appeal decision will contain any instructions for continuation of benefits pending State Fair Hearing. Federal and state rules applicable to the specific plan determine whether recovery of costs applies if the Member receives an adverse decision on Appeal or at State Fair Hearing.

Further Appeal Rights

If CCHP upholds the initial adverse determination, in whole or in part, for a Medicare Part C item or service (including a Part B drug), the Appeal will be forwarded to an Independent Review Entity (IRE). For Part D upholds, the Member must request review by the IRE. The IRE is a CMS contractor independent of CCHP. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of Appeal with an Administrative Law Judge (ALJ) or attorney adjudicator. Additional levels of Appeal are available to the Member if amount in controversy requirements are met, including appeal to the Medicare Appeals Council (MAC) and federal court. The Member may have additional appeal rights. In these plans, when the item or service is or could be covered by Medi-Cal or by Medicare and Medi-Cal (overlap), the Member will be provided with their State Fair Hearing (SFH) rights and any other state appeal rights to which they are entitled. (For example, the Member may be entitled to additional appeal rights for Medi-Cal-covered services under the state HMO law.) Additional levels of appeal follow the applicable state rules and requirements.

Hospital Discharge Appeals

Hospital discharges are subject to an expedited Member appeal process. Members receive their appeal rights through the delivery of the Important Message from Medicare (IM, Form CMS-10065) by the hospital. For additional information on delivery of the IM, see the Termination of Inpatient Hospital Services section of this Provider Manual.

Members disputing their discharge decision may request an immediate Appeal to the QIO. The QIO will typically respond within one day after it receives all necessary information.

If the QIO agrees with the discharge decision, the Member may request reconsideration from the QIO if they remain in the hospital. If the QIO continues to agree with the discharge decision, the Member may appeal to an Administrative Law Judge (ALJ) or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care without proper notification that includes their appeal rights located within the IM. The Member will then have an opportunity to appeal that subsequent discharge determination.

If the Member misses the deadline to file an Appeal with the QIO and is still in the hospital, the Member (or their authorized representative) may request an expedited pre-service Appeal with CCHP. In this case, the Member does not have financial protection during the expedited pre-service Appeal and may be financially liable for paying for the cost of additional hospital days beyond the discharge date if the original decision to discharge is upheld.

SNF, CORF, & HHA Discharge Appeals

Discharges from care provided by a Skilled Nursing Facility (SNF) (including a swing bed in a hospital providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF), or home health agency (HHA) are subject to an expedited (fast track) Member Appeal process. For this purpose, a discharge means the complete termination of services and not the termination of a single service when other services continue (e.g., when the Member is receiving skilled nursing, skilled therapy, and home health aide services from an HHA and only the home health aide services are terminated while the other services continue). When a single service is terminated and other services continue, a Plan Coverage Decision Letter with Member appeal rights is issued to the Member. Members receive their discharge appeal rights through the delivery of the Notice of Medicare Non-Coverage (NOMNC) by the SNF, CORF or HHA. For additional information on

delivery of the NOMNC, see the Termination of SNF, CORF, and HHA Services section of this Provider Manual. The Member must appeal to the QIO by noon (12:00 pm) of the calendar day after the NOMNC is delivered. The QIO will typically respond by the effective date provided in the NOMNC (the last covered day).

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care received beyond the last covered day provided in the NOMNC. The Member has an opportunity to request a reconsideration from the QIO if they remain in the SNF or continue to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC. If the QIO continues to agree with the discharge decision, the Member may appeal to an Administrative Law Judge (ALJ) or attorney adjudicator. If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or co-payments) without proper notification that includes their appeal rights located within the NOMNC. The Member will then have an opportunity to appeal that subsequent termination of services (discharge) determination.

If the Member misses the deadline to file an Appeal with the QIO and is still in the SNF or continuing to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC, the Member (or their Authorized Representative) may request an expedited pre-service Appeal with the Plan. In this case, the Member does not have financial protection during the expedited pre-service Appeal and may be financially liable for paying for the cost of additional services provided beyond the discharge date (last covered day) if the original decision to discharge is upheld.

Contracted Provider Responsibilities in the Medicare Member Appeals Process

Providers can request Expedited or Standard Pre-service Appeals on behalf of their Members. When submitting an Appeal, include all medical records and/or documentation to support the Appeal at that time. Please note that if additional information must be requested, processing of the Appeal may be delayed.

Expedited Appeals should only be requested if waiting the timeframe for a Standard Appeal could jeopardize the Member's life, health, or ability to regain maximum function.

Obtaining Additional Information about the Member Appeal Process

For additional information about Member Appeal rights, call CCHP member services at toll free at 1-877-661-6230, option 2 for persons with hearing impairments (TTY/TDD). A detailed explanation of the Appeal process is also

included in the Member Handbook / Evidence of Coverage (EOC), which is available on CCHP's web site.

Medicare Member Grievances

A Member may file a Grievance verbally or in writing within sixty (65) calendar days of the event precipitating the Grievance. Members may file a Grievance for Medicare covered services (including Part C and D) or Medi-Cal coverage at any time.

A Member may file a Grievance by contacting CCHP Member Services by telephone, in writing by mail, or online:

- By phone: Call CCHP at 1-877-661-6230, option 2 TTY 711 between Monday – Friday, 8am – 5pm. Give your name, health plan ID number, and the service you are appealing.
- By mail: Call CCHP at 1-877-661-6230, option 2 TTY 711 and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number, and the service you are appealing. Mail the form to: Contra Costa Health Plan Member Appeals / Grievance Unit 595 Center Ave, Suite 100 Martinez, CA 94553 Your doctor's office will have appeal forms available.
- Online: Visit the CCHP website. Go to <https://www.contracostahealthplan.org/>

Grievances are responded to by CCHP within 30 calendar days. CCHP may be allowed to take an extension under certain circumstances.

Medicare allows for Expedited Grievance only if CHHP denies an expedited request for an Organization Determination, Coverage Determination, or Appeal or if the Plan takes an extension in making an Organization Determination or Coverage Determination or deciding an Appeal (when allowed). These Expedited Grievances are decided within 24 hours.

Contact Directory

- **Claims Inquiries:** claimstatus@cchealth.org
- **EDI Support:** EDIsupport@cchealth.org
- **Provider Portal Support:** CCHPportalsupport@cchealth.org

Fraud, Waste and Abuse

The Patient Protection and Affordable Care Act (H.R. 3590) Section 6507 (Mandatory State Use of National Correct Coding Initiative (NCCI) required State

Medicaid programs to incorporate "NCCI methodologies" in their claims processing systems. The purpose of the NCCI edits is to prevent improper payments when inappropriate code combinations or unlikely units of service are reported.

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare Part B claims. Medicare carriers and FFS Medi-Cal have already implemented NCCI payment methodology. CCHP has applied NCCI edits for claims processed on or after April 1, 2016.

The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by providers as a general reference tool that explains the rationale for NCCI edits.

CMS NCCI Overview:

[NCCI for Medicare | CMS](#)

The CMS developed its coding policies based on the following:

- Coding policy defined in the American Medical Association's CPT manual,
- Coding based on national and local policies and edits,
- Coding guidelines developed by national societies,
- Through analysis of standard medical and surgical practices, and
- By review of current coding practices.

NCCI edits consist of two types:

1. Procedure-to-procedure (Column1/Column2) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons.
2. Medically Unlikely Edits (MUE), which are units of service edits, that define for each HCPCS/CPT code identified, the allowable number of units of service; units of service in excess of this value are not feasible for the procedure under normal conditions (e.g., claims for excision of more than one gall bladder or more than one appendix).

You may be contacted regarding billing practices and application of these claims' edits by the CCHP Claims Unit or Provider Relations.

For any questions regarding the Fraud, Waste and Abuse Program please e-mail the CCHP Claims unit at claimstatus@cchealth.org.

Fraud, Waste and Abuse Training

Fraud: An intentional act to deceive or misrepresent by a person who knows the deception could result in some unauthorized benefit for the person or someone else.

Waste: means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W. & I. Code Section 14043.1(a).)

CCHP views the integrity of its staff, providers, contractors and members to be paramount and uncompromising. The materials provided reiterate the procedure for handling discovery of fraudulent activity involved with CCHP and to remind contracting entities that you must also have appropriate policies and procedures to address FWA. When CCHP has reason to believe there is a valid incident of fraud, waste or abuse that has occurred, by subcontractors, members, providers, or employees, CCHP will report the incident to DHCS' Program Integrity Unit within ten (10) business days of the date when CCHP first becomes aware of or is on notice of such activity. Similarly, a provider or downstream contractor must submit any valid incident of fraud, waste or abuse that has occurred within ten (10) business days to CCHP. A provider or downstream contractor may submit a potential or suspected FWA case directly to the CCHP Provider Relations Unit by mail, fax or e-mail to the following address:

Contra Costa Health Plan
595 Center Ave., Ste. 200
Martinez, CA 94553
Phone: 925-608-9400
Fax: 925-608-9411
E-mail: ProviderRelations@cchealth.org

In addition to your report to CCHP, FWA may also be reported to the Office of Inspector General at: 1-800-HHSTIPS.

For cases involving Medicare prescription drugs, contact the Health Integrity Unit at: 1-877-772-3379.

Fraud Waste and Abuse Reporting and Investigation

Federal and state regulations require Contra Costa Health Plan to work with its providers to identify and report potential cases of health care fraud, waste, or abuse to law enforcement agencies and other regulators.

Examples of health care fraud, waste, or abuse can include:

- A person using someone else's Contra Costa Health Plan membership card
- A Medi-Cal member getting a bill for services covered by Contra Costa Health Plan
- A member getting a bill for unnecessary services or services not performed
- A provider submitting claims for duplicate services, unbundled services, or up-coded services
- A provider submitting claims for members that have declined services or did not receive services
- A supply or equipment company sending a bill for DME (e.g. wheelchair or diabetic supplies) that was not ordered by a physician or delivered to the member

False Claim Act

The Federal False Claims Act (FCA) identifies several actions that constitute violations of the FCA, including, but not limited to:

1. **False Claims** – Presenting, or causing the presentment, of a false claim for payment or approval. [31 U.S.C. §§ 3729\(a\)\(1\)\(A\)](#).
2. **False Records or Statements** – Making, using, or causing others to make or use, a false record or statement that is material to a false or fraudulent claim. [31 U.S.C. §§ 3729\(a\)\(1\)\(B\)](#).
3. **Conspiracy** – Conspiring to violate the False Claims Act. [31 U.S.C. §§ 3729\(a\)\(1\)\(C\)](#).
4. **Reverse False Claims** – Making, using, or causing to be made or used, a false record or statement material to an obligation to pay money to the government; or conceals, avoids, or decreases an obligation to pay money to the government. [31 U.S.C. §§ 3729\(a\)\(1\)\(G\)](#).

The FCA imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government (i. Medi-Cal or Medicare funds).

Some examples include:

- A provider who submits a bill to Medicare for medical services they know they have not provided.

- A provider who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

The Federal FCA protects employees and contractors who report a violation (“whistleblowers”) from discrimination, harassment, suspension or termination of employment as a result of making the report. Employees, contractors, and agents who are retaliated against in their employment (e.g. via termination, demotion, suspension, or other acts of discrimination) for lawful actions related to the FCA reporting, or other efforts to prevent FCA violations, are entitled to all relief necessary to be made whole.

How to Report Suspected Health Care Fraud

Suspected fraud or abuse should be reported to Contra Costa Health Plan immediately through the following methods (available 24 hours a day, 7 days a week):

Phone: call the FWA Reporting Hotline at **1-800-304-9490 (can report anonymously)**

Email: compliance@cchealth.org

Mail:

Contra Costa Health Plan Compliance Unit
595 Center Avenue, Suite 100
Martinez, CA 94553

What to Include When Reporting

- Names and contact information of individuals or organizations involved.
- Description of the alleged fraudulent activity or abuse.
- Dates and locations where the suspected activity occurred.
- Any supporting documentation or evidence.

Confidentiality: Reports can be made anonymously, and confidentiality is protected to the extent allowed by law.

If you are contracted with the state Department of Health Care Services (DHCS), reports can also be made directly to DHCS by:

Phone: FWA Hotline Number: 1-800-822-6222

Email: fraud@dhcs.ca.gov

Online: DHCS Fraud Reporting Form: [Stop Medi-Cal Fraud](#)

Mailing Address:

Medi-Cal Fraud Complaint - Intake Unit
Audits and Investigations

PO Box 997413, MS 2500
Sacramento, CA 95899-7413

A First Tier, Downstream, or Related Entity (FDR), health network or any other delegated entity with a contractual obligation to report suspected fraud, waste, or abuse must notify Contra Costa Health Plan in accordance with the terms and conditions of its contract and applicable Contra Costa Health Plan policies.

Contra Costa Health Plan's FWA team will investigate cases to determine if potential fraud or abuse exists, document and log incidents, and refer potential cases to the Department of Health Care Services Program Integrity Unit (PIU) and any other regulator or law enforcement agency as required. Contra Costa Health Plan's investigation may require coordination with other internal departments, FDRs or other delegated entities, health networks, or the services of contracted investigators as needed.

Monthly and Annual Requirements

Federal and state regulations require Contra Costa Health Plan to ensure that an FDR, health network, or any other delegated (1) ensures that no individuals or entities that are excluded from participating in federal health care programs are paid with Contra Costa Health Plan funds; and (2) monitors the following on a monthly basis:

- General Services Administration (GSA) System for Award Management (SAM) website: <https://sam.gov/>
- Office of Inspector General Exclusions Database: <https://exclusions.oig.hhs.gov/>
- Medicare Exclusion Database (MED): <https://med.cms.gov/>
- Social Security Administration Death Master File: <https://dmf.ntis.gov/>
- Medi-Cal's Suspended and Ineligible (S&I) list: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/sandi>

Contra Costa Health Plan requires FDRs, delegates, and health networks to implement comprehensive corporate compliance programs in accordance with the Office of Inspector General's (OIG) seven elements of an effective compliance program: <https://oig.hhs.gov/compliance/general-compliance-program-guidance/>

Contra Costa Health Plan also requires FDRs, delegates, and health networks to train all their employees, including board members, contractors, and sub-contractors on an annual basis about Fraud, Waste, and Abuse prevention and reporting. Upon completion of FWA training, Contra Costa Health Plan requires FDRs, delegates, and health networks to sign and attestation of completion of the FWA training.

Section 8 - Access

Access Standards

Ensuring timely access to care is a fundamental priority at Contra Costa Health Plan. We adhere to state access standards to guarantee that our members can easily reach the care they need. This includes monitoring and evaluating appointment scheduling, wait times, and the availability of urgent and routine care services. We are committed to maintaining these standards and continuously improving our access to care. Regulatory agencies, including the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS), conducting monitoring of appointment availability through provider surveys. Providers, Subcontractors, and Downstream Subcontractors are required to fully participate in all Timely Access Surveys administered by state agencies or vendors on the behalf of state agencies. A pattern of non-compliance with Timely Access standards may result in a corrective action plan.

Primary Care	
Urgent Appointment	Within 48 hours
Non-Urgent (Routine) Primary Care Appointment	Within 10 business days
First Prenatal Visit	Within 14 calendar days of request
Initial Health Appointment	Within 120 calendar days of Medi-Cal enrollment
Specialty & Ancillary Care	
Urgent Appointment	Within 48 hours (does <u>not</u> require prior authorization)
	Within 96 hours (does require prior authorization)
Non-Urgent Specialty Care Appointment	Within 15 business days
Non-Urgent Ancillary Appointment	Within 15 business days
Behavioral Health	
Non-Urgent Behavioral Health Initial Appointment	Within 10 business days
Non-Urgent Behavioral Health Follow-up Appointment	Within 10 business days
Urgent Behavioral Health Appointment	Within 48 hours
Non-life threatening behavioral health emergency	Within 6 hours
Behavioral Health – Emergency	Immediate, 24/7
Telephone Access Standards	
Telephone Triage	Telephone triage will be available 24/7. Telephone triage or screening wait time

	(including call back) will not exceed 30 minutes
Telephone wait time to answer	Within 10 minutes
Telephone call back waiting time	By end of the next business day
Emergency Care and After-Hours Services	
Emergency Care	Immediate, 24/7
Emergency Instructions	Phone message and/or live person must instruct member to call 911 or go to the nearest emergency room
After Hours Care	A PCP or designee will be available 24/7 a week to respond to after-hours member or hospital practitioners. The CCHP advice nurse can be contacted 24/7 for afterhours services. 1-877-661-6230 option 1.
Other Access Standards	
Shortening or Extending Appointments	Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member’s medical record that a longer timeframe will not have a detrimental impact on the Member’s health.
In-Office Waiting Room Time	Within 45 minutes or less from the time of the appointment to be taken to an exam room
Language Accessibility	Provide 24-hour interpretation services through in-person or telephone interpretation
Follow up on missed appointments	Providers are expected to review all members that do not show up for scheduled appointments and to identify those requiring follow-up, based on their medical condition
Skilled Nursing Facility/Intermediate Care Facilities Placement	Within 5 business days of request

Shortening Or Expanding Timeframes

To appropriately understand cause and corrective actions, all timely access monitoring is conducted with consideration to the context of provider resources and member needs. Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member’s medical record that a longer timeframe will not have a detrimental impact on the Member’s health.

Please see your CCHP Provider Manual Section 3 Utilization Management which explains in detail the process for you to obtain timely referrals to specialists for your members. If you have a timely access concern, you can contact CCHP's Utilization Management at 1-877-800-7423, option 3 or file a complaint with the California Department of Managed Health Care by calling the DMHC Toll-free provider complaint line at: 1-877-525-1295.

Alternative Access Standards

On an annual basis, Provider Relations has the responsibility to submit to the Department of Health Care Services (DHCS) network data according to APL 23-001 Annual Network Certification Requirements (ANC) [Managed Care All Plan Letters - 1998 to Current](#), to determine network adequacy. Targeted recruitment efforts are to address shortages found by this review and a request for an Alternative Access Standard submitted for review and approval if needed. For any provider type in Contra Costa County, which CCHP is non-compliant under an ANC Corrective Action Plan, CCHP will comply with time elapsed standards as stated in Quality Management (QM) Policy 14.101. Refer to QM 14.101 for monitoring process.

Provider Availability and Coverage

CCHP requires primary care providers to be available twenty-four (24) hours a day, seven (7) days a week, with appropriate coverage and/or on-call arrangements and clinical telephone triage.

Providers are requested to make coverage arrangements with a CCHP contracted provider whenever possible. The covering provider should indicate on the CMS-1500 billing form, in box 31 o/c and their name along with the contracted doctor's name underneath or attach a note stating that he/she is covering or on-call for the PCP to be reimbursed.

After Hours Care

After hours care is a critically important element in the delivery of quality healthcare. The following is designed to assist our providers in clarifying specifics regarding after hours care visits.

Referral Sources

CCHP members may self-refer or referred to afterhours care from one of two sources, either our Advice Nurse (AN) Unit or our Case Management (CM) unit. CCHP encourages members to call the AN prior to obtaining services

Coordination Of Care with the PCP

After-hours care service providers have an important role in the continuity of care of CCHP members. Members seeking treatment are for single visits. Members requiring continuing treatment must be redirected to their PCP for follow up care.

After-hours care providers are obligated to send a copy of the medical record to the member's PCP within forty-eight (48) hours of their after-hours care appointment. Primary care providers who are also after-hours care providers will not receive additional compensation for treating their assigned panel members.

Co-Payments

Co-payment information can be found on the ccLink provider web portal or by calling the 24/7 Eligibility line at 1-877-800-7423, option 1 or can be found on the member's ID card.

CCHP is not responsible for member co-pays.

Billing Procedure

All after-hours care visits provided by contracted CCHP providers must be billed with place of service (POS) code 20. After-hours care services not billed with POS code 20 may be denied.

Section 9 – Advice Nurse

The Advice Nurse Telephone Triage Program is available twenty-four (24) hours a day, seven (7) days a week (including holidays) to all CCHP members regardless of their CCHP benefit plan. Providers may refer their CCHP members to this service after the close of business or on weekends and holidays.

Advice Nurses, who are Registered Nurses, triage the member according to his/her reported symptoms and determine the appropriate level of care. All Advice Nurses are experienced in telephone triage and in providing multi-lingual services.

Triage System

Advice Nurses use computerized medical protocols that are tailored to community needs and resources. Medically approved guidelines assist the Nurses in identifying high-risk situations to ensure that members are appropriately directed to care as needed.

Services include but are not limited to the following:

- Answering questions regarding medications
- Guiding members to recognize significant changes in symptoms
- Monitoring conditions meeting stay-at-home criteria
- Non-English-speaking language capabilities of up to one-hundred and forty (140) languages
- Referral to appropriate level of needed care when services are needed outside regular hours of provider operation
- Addressing benefit related questions after hours

To access the Advice Nurse Telephone Triage Program Call: 1-877-661-6230, option 1.

Urgent Care

Members may occasionally have the need for immediate, Urgent Care services, especially when their community Primary Care Provider's practice is impacted or off hours. Members needing Urgent Care appointments may call the Advice Nurse/Triage Unit and depending on reported symptoms, be referred to one of our contracted Urgent Care Centers. Members may also self-refer for services. In addition to the contracted Urgent Care Centers, members can go to the nearest emergency service facility providing care on a twenty-four (24) hour seven (7) days per week basis.

The members may be initially triaged by an Advice Nurse, who decides based on

member's disposition and symptoms whether an urgent care appointment is needed. Acceptable dispositions are usually in a range of See Within 8 to 24 hours. Once the decision has been made, and the member agrees to an urgent care appointment with one of our contracted urgent care centers, the Advice Nurse either makes the appointment with the urgent care facility, or the member is directed to call the facility to schedule the appointment. The Advice Nurse documents the call in ccLink and faxes the information to the specific urgent care facility. The Advice Nurses conduct a follow up call the following day to assure the members was seen and to follow up on the member's condition.

Being able to schedule an appointment with a contracted urgent care facility decreases the number of unnecessary emergency visits. It also increases the member's satisfaction as they are seen for their urgent medical needs in a timely manner.

Telephone Consultation Clinic

The Telephone Consultation Clinic (TCC) program allows for members calling in to the Advice Nurse to be referred to a medical provider working with the ANs for assistance in obtaining lab orders, refills for maintenance medications, referrals, and most importantly, advice to help address member needs without requiring them to be seen in clinic, urgent care, or the emergency department whenever possible.

This program began as a pilot in late 2011, now available seven days a week, to increase the level of care and access to care for CCHP members and all others handled by CCHP. With appointments difficult to come by, some of the common concerns members have been able to be managed by providers speaking with members over the phone. This initial contact helps to streamline the member care process, allowing for member needs to be met by providers to hold them over until they're next able to be seen by their physician in clinic. It's also aimed to help cut back on unnecessary emergency room visits due to a lack of availability of appointments elsewhere, difficulties in reaching PCPs, and other such factors.

- Advice: TCC providers can offer advice and reassurance to members regarding at-home care, or further assessment of symptoms.
- Lab work: Often, TCC can assist in ordering lab work for members ahead of a clinic visit, allowing members to complete lab work beforehand for discussion during their visit. TCC can also order treatment room nurse services, such as throat swabs, to rule out and identify cases of strep throat.
- Medication changes: In cases where a member or pharmacy is unclear on medication directions, unable to fill based on insurance limitations,

or a member is reacting to their current medication, TCC providers may be able to help when PCPs are unavailable.

- Medication refills: TCC is also able to assist with medication refills for members having a difficult time getting into the clinics to see a provider in person. In most cases, these are refills for maintenance medication, dealing with diabetes or asthma or blood pressure medication.
- Prescriptions: TCC can also write and fill new prescriptions depending on what the provider feels will benefit the member. For example, this may be in response to finalized lab results received for potential urinary tract infections or bacterial vaginosis, allowing the TCC provider to order an appropriate anti-biotic as indicated in the lab results themselves. Members who suffer from chronic UTIs and BV may also be given a prescription prior to completing lab results, dependent on member history. The situations in which TCC providers may order a medication run a broad range, such as conjunctivitis, well described and identifiable rashes, cough (for standard cough medicines), flu exposure, and more.
- Referrals: TCC providers are also able to assist in inputting new referrals into the CCHP system. This encompasses changing urgency of a referral, assisting in putting in referrals based on Urgent Care provider request, and/or referrals into Physical or Occupational Therapy, and other such programs within CCHS as appropriate.
- TCC Clinic Appointments: The Appointment Program is usually able to set aside one to three (on average) appointments in the Extended Clinics at the CCHP Clinics. TCC providers who believe a member will best benefit from being seen by a provider firsthand may ask the support staff working with them in the Advice Nurse Program to schedule a member into one of the on-hold clinic appointments. This is particularly useful for members who are followed in CCHP clinics but who do not have qualifying insurance for Urgent Care. (Straight Medi-Cal, Straight Medicare.)
- Urgent Care: In cases where TCC providers believe it's beneficial for a member to be seen and evaluated for their symptoms, they can ask the support staff working with them in the Advice Nurse Program to assist in scheduling an Urgent Care appointment in one of CCHP's contracted urgent care providers.

Emergency Protocols

Providers may list the Advice Nurse number, 1-877-661-6230, option 1, on their afterhours message as well as listing 911 for all emergencies.

When a member reaches the Advice Nurse, the member will be triaged according

to:

- Telephone Triage Protocols - Adult and Pediatric After-Hours Version
2018 - David A. Thompson, MD and Barton D. Schmitt, MD

Should emergency care be indicated, the member is referred to Contra Costa County Regional Medical Center or other contracted emergency care sites.

Confirmation of a member visit to emergency care will include care given during visit and referral back to PCP for follow up and include recommendation for referral to specialist as indicated.

Member emergency room tracking is monitored through encounter data, collected by the Case Management Department.

Section 10 – Behavioral Health Services

CCHP works to ensure member access and coordination to mental and behavioral health services across its entire contracted network and across systems of care. Further, CCHP ensures that access to Mental Health Services will be available in a timely manner, at the appropriate level of care, and in accordance with member Health Plan benefits.

For urgent or crisis behavioral health situations, providers should direct members to the county's 24/7 behavioral health access line 1-888-678-7277 TTY 711.

“Mental health and substance use disorders” means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

Medically necessary mental health services provided by contracted mental health providers within the scope of their practice and in an ambulatory setting (e.g. outpatient psychotherapy (including but not limited to 1:1, group, and family therapy), and psychiatry / medication management services), are not intended to require prior authorization. Providers are guided to refer to the CPT Code Search to verify authorization requirements of specific codes. Unauthorized services are subject to payment denial.

Mental Health Services can be provided by PCPs and licensed mental health care providers within their scope of practice.

CCHP works in collaboration with Contra Costa Behavioral Health Services (BHS) in the implementation of both Specialty Mental Health Services (SMHS) and Alcohol and Other Drug (AOD) treatment.

Additionally, CCHP partners with the Regional Center of the East Bay (RCEB) and Contra Costa First-5, to improve care outcomes for members with signs and symptoms or formal diagnosis of developmental delay or neurodevelopmental

disorder (e.g. Autism Spectrum Disorder).

Mental & Behavioral Health in Primary Care

PCPs are required to:

- Provide a mental health screening to assess the member's concerns. Members with positive screening results may be further assessed either by the PCP or by referral to a licensed mental health provider. See below for additional information regarding Alcohol and Drug Screening.
- Refer members to a licensed mental health provider within the CCHP network when the condition is beyond the PCP's scope of practice.
 - For Medi-Cal and Care Plus (HMO D-SNP) members with significant impairment or whose diagnosis is uncertain, refer member for further evaluation to BHS / County Mental Health.
- Provide the following if within their scope of practice:
 - Mental health evaluation and treatment
 - Outpatient services for the purposes of monitoring drug therapy
 - Outpatient laboratory*, drugs, supplies, and supplements (excluding medications listed in the Medi-Cal Provider Manual in the following link: [Provider Manual | Medi-Cal Providers](#))

*Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies. Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).

Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) for Alcohol and Other Drugs

SABIRT services may be provided by a licensed health care provider, including but not limited to the following:

- | | |
|---|---|
| ○ Licensed Physician | ○ Physician Assistant |
| ○ Nurse Practitioner | ○ Psychologist |
| ○ Certified Nurse Midwives | ○ Licensed Midwives |
| ○ Licensed Clinical Social Workers | ○ Licensed Professional Clinical Counselors |
| ○ Licensed Marriage and Family Therapists | |

SABIRT Unhealthy alcohol and drug use screening must be conducted using validated screening tools.

Validated Screening tools include, but are not limited to:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
- The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

Brief Assessment

When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools.

Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)

Alcohol Use Disorders Identification Test (AUDIT)

If intervention is needed, the PCP can then perform a brief 15-minute intervention. The PCP can perform up to 3 brief interventions per year.

Brief Interventions and Referral to Treatment

Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable 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 member regarding screening and assessment results.
- Discussing negative consequences that have occurred and the overall severity of the problem.

- Supporting the member in making behavioral changes; and
- Discussing and agreeing on plans for follow-up with the member, including referral to other treatment if indicated

Documentation Requirements

Member medical records must include the following:

- The service provided (e.g., screen and brief intervention);
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and
- If and where a referral to an AUD or SUD program was made

When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services. Further need for mental health and/or substance use disorders services must be referred to a licensed mental health care provider via the Mental Health Access line. Additional resources can be found at:

- Technical Assistance Publication 33: Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment
<https://www.samhsa.gov/grants/grantannouncements/ti-16-002>
- Treatment Improvement Protocols 35: Enhancing Motivation for Change in Substance Abuse Treatment
<http://www.ncbi.nlm.nih.gov/books/NBK64967/pdf/TOC.pdf>
- Quick Guide: Opioids and Substance Misuse | SAMHSA

Licensed Mental Health Care Provider

Licensed Mental Health Care Providers are required to:

- Provide a mental health assessment using a mutually agreed upon tool with the MHP to assess the member's disorder, level of impairment, and appropriate care needed, which may include the following:
 - Individual and group mental health evaluation and treatment (psychotherapy),
 - Psychological 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 medications listed in the Medi-Cal Provider Manual in

- the following link [Provider Manual | Medi-Cal Providers](#))
- Psychiatric consultation
 - Collaborate with CCBHS to provide comprehensive behavioral health care for members with Medi-Cal – including but not limited to completion of Transitions of Care tools and completion of Closed-Loop Referral process, as required by DHCS (for Medi-Cal members).

Mental Health Services

CCHP Medi-Cal

For CCHP's Medi-Cal Members, CCHP covers Non-Specialty Mental Health (NSMHS - for Mild-to-Moderate acuity). Specialty Mental Health Services (SMHS – for Moderate-to-Severe acuity), including inpatient psychiatric hospitalizations, are administered by Contra Costa Behavioral Health Services (BHS).

CCHP Medi-Cal members (assigned to PCP's in either the CPN or CCRMC) can be screened for level of acuity and thereby linked to services via the ACCESS line (888-678-7277). Alternatively, members may self-refer using the access line. For members who screen as in need of Specialty Mental Health Services (SMHS – for moderate-to-severe acuity), the ACCESS line facilitates referral to providers in the County Behavioral Health Services division.

No Wrong Door for Behavioral Health: In accordance with DHCS guidelines (“No Wrong Door”), CCHP will promote the coordination of medically necessary mental health care services across non-specialty and specialty sectors. This includes reimbursement of non-duplicative services by Medi-Cal enrolled providers operating within their scope of practice.

CCHP Care Plus (HMO D-SNP)

Like CCHP Medi-Cal members, CCHP Care Plus (HMO D-SNP) Members may be eligible for SMHS. As such, Care Plus (HMO D-SNP) members seeking to initiate Mental Health Services should be referred to the Access Line for screening and referral to the appropriate system of care.

Behavioral health care for Care Plus (HMO D-SNP) members includes services covered under both Medicare and Medi-Cal, delivered through a coordinated system that involves the Care Plus (HMO D-SNP) plan, county behavioral health departments, and contracted providers. Providers play a critical role in identifying behavioral health needs, making timely referrals, and collaborating with interdisciplinary care teams to support members' overall well-being. As such, following clinical assessment and initiation of care, per CMS guidelines (42 CFR §

422.101(f)), treating providers are expected to participate in Interdisciplinary Care Team (ICT) and annual Interdisciplinary Care Plan (ICP) process (refer to corresponding sections for additional information regarding ICT and ICP).

CCHP Commercial

For CCHP's commercial members, distinctions between Non-Specialty (mild-moderate) and Specialty Mental Health Services (moderate-severe) do not apply. CCHP covers Behavioral Health benefits at all levels of acuity via Member Service or by accessing the provider directory.

CCHP has implemented the expanded definition of Medical Necessity services for the Commercial members assessing Mental Health/Behavioral Health Substance Use Disorder Services. Medically necessary treatment of a mental health or substance use disorder means a service or product addressing the specific needs of that member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the generally accepted standards of mental health and substance use disorder care as required by California Senate Bill 855.
2. Clinically appropriate in terms of type, frequency, extent, site, and duration.
3. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the member, treating physician, or other health care provider.

CCHP shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

- CCHP Commercial Plan members may access Mental Health Services in accordance with their benefit plan and limitations. Mental Health Parity rules apply for the Commercial Plan members as with other product lines (e.g. Medi-Cal). For questions regarding member benefits call Member Services at (877) 800-7423, option 7. For outpatient therapy and psychotherapy, members may self-refer to a CCHP contracted provider, be referred by their PCP, or call the CCHP Advice Nurse Unit at (877) 661-6230, option 1. A list of CCHP contracted provider cans be found on the CCHP website at: [Provider Directory](#)
- Medically necessary mental health services provided by contracted mental health providers within the scope of their practice and in an ambulatory setting (e.g. outpatient psychotherapy (including but not limited to 1:1, group, and family therapy), and psychiatry / medication

management services), are not intended to require prior authorization. Providers are guided to refer to the CPT Code Search to verify authorization requirements of specific codes. Unauthorized services are subject to payment denial.

Access to Inpatient, Partial Hospitalization, and Intensive Outpatient Programs for Commercial Members

Inpatient

In an emergency, inpatient services (for both mental health and substance use disorder), a Commercial member can go to any emergency department. No prior authorization or referral is needed.

Partial Hospitalization and Intensive Outpatient

For partial hospitalization, members can refer to the CCHP Provider Directory for a listing of contracted providers. Prior authorization is required. If deemed medically necessary, the facility will proceed with admissions and CCHP will conduct a concurrent review.

Intensive Outpatient

For intensive outpatient treatment, members can refer to the CCHP Provider Directory for a listing of contracted providers. Prior authorization is required. If deemed medically necessary, the treating provider will submit to CCHP for authorization.

For questions about referrals or authorizations, contact the Behavioral Health Department at CCHPBHD@cchealth.org.

Alcohol and Other Drug (AOD) Services

CCHP Medi-Cal

Following screening by PCP (above), or by member self-referral, CCHP works in collaboration with Contra Costa Behavioral Health Services (BHS) in the implementation of and Alcohol and Other Drug (AOD) treatment. ACCESS line screening with substance use disorder counselors facilitates referral to appropriate treatment options 1-888-678-7277.

CCHP Care Plus (HMO D-SNP)

As per Medi-Cal above, access to AOD services for Care Plus (HMO D-SNP)

members is best obtained via the ACCESS Line.

As per above, AOD providers caring for Care Plus (HMO D-SNP) members are expected to participate in Interdisciplinary Care Team (ICT) and annual Interdisciplinary Care Plan (ICP) process (refer to corresponding sections for additional information regarding ICT and ICP).

CCHP Commercial

Following screening by PCP (above), or by member self-referral, CCHP maintains a network of providers who can provide Alcohol and Other Drug (AOD) treatment. Providers may refer to treating providers without authorization from the plan or can direct patients to CCHP member services to identify appropriate treatment options 1-888-678-7277.

Behavioral Health Treatment and Developmental Delay

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for Preventive Behavioral Health Treatment

Under the EPSDT Program CCHP will ensure that providers deliver the medically necessary Behavioral Health Treatment (BHT) services, consistent with the requirements for members under the age of 21 for all lines of business (Medi-Cal and Commercial). CCHP's Policy BHD 18.004 outlines these services that includes BH services (this policy is available upon request).

Coordination and Access to services for ASD and Developmental Delay

Children with developmental delays or disabilities under three (3) years of age may be eligible to receive services through The Regional Center of the East Bay (RCEB). These services are available without financial qualifications. The provider can refer their member directly to the Regional Center of the East Bay by phone at 1-510-618-6195 or online at For Providers - RCEB.

At age three (3) years, children with hearing, vision or other developmental delays may be eligible to receive services for these conditions from local education systems. This may require that each child has an Individual Education Plan (IEP) to assure that all needs are met, and services are delivered.

This may involve enrollment in the Early Start Program. Referral may be made directly to the involved School District, or referral may be directed to our Referral/Authorization Unit, who will forward to the school district for processing.

Behavioral Health Treatment (BHT)

BHT services include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.

- Primary Care Providers who suspect autism or other behavioral diagnoses should submit a referral request to CCHP Behavioral Health Department for a comprehensive diagnostic evaluation (CDE). CDE will provide a robust diagnostic assessment. See Section 3 – Utilization Management for referral instructions. CCHP Behavioral Health Department will review the request for medical necessity, and a Comprehensive Diagnostic Evaluation will be authorized if medically indicated. Applied Behavior Analysis (ABA) services can be ordered independently from CDE evaluations. The CCHP Behavioral Health Department (BHD) will authorize a Functional Behavioral Assessment (FBA) and ongoing Applied Behavior Analysis (ABA) services that are medically necessary. ABA services require authorization and ABA providers are expected to submit Authorization requests, including full treatment plans, for continuation of services (typically on a 6 month recurring schedule).

CCHP Medi-Cal

Behavioral Health Treatment for Autism Spectrum Disorder (ASD) and other diagnoses is a covered benefit for children with Medi-Cal coverage up to the age of 21.

Integration of Medicare and Medi-Cal Behavioral Health Benefits

Under California's CalAIM initiative, D-SNPs are required to coordinate Medicare-covered services with Medi-Cal covered behavioral health services. This includes:

- Ensuring seamless transitions between levels of care (e.g., inpatient to outpatient).
- Collaborating with county mental health plans (MHPs) and Drug Medi-Cal programs.
- Using a unified Health Risk Assessment (HRA) that identifies behavioral health and caregiver needs.
- Actively involving members in developing their individualized Care Plan (ICP), which includes behavioral health goals.
- Engaging caregivers, when appropriate, to support behavioral health recovery and stability.

Providers should be aware that behavioral health services are delivered through a combination of direct D-SNP contracted networks and county-operated programs. Coordination across these systems is essential and supported through data sharing provisions under HIPAA that allow for care coordination without a business associate agreement (per 45 CFR §§164.502 and 164.506).

Section 11 – Sensitive Services

Abortion, Contraception, HIV, And STDs

Sensitive Services include diagnosis and treatment of sexually transmitted diseases (STD), family planning services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy, initial HIV testing and counseling, abortion and treatment for rape.

Only our Medi-Cal members may self-refer (without referral by the PCP or authorization from CCHP), to any Medi-Cal provider even if not under contract with CCHP. A Medi-Cal member may go out-of-network/out-of-plan for abortion services at any time for any reason.

However, no physician or other healthcare provider who objects to performing an abortion may be required to do so, and no person refusing to perform an abortion may be punished for such a choice (H & S Code, Section 123420).

All other members must receive Sensitive Services through their chosen Network. CCHP informs potential members (through our directories and on-line search engine) when they enroll if hospitals, clinics and other providers, in their network refuse to provide abortions.

Minor Consent Services

Members under the age of eighteen (18) may access certain services, considered sensitive services, without approval from their parents and without parental consent. These services include:

- Family Planning Services
- Substance Use Disorders for members twelve (12) and older (Refer to Section 8)
- HIV testing
- Outpatient Mental Health Services for members twelve (12) & older (Refer to Section 8)
- Pregnancy testing and other pregnancy-related services
- Treatment for rape and sexually transmitted diseases for members twelve (12) and older

Abortion is also a sensitive service. A minor who is alleged to have been sexually assaulted may consent to medical care related to the diagnosis and treatment of the condition, and the collection of medical evidence regarding the alleged sexual assault.

Minors may call the Advice Nurse Program to get information, or they can go to their PCP, local Public Health Department or, for Medi-Cal members, any other qualified provider.

Advice Nurse Program: 1-877-661-6230, option 1.

Domestic Violence/Child Abuse Reporting

If child abuse is suspected, it is mandatory to report the case. The Suspected Child Abuse form must be completed and submitted as indicated on the bottom for each episode of suspected or identified abuse.

Children and adult domestic violence are reported on Suspected Violent Injury Report, and elder abuse is reported on Suspected Dependent/Elder Abuse Report. Prior to submitting the written report, it is required to call the Abuse Reporting Line to report verbally. Reports should be submitted within twenty-four (24) hours (See Appendix A).

Abuse Reporting Lines:

Contra Costa County: 1-877-881-1116, **East County** 1-925-427-8811, **West County** 1-510-374-3324, and **Central County** 1-925-646-1680

Section 12 – Cultural and Linguistic Services

By law, CCHP must ensure members have access to no-cost interpreter services. Interpreter services must be available 24-hours a day, 7-days a week for medical encounters. CCHP provides access to interpreter services 24- hours a day, 7-days a week. Providers are required by regulations to discourage members from using their own interpreters, such as family members, friends or minors.

Please note that the member has the choice to refuse professional interpreters and use adult family members or friends. If the member chooses to bring an interpreter after they were offered a professional interpreter, the provider must document this choice in the member's medical record.

Translation Services

CCHP can assist your office to translate written materials for CCHP members in languages other than English. To inquire about translating a document e-mail: CCHP.Quality@cchealth.org

Interpreter Services – Community Provider Network

These instructions are valid for Community Providers only and do not include hospitals, skilled nursing facilities or Regional Medical Center facilities. Hospitals and SNF's please use your own contracted vendor. Instructions are also available on our website at [Interpreter Services | Contra Costa Health](#).

Interpreter Over the Phone

Available for all routine office visits of CCHP patients, appointment scheduling, urgent care, labs, health education, pharmacy, etc. Offices can use any phone with a speaker.

Dial: 1-866-874-3972

Provide: your 6-digit **Client ID 298935** (Mental/Behavioral Health providers use ID, 525970)

Indicate: the language you need or press 1 for Spanish, 2 for all other languages and state the name of the language you need. 0 for assistance if you don't know what language you need.

Provide:

- Patient Name
- Patient Date of Birth
- Contra Costa Health Plan Member ID
- Doctor/Practitioner Name
- Doctor/Practitioner Phone Number

Connect: to an interpreter, document their name and ID number in the patient's chart for reference. Summarize what you wish to accomplish and give any special instructions.

When calling or receiving a call from a patient who needs language services:

Use the conference feature on your phone to make a 3-way call and follow the instructions above to connect to an interpreter.

In-Person/Face-to-Face Interpretation Guidelines

We require 5 full business days advance notice.

CPN providers can only ask for in-person or face-to-face interpretation services for:

- ASL (American Sign Language) for deaf or hard of hearing
- End of life issues
- Sexual assault/abuse issues
- Life threatening diagnosis like cancer, chemotherapy, transplants
- Allergy testing, food trials, asthma education
- Surgical procedure consent
- Initial physical therapy evaluation
- Complex behavioral health appointments
- Other conditions by exception determined by medical director

To arrange for In Person/Face to Face Interpreter Services you may submit your request by:

- Completing the online form at [Interpreter Services | Contra Costa Health](#).
- Calling 1-877-800-7423, Option 4. This rings to Member Services during the day and to Advice Unit after 5 p.m. They gather the information needed, if you meet the criteria listed above, we will make arrangements with our vendor (Fluent Language Solutions).

Virtual Interpreter

We require 2 full business days advance notice.

If you need interpreters for a Telehealth appointment:

- Complete Virtual Interpreter Request form, email to onsiterequests@languageline.com and copy CCHP.Quality@cchealth.org
- Email CCHP.Quality@cchealth.org or Provider Relations for the request form

Printed materials for your reception area: We provide flyers you can post in your office which state: Point to your language! We will get you an interpreter. To print a copy of the flyer, go to our website at: [Point to your Language Flyer](#).

Instructions on using Interpreter Services for Telehealth visits are available by e-mailing CCHP.Quality@cchealth.org

If you have any problems accessing the Linguistic Services listed above, you can e-mail CCHP.Quality@cchealth.org

To make a California Relay Service Call-Dial 711 or 1-800-735-2922.

The California Relay Service may be used when the provider needs to call a person who is deaf, hard of hearing, deaf-blind, or has a speech-disability.

Alternative Format Material Selections for Visual Impairments

Contra Costa Health Plan (CCHP) and subcontractors must accommodate the communication needs of members with disabilities, [including Braille, audio format, large print \(no less than 20-point Arial font\), and accessible electronic format](#), such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate.

- CCHP members who are visually impaired can call the CCHP Member Services Department to get assistance with alternative format selections:
 - Monday through Friday, 8 a.m. to 5 p.m.
 - 1-877-661-6230, Option 2.
- CCHP members who are hearing impaired can call California Relay toll free at 711.

If provider offices need assistance with converting documents to alternative formats including braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format they can e-mail CCHP at

CCHP.Quality@cchealth.org.

Additional Resources:

Free Text To Speech Reader (<https://ttsreader.com/>)

- Instantly reads out loud text, PDFs & eBooks with natural sounding voices. Just copy and paste the text and click play.

Examples of other auxiliary aids and services can be found at the ADA website:

<https://www.ada.gov/effective-comm.htm>

Regional Medical Center Network

CCRMC hospital and clinics providers use HCIN – Health Care Interpreter Network. Video interpreter units are available in each health center exam room and at each bedside at CCRMC.

Easy Steps for Using Video Interpreter Services at CCHS.

- Check in Epic under demographics member preferred spoken and written language. Check to see what the interpreter sees by pressing ‘more’, ‘self-view’– adjust the camera (especially important for ASL), then ‘exit’.
- Use speed dial for Spanish, ASL or All other languages
- When recording comes on for all languages, choose from the attached list or badge card at any time
- Please state your name and where you are calling from and speak directly to your member/client – use first person
- Document in the medical record, include interpreter ID#

If you need instructions for Telehealth or have any questions about accessing Interpreter Services, contact Sally McFalone: Sally.McFalone@cchealth.org or Phone: 1-925-313-6242.

Section 13 – Member Services

CCHP's Member Services Department Representatives are available Monday through Friday from 8 a.m. to 5 p.m. CCHP safeguards the rights of its members to file a grievance and will ensure that there are no discriminatory actions (including disenrollment) taken against a member because they have filed a grievance. (Refer to Appendix G).

Referring To Member Services

Contact Member Services for the following:

- A member wants to know about CCHP or has questions about benefits or CCHP services
- A member wants to choose or change a PCP for themselves, a family member (with member consent) or a minor family member
- A member's CCHP identification card is lost or stolen
- A member wants to request a second opinion or option for treatment
- A member has received a medical bill
- A member wants to discuss or file a grievance or an appeal

Member Services: 1-877-800-7423, option 7.

Member Complaints and Grievances

If a member is dissatisfied with the service delivered by the provider, providers should offer the member the CCHP grievance form to complete and return it immediately to CCHP's Member Services Department or see Appendix G for the online fillable form. You may also advise the member to call Member Services at 1-877-661-6230, option 2 to help resolve the member's issue.

The member can also go to the CCHP office to talk to a Member Services staff in person.

Complaints regarding providers of CCHP (Doctors, Nurses, Health Centers, etc.) should be sent to CCHP for resolution.

It is the member's right to talk to someone who speaks his or her own language. Members have the right to see the files pertaining to their concern such as, medical records, plan policies, and any information maintained by CCHP. It is also the member's right to designate a friend, family member, or a lawyer to help them. The member's Evidence of Coverage (EOC) is also available to members to read more

about the complaints and grievances process. Refer members to Member Services if they would like a copy of the CCHP Grievance Policy.

Time Frames for Resolving Member Complaints and Grievances

CCHP Member Services Representatives will make every attempt to resolve the complaint or grievance immediately. If an immediate resolution is not possible, the member may file a formal grievance.

- Commercial members have one hundred and eighty (180) days from the date of the incident to file a formal grievance.
- Medi-Cal members can file a grievance at any time.

After receiving a grievance, Member Services staff will inform the member within five (5) days that CCHP is in receipt of the grievance and will submit to the member, in writing, a resolution within thirty (30) days. If the member's clinical condition is critical, the grievance may be expedited. Members can file grievance by telephone, fax, through the Health Plans' website, in person or in writing.

Written member grievances should be sent to:

Contra Costa Health Plan
Member Services Department
595 Center Avenue, Suite 100
Martinez, California 94553
Phone: 1-877-661-6230, option 2
website: <https://www.cchealth.org/health-insurance>
Fax: 1-925-313-6047

Member Appeals for Denied Claims or Services

If a member believes that a service or payment for a service has been denied, deferred or modified inappropriately, the member may submit an appeal in writing to Member Services.

For Medi-Cal members, the appeal must be submitted within sixty (60) days from the date of the notification of the denial of the service or claim.

Commercial members have one hundred and eighty (180) days from the date of the notification to file an appeal.

Providers can file a Member Appeal on behalf of their members. However, the provider needs to submit a signed member consent form to file the appeal. See Appendix G for the online form.

Expedited Reviews

The Expedited Review process applies to requests for services and/or supplies that:

- the member has not received, which is believed to be medically urgent
- or*
- the member is not getting, which the Provider believes should be urgently provided

The member can ask CCHP for an expedited review (72 hour) when they file a grievance. The Plan will provide an expedited review if waiting thirty (30) days for a resolution could seriously harm the health of the member.

For cases requiring expedited review, The Plan will decide no later than 72 hours after the request is received. If CCHP denies the request for an expedited review the member will be notified in writing within three (3) days and then CCHP will follow the thirty (30) day grievance process.

When an expedited review is requested, the member also has the right to immediately notify the Department of Managed Health Care (DMHC) about the grievance.

Member Rights & Responsibilities

Members of Contra Costa Health Plan (CCHP), including those enrolled in Medi-Cal or Care Plus (HMO D-SNP) or Commercial, are guaranteed specific rights and are expected to uphold certain responsibilities. These rights are grounded in California state and federal law and are designed to ensure equitable, informed, and dignified care. Providers are expected to respect and support these rights, and to encourage members to fulfill their responsibilities in pursuit of effective care.

Members have the right to:

1. Receive information about their rights and responsibilities.
2. Receive information about the health plan, the services it offers, and the network of Health Care Providers available to them.
3. Make recommendations regarding the Plan's member rights and responsibilities policy.
4. Receive clear information about all available health care services, including how to access them and any limitations that may apply.
5. Know the costs of their care, including whether their deductible or out-of-pocket maximum has been met.

6. Choose a Health Care Provider within the Plan's network and request a different provider if they are dissatisfied.
7. Access timely and geographically appropriate health care.
8. Schedule timely appointments with in-network Health Care Providers, including specialists.
9. Obtain out-of-network appointments when the Plan cannot provide timely access to care in-network.
10. Receive reasonable accommodations for disabilities, including:
 - a. Accessible exam rooms and medical equipment.
 - b. Full and equal access to facilities.
 - c. Extra time during appointments, if needed.
 - d. Access for service animals in exam rooms.
11. Determine eligibility for and purchase coverage through the California Health Benefit Exchange (Covered California).
12. Receive care that is considerate, courteous, and respectful of their dignity.
13. Receive culturally competent care, including:
 - a. Trans-Inclusive Health Care, including Medically Necessary services related to gender dysphoria or intersex conditions.
 - b. Being addressed by their preferred name and pronoun.
14. Request and receive information from their provider about their health condition, treatment options, and expected outcomes, regardless of cost or coverage.
15. Participate in decision-making and provide informed consent for treatment or refuse treatment to the extent permitted by law.
16. Discuss appropriate or Medically Necessary treatment options, regardless of cost or coverage.
17. Receive coverage even with a pre-existing condition.
18. Access Medically Necessary behavioral health or substance use disorder services.
19. Receive certain preventive health services, often at no cost.
20. Be free from annual or lifetime limits on basic health services.
21. Maintain eligible dependents on their coverage.
22. Be notified of unreasonable rate increases or changes, when applicable.
23. Be protected from illegal balance billing by providers.
24. Request a second opinion from an appropriately qualified provider.
25. Expect that their personal health information is kept private in accordance with applicable law.
26. Request a list of who has accessed their health records.
27. Ask that communications from the Plan or provider occur in specific ways or locations.
28. Have sensitive services and related information kept confidential.

29. Access and amend their medical records, or add statements when corrections are denied.
30. Request an interpreter at all points of contact and receive language assistance services at no cost.
31. Receive written materials in their preferred language, where required by law.
32. Receive materials in accessible formats if blind, deaf, or have low vision.
33. Request continuity of care when a provider leaves the network or when joining the Plan.
34. Create and maintain an Advanced Health Care Directive.
35. Be informed about the Plan's grievance process and use it without disruption to their care.
36. File a complaint, grievance, or appeal—verbally or in writing and in their preferred language—about:
 - a. A Health Care Provider or the Plan.
 - b. The care they received or their ability to access care.
 - c. Any decision to deny, delay, or modify coverage of a service.
 - d. Billing or charges they believe are improper.
 - e. Discrimination, including on the basis of gender identity or expression, or denial of Trans-Inclusive Health Care.
 - f. Failure to meet language needs.
37. Receive an explanation of why a service or treatment was denied.
38. Contact the California Department of Managed Health Care for assistance with accessing services or Plan concerns.
39. Request an Independent Medical Review when the Plan denies, delays, or modifies a service.

Members are responsible for:

1. Treating Health Care Providers, their staff, and Plan staff with respect and dignity.
2. Sharing information necessary to help the Plan and providers deliver appropriate care.
3. Collaborating with providers to develop care goals and following treatment plans as agreed.
4. Attending scheduled appointments and notifying providers when they must cancel or reschedule.
5. Refraining from submitting false or misleading information or claims.
6. Informing the Plan of changes to name, address, or household.
7. Paying any applicable premiums, co-payments, or costs for non-covered services in a timely manner.
8. Reporting billing concerns or inappropriate charges to the Plan as soon

as reasonably possible.

Department Of Managed Health Care (DMHC)

The California Department of Managed Health Care is responsible for regulating health care service plans for Commercial and Medi-Cal members. If you have a grievance against your health plan, you should first telephone your health plan at Contra Costa Health Plan **1-877-661-6230, option 2** 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 website <http://www.dmhc.ca.gov> has complaint forms, IMR application forms and instructions online.

Medi-Cal Ombudsman

Medi-Cal members can also call the Medi-Cal Ombudsman to help with enrollment problems or with complaints about our plan. You can contact them at 1-888-452-8609.

Medi-Cal Fair Hearings or Independent Medical Review (IMR)

If you disagree with the appeal decision:

If you filed an appeal and received a “Notice of Appeal Resolution” letter telling you that your health plan will still not provide the services, or you never received a letter telling you of the decision and it has been past 30 days, you can:

- Ask for an “Independent Medical Review” (IMR) and an outside reviewer that is not related to the health plan will review your case

- Ask for a “State Hearing” and a judge will review your case

You can ask for an IMR and State Hearing at the same time. You can also ask for one before the other to see if it will resolve your problem first.

For example, if you ask for an IMR first, but do not agree with the decision, you can still ask for a State Hearing later. However, if you ask for a State Hearing first, but the hearing has already taken place, you cannot ask for an IMR. You will not have to pay for an IMR or State Hearing.

Members have only 120 days after the order or action you are complaining of to file your Fair Hearing by calling 1-800-743-8525 or write to:

Medi-Cal Fair Hearing Rights:
California Department of Social Services
State Hearing Division
Box 944243, Mail Station 9-17-433
Sacramento, CA 94244-2430
By Fax to 833-281-0905

The Department of Managed Care also has a toll-free telephone number 1-888-HMO-2219 and a TDD line 1-877-688-9891 for the hearing and speech impaired. The Department’s Internet Website <https://www.dmhc.ca.gov/> has complaint forms, IMR application forms and instructions online.

CCHP is required by Senate Bill 853 to provide access to IMR information in formats that our members can speak and understand. Non-English formats for the IMR are available at [Independent Medical Review/Complaint Forms](#)

If you have any questions or problems, please contact:

Member Services
595 Center Avenue, Suite 100,
Martinez, CA 94553
Phone: 1-877-661-6230, option 2

Eligibility & Enrollment

Contra Costa Health Plan (CCHP) receives eligibility data for members enrolled in one of three lines of business: a single Medi-Cal plan, a single D-SNP plan, and four Commercial plans. While enrollment is typically determined by upstream agencies, CCHP may directly execute enrollment for its Commercial and D-SNP lines of business and receives eligibility files accordingly.

Eligibility is determined by external governing authorities, with the applicable

agency varying by line of business. In general, coverage begins on the first day of the calendar month following enrollment. For example, if a member enrolls on September 8, their coverage will typically begin on October 1. Exceptions may apply in cases of retroactive eligibility or other regulatory allowances.

The list below outlines which agency governs eligibility for each line of business:

- **Medi-Cal (Contra Costa Health Plan):** Eligibility is determined by the California Department of Health Care Services (DHCS) and administered locally by the Contra Costa Employment and Human Services Department (EHSD).
- **Medicare/Medi-Cal D-SNP (Contra Costa Health Care Plus (HMO D-SNP):** Eligibility is based on federal Medicare (CMS) and state Medi-Cal (DHCS) requirements. Members must qualify for both programs to be enrolled.
- **Commercial (Plan A, Plan B, Plan A2, IHSS Plan A2):** Eligibility is managed in partnership with Contra Costa County and supporting contracted agencies.

Providers should always verify a member's eligibility and active coverage status before rendering services. The following section provides step-by-step instructions for confirming eligibility through approved systems and contact points.

Eligibility Verification

Providers are required to verify member eligibility at the point of service.

Eligibility may change from month to month, and possession of a CCHP or Care Plus (HMO D-SNP) member ID card does not guarantee active coverage or reimbursement for services rendered.

Real-time eligibility verification is available through ccLink, CCHP's Provider Portal, at cclinkproviderportal.cchealth.org.

If you are not yet enrolled in the Provider Portal, please refer to Section 2 – Provider Relations in this Manual for instructions on registration and access.

Eligibility Criteria

Contra Costa Health Plan members must meet specific criteria based on the line of business in which they are enrolled. The table below outlines the general eligibility requirements for Medi-Cal and Contra Costa Care Plus (HMO D-SNP). These requirements are subject to change based on state and federal program rules.

CCHP Medi-Cal	Care Plus (HMO D-SNP)
<p>Must be a resident of Contra Costa County</p> <p>Must meet California income requirements for Medi-Cal</p> <p>Must be in an eligibility aid category, including:</p> <ul style="list-style-type: none"> • Children and young adults under 26 • Adults aged 26-49 • Adults aged 50 or older • Pregnant individuals • People with disabilities • Other special groups <p>Automatic enrollment may occur for individuals receiving certain public assistance</p>	<p>Must be a resident of Contra Costa County</p> <p>Must be 21 years-of-age or older at the time of enrollment</p> <p>Must be enrolled in or eligible for Medicare Part A and Part B</p> <p>Must receive full-scope Medi-Cal benefits and/or qualify for Medicare Savings Program assistance (such as help with premiums or cost-sharing)</p>

Enrollment Process

Members may enroll in Medi-Cal or CCHP Care Plus (HMO D-SNP) through different methods depending on program requirements. The table below summarizes key enrollment pathways for each product, including online, mail, phone, and in-person options where applicable.

Method	CCHP Medi-Cal	Care Plus (HMO D-SNP)
Online	Visit Contra Costa County Employment & Human Services Department (EHSD) website for application information.	Apply online at our Care Plus website or Medicare.gov
Mail	Download a paper application in multiple languages from the Medi-Cal Apply page (click the Mail icon).	Not available.
In-Person	Apply at an EHSD location. For details, visit ehsd.org or go directly to Find an Office .	Not available.
Phone	Call the EHSD Service Center at 1-866-663-3225 to ask questions or request an application.	Call 1-844-729-8412 to apply or ask questions about enrollment.

Selection and Assignment

At the time of enrollment, Members must select a PCP (or clinic if applicable). Members may choose to keep their current doctor(s), or clinic(s) as long as the doctor(s), or clinic(s) participates with the Care Plus (HMO D-SNP). Members may select a Provider within the Care Plus (HMO D-SNP) Provider and Pharmacy directory. The directory also has helpful information about each PCP and clinic. Members may choose a specialist as a PCP as long as the specialist is listed as a PCP in the provider directory. Members who do not choose a PCP or clinic will be

assigned to a PCP or clinic by Contra Costa Health Plan. Refer to Continuity of Care (COC) for Medicare Primary and Specialty Providers section.

Change of PCP

Members may change their PCP on a monthly basis online at <https://mychart.cchealth.org> or by calling Contra Costa Health Plan member services at 1-844-729-8411. The change will occur on the 1st of the following month, provided the request is received by member services by the twentieth (20th) of the month.

Changes in the Care Plus (HMO D-SNP) provider network may result in changes to Members' PCPs. Contra Costa Health will notify the Members of the change, the effective date of the change, and their right to request a different Provider.

Disenrollment and Change in Enrollment Status

Enrollment in CCHP Medi-Cal or Care Plus (HMO D-SNP) may change based on Medi-Cal eligibility, relocation outside of Contra Costa County, or other regulatory events. Members may also request disenrollment or choose another plan during specific enrollment periods. Providers should confirm eligibility prior to rendering services.

Deeming Period for Care Plus (HMO D-SNP) Members

Contra Costa Health Care Plus (HMO D-SNP) members may continue to receive full-scope Medi-Cal benefits for up to three months even if they experience a temporary loss of eligibility. This is known as a deeming period.

During this period, members retain coverage while their eligibility is redetermined. Deeming supports uninterrupted access to care for dual-eligible members enrolled in Contra Costa Health Care Plus (HMO D-SNP). If a member is in a deemed status, they may still appear active on eligibility verification tools, and providers should continue to treat and submit claims as usual unless otherwise notified.


Member Identification (ID) Cards

Members are instructed to present their Member ID card at each visit. Providers should confirm active enrollment using the eligibility verification methods outlined earlier. ID cards typically include:

- Member name and ID number
- Important phone numbers and details
- Primary Care Provider (PCP) information

- Plan line of business

Contra Costa Health Care Plan Medi-Cal ID Card


MEDI-CAL
 CONTRA COSTA HEALTH PLAN
www.contracostahealthplan.org

Name: Example, Maria
ID #: 000000000 **DOB:** 11/16/1955
PCP: Call CCHP for PCP Information*
Rx: Call Medi-Cal Rx* * See back of card
Issued: 1/1/2026
This card does not constitute proof of eligibility.

Front of Card

FOR A LIFE THREATENING EMERGENCY CALL 911
 Emergency providers will be paid without prior authorization.
 Members may seek emergency services from out-of-network providers.


Member Call Center: 1-877-661-6230
 (#1) 24-Hour Advice Nurse, (#2) Member Services,
 (#3) Pharmacy Services, (#4) Behavioral/Mental Health Services,
 (#5) County Health Center Appointments, (#6) Marketing, (#9) Check Eligibility/PCP

Provider Call Center: 1-877-800-7423
 (#1) Check Eligibility/PCP, (#2) Pharmacy,
 (#3) Authorizations/Referrals, (#4) Interpreters,
 (#5) Claims, (#6) Provider Relations, (#7) Member Services

Medi-Cal Rx Call Center: 1-800-977-2273
 Medi-Cal Rx covers prescription drugs obtained at a pharmacy.
www.Medi-CalRx.dhcs.ca.gov
www.contracostahealthplan.org

Back of Card

Commercial County Plan A ID Card


COUNTY PLAN A
 CONTRA COSTA HEALTH PLAN
www.contracostahealthplan.org

Name: Example, Maria
ID #: 000000000 **DOB:** 11/16/1955
PCP: Call CCHP for PCP Information (See back of card)
PERFORMRx RxBin: 019595 **RxPCN:** PRX12397
Issued: 1/1/2026
This card does not constitute proof of eligibility.

Front of Card

FOR A LIFE THREATENING EMERGENCY CALL 911
 Emergency providers will be paid without prior authorization.


Member Call Center: 1-877-661-6230
 (#1) 24-Hour Advice Nurse, (#2) Member Services,
 (#3) Pharmacy Services, (#4) Behavioral/Mental Health Services,
 (#5) County Health Center Appointments, (#6) Marketing, (#9) Check Eligibility/PCP

Provider Call Center: 1-877-800-7423
 (#1) Check Eligibility/PCP, (#2) Pharmacy,
 (#3) Authorizations/Referrals, (#4) Interpreters,
 (#5) Claims, (#6) Provider Relations, (#7) Member Services

PerformRx Pharmacy Call Center: 1-877-234-4269
 Prescription drugs must be obtained at a network pharmacy.
 Present this card at the time of service with every prescription.
www.contracostahealthplan.org

Back of Card

Commercial County Plan A2 ID Card


COUNTY PLAN A2
 CONTRA COSTA HEALTH PLAN
www.contracostahealthplan.org

Name: Example, Maria
ID #: 000000000 **DOB:** 11/16/1955
PCP: Call CCHP for PCP Information (See back of card)
PERFORMRx RxBin: 019595 **RxPCN:** PRX12397
Issued: 1/1/2026
This card does not constitute proof of eligibility.

Front of Card

FOR A LIFE THREATENING EMERGENCY CALL 911
 Emergency providers will be paid without prior authorization.

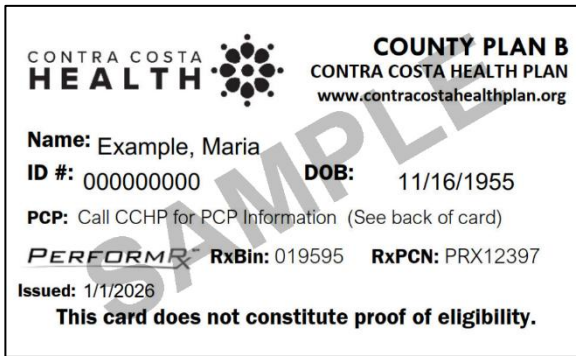
Member Call Center: 1-877-661-6230
 (#1) 24-Hour Advice Nurse, (#2) Member Services,
 (#3) Pharmacy Services, (#4) Behavioral/Mental Health Services,
 (#5) County Health Center Appointments, (#6) Marketing, (#9) Check Eligibility/PCP

Provider Call Center: 1-877-800-7423
 (#1) Check Eligibility/PCP, (#2) Pharmacy,
 (#3) Authorizations/Referrals, (#4) Interpreters,
 (#5) Claims, (#6) Provider Relations, (#7) Member Services

PerformRx Pharmacy Call Center: 1-877-234-4269
 Prescription drugs must be obtained at a network pharmacy.
 Present this card at the time of service with every prescription.
www.contracostahealthplan.org

Back of Card

Commercial County Plan B ID Card

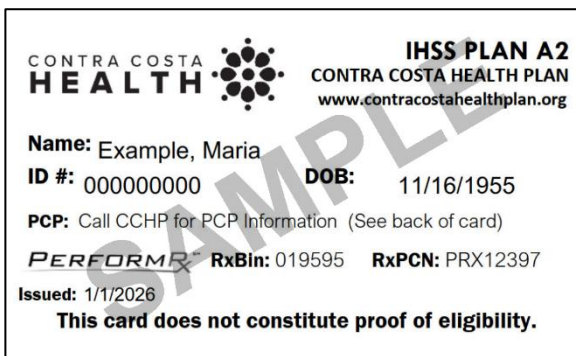


Front of Card



Back of Card

Commercial County IHSS Plan A2 ID Card

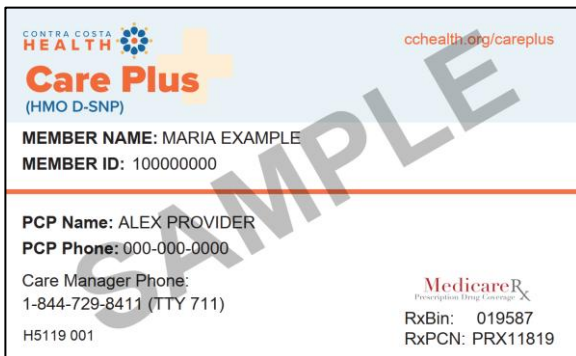


Front of Card

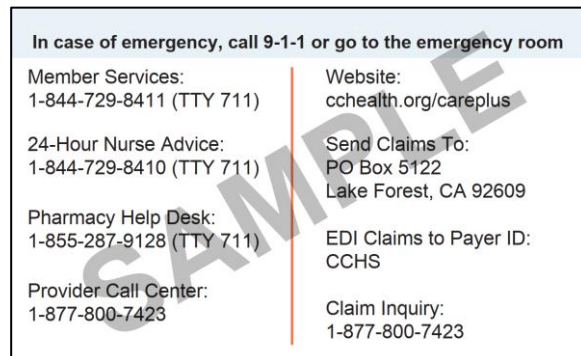


Back of Card

Care Plus (HMO D-SNP) ID Card



Front of Card



Back of Card

Care Plus (HMO D_SNP) Members and Cost-Share

Care Plus (HMO D-SNP) members are eligible to receive benefits and services from both Medicare and Medi-Cal programs. Additionally, Members will have their Medicare premiums, deductibles, and cost sharing covered by the Medi-Cal program.

Members are not subject to out-of-pocket costs or cost sharing for services

covered by Care Plus (HMO D-SNP) with the exception of certain Part D prescription drugs, which may incur a cost share based on low income subsidy (LIS) level. Providers may not impose cost sharing on Members for any covered services. C Care Plus (HMO D-SNP) has a yearly maximum out-of-pocket (MOOP) threshold set by CMS for all accumulated payments covered under Medicare Part A and Part B. Once met, all covered Medicare benefits are covered at 100%.

For more information on D-SNP benefits, please review the D-SNP Member Handbook / EOC at: <https://www.cchealth.org/careplus>.

Links to Benefit Materials

Member benefit materials, including the Summary of Benefits and the Member Handbook/Evidence of Coverage documents, can be found on CCHP's Care Plus (HMO D-SNP) website <https://www.cchealth.org/careplus>.

Obtaining Access to Covered Services

Preventative Services

Medicare covered initial preventive and physical examination (IPPE) and the annual wellness visit are covered at zero cost sharing. In addition, Medicare-covered preventive services are available at no cost to the Member.

For more information on Care Plus (HMO D-SNP) benefits, please visit the Care Plus (HMO D-SNP) Member Handbook / EOC at: <https://www.cchealth.org/careplus>.

Telehealth and Telemedicine Services

Members may obtain covered services through the use of telehealth and telemedicine services if capability is available. The following additional provisions apply to the use of telehealth and telemedicine services:

1. Services must be obtained from a participating Provider
2. Services are meant to be used when care is needed now for non-emergency medical issues
3. Services are not permitted when the Member and participating Provider are in the same physical location
4. Services do not include texting, facsimile or email only
5. Services include preventive and/or other routine or consultative visits during a public health emergency
6. Covered services provided through store-and-forward technology must include an in-person office visit to determine diagnosis or treatment.

Supplemental Benefits

Contra Costa Health Care Plus (HMO D-SNP) members are eligible for Supplemental Benefits as outlined in the current contract year's Summary of Benefits and Evidence of Coverage. Providers should direct members to CCHP's Member Services department for assistance in accessing supplemental benefits.

Section 14 – Model of Care for Care Plus

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage Dual Special Needs Plans (D-SNPs) to maintain an approved Model of Care (MOC). The MOC serves as the foundation for Contra Costa Health Plan's Care Plus (HMO D-SNP) operations, ensuring that care management policies, procedures, and systems are clearly defined and consistently applied.

The Contra Costa Health Care Plus Model of Care is organized around four key elements:

1. Model of Care 1: Description of SNP Population
 - Element A: Overall D-SNP Population
 - Element B: Sub-Population – Most Vulnerable Enrollees
2. Model of Care 2: Care Coordination
 - Element A: SNP Staff Structure
 - Element B: Health Risk Assessment (HRA)
 - Element C: Face-to-Face Encounter
 - Element D: Individualized Care Plan (ICP)
 - Element E: Interdisciplinary Care Team (ICT)
 - Element F: Care Transition Protocols
3. Model of Care 3: Provider Network
 - Element A: Specialized Expertise
 - Element B: Use of Clinical Practice Guidelines (CPGs) and Care Transition Protocols (CTPs)
 - Element C: MOC Training for the Provider Network
4. Model of Care 4: Quality Measurement and Performance Improvement
 - Element A: MOC Quality Performance Improvement Plan
 - Element B: Measurable Goals and Health Outcomes
 - Element C: Measuring Patient Experience of Care
 - Element D: Ongoing Evaluation of the MOC
 - Element E: Dissemination of MOC Quality Performance

Model of Care 1: Description of SNP Population

Overall D-SNP Population

CCHP is a county-sponsored Health Maintenance Organization (HMO) serving more than 265,000 residents. Beginning in 2026, CCHP will operate a D-SNP for elderly, disabled, developmentally delayed, and multi-chronic members.

- Eligibility and Enrollment: Members must maintain both Medicare and Medi-Cal eligibility. Eligibility is verified through Epic, CMS, and state

Medicaid/Medicare files. Enrollment occurs during Initial, Annual, or Special Enrollment Periods.

- **Health Status and Disparities:** Members often present with multiple chronic conditions, including hypertension (59%), developmental disorders (53%), diabetes (34%), and depression (28%). Disparities exist across race/ethnicity and geography, reflecting the impact of social determinants of health (SDOH).
- **Demographics:** The majority of members are between ages 60–79 (average age 68.2). Approximately 56.7% are female. The population is ethnically diverse: White (27%), Hispanic (21%), Asian (18%), Black (16%). More than 25% speak a primary language other than English. Educational attainment is low, and many members are retired or unemployed.
- **Care Needs:** Members often require assistance for chronic conditions, disabilities, mental health or substance use disorders, limited English proficiency (LEP), and low health literacy. These needs require person-centered care, coordination, and support during care transitions.
- **Preventive and Supplemental Services:** Members have access to screenings, immunizations, health education, vision care, and programs that address social connectedness, financial barriers, and SDOH.

Most Vulnerable Members

- **Identification:** High-risk members are identified through claims, encounters, pharmacy data, electronic health records, HRAs, social services data, and provider referrals. Members are stratified to Complex Case Management (CCM) or California Integrated Care Management (CICM) as appropriate.
- **High-Risk Criteria:**
 - CCM: Frequent hospitalizations or ED visits, polypharmacy (15+ medications), transplant candidates/recipients.
 - CICM: Homelessness, avoidable utilization risk, serious mental health/substance use needs, post-incarceration, risk of long-term care institutionalization, nursing facility transitions, pregnancy/postpartum disparities, dementia care needs.
- **Demographic Factors:** Age, gender, race/ethnicity, language, socioeconomic status, chronic stress, mental health, and access to technology may affect health outcomes.
- **Services for High-Risk Members:**
 - CCM: Comprehensive assessments, care planning, transitional care, coordination with providers and social services.
 - CICM: Enhanced outreach, ICT coordination, health promotion, member/family support, and community resource connections.

- D-SNP Care Management: Ongoing coordination for all dual-eligible members, integrating CCM and CICM as needed.

Community and Provider Partnerships: CCHP collaborates with community-based organizations (CBOs), public health agencies, LTSS providers, behavioral health services, and disease management programs. Staff use a centralized directory (cocohealth.findhelp.com) for referrals, ensuring timely access to resources.

Model of Care 2: Care Coordination

SNP Staff Structure

- Administrative Staff: Manage enrollment, member services, compliance, scheduling, and referrals. Clear roles and responsibilities are defined through job descriptions and training.
- Clinical Staff: Provide care management, medication reconciliation, care transitions, and coordination across medical, behavioral, LTSS, and community services. Staff monitor quality, identify gaps, and intervene to improve outcomes. All staff receive orientation, job-specific training, and ongoing education.

Health Risk Assessment (HRA)

- Completed within 90 days of enrollment and annually thereafter.
- Assesses medical, functional, cognitive, psychosocial, behavioral health, SDOH, and LTSS needs.
- Results inform the Individualized Care Plan (ICP).
- Conducted in threshold languages and accessible through MyChart.
- High-risk members are prioritized for intensive management and frequent reassessment.

Face-to-Face Encounter

- Required within 12 months of enrollment and annually thereafter.
- May be completed by PCPs, care managers, specialists, or behavioral health staff.
- Can occur in-person or via telehealth with video.
- Supports ICP updates, preventive services, and health education.

Individualized Care Plan (ICP)

- Developed within 30 days of HRA completion.
- Person-centered and integrates Medicare and Medi-Cal services.
- Includes health goals, interventions, caregiver involvement, and benchmarks.
- Reviewed annually or as health status changes.

- Accessible through Epic, Care Link, Care Everywhere, and MyChart.

Interdisciplinary Care Team (ICT)

- Customized to each member's needs.
- Core members include care managers, PCPs, pharmacists, social workers, the member, and caregiver(s).
- Expanded members may include specialists, CBOs, dementia/palliative care experts, and LTSS providers.
- ICT reviews progress, updates the ICP, and supports care transitions.

Care Transition Protocols

- Standardized protocols for both planned and unplanned transitions.
- Emphasize safe handoffs, medication reconciliation, and addressing barriers (housing, transportation, food access).
- Care managers provide follow-up within 7 days of notification
- Members and caregivers are educated on conditions, red-flag symptoms, and follow-up care.

Model of Care 3: Provider Network

- **Specialized Expertise:** Network includes PCPs, specialists, behavioral health, LTSS, CBOs, and palliative care providers.
- **Credentialing and Oversight:** Providers undergo credentialing every three years; ongoing monitoring ensures compliance.
- **Provider Information Management:** Centralized, regularly updated provider database feeds into the Provider Directory.
- **Collaboration:** Providers actively participate in ICTs, sharing notes and treatment recommendations.
- **Clinical Guidelines:** Providers are monitored for adherence to evidence-based guidelines.
- **Provider Training:** All providers complete mandatory annual training on D-SNP population needs, care coordination, clinical guidelines, and dementia care.

Model of Care 4: Quality Measurement and Performance Improvement

- **Quality Program:** Overseen by the Quality Council (QC) and Joint Conference Committee (JCC) through the Quality Improvement, Health Equity, and Transformation Program (QIHETP).
- **Goals:** Improve access, care coordination, preventive/chronic care, reduce disparities, and enhance member experience.
- **Data Collection:** Includes claims, EHR, HRA/ICP, HEDIS, CAHPS, HOS,

- pharmacy, behavioral health, and grievances.
- Evaluation: Performance measured through metrics, dashboards, root cause analysis, and PDSA cycles.
- Stakeholder Engagement: Involves leadership, providers, staff, and the Community Advisory Committee (CAC).
- Patient Experience: Measured through CAHPS, HOS, and grievance analysis.
- Continuous Improvement: Rapid-cycle interventions and quarterly updates ensure timely adjustments.
- Reporting: Results disseminated internally, to committees, CAC, and regulatory bodies.
- Feedback Integration: Member, staff, and provider input informs ongoing refinement of the MOC.

Care Management

The Care Management program provides comprehensive, member-centered services to support Care Plus (HMO D-SNP) members with medical, behavioral, functional, and social needs. Care Management emphasizes proactive interventions, health promotion, and collaboration across providers and community-based organizations (CBOs). The goal is to ensure members receive person-centered, coordinated, and integrated care across Medicare, Medi-Cal, and community-based services, with the aim of improving health outcomes, enhancing quality of life, and reducing avoidable hospitalizations and emergency department utilization.

Care Management Framework

Care Management is structured around four core activities:

1. Assessment: Each member completes a Health Risk Assessment (HRA) within 90 days of enrollment and annually thereafter. The HRA identifies medical conditions, functional limitations, behavioral health needs, long-term services and supports (LTSS), and social determinants of health (SDOH).
2. Individualized Care Plan (ICP): Based on the HRA, an ICP is developed within 30 days. The ICP outlines member goals, clinical interventions, caregiver support, and measurable outcomes. Plans are updated annually or as the member's condition changes.
3. Interdisciplinary Care Team (ICT): Each member is supported by an ICT tailored to their needs. Core members may include the Care Plus (HMO D-SNP) care manager, primary care provider (PCP), the member, and caregiver(s). ICT meetings are used to review progress, resolve barriers, and adjust the ICP as needed.

4. Care Transitions: Care managers support members during hospital admissions, discharges, or changes in living settings. Standardized protocols ensure safe handoffs, medication reconciliation, timely follow-up, and education on “red flag” symptoms.

Care Management Services

Care Management includes, but is not limited to:

- Coordinating medical, behavioral health, LTSS, and social services.
- Monitoring member status through outreach, follow-up calls, and face-to-face visits (in-person or via telehealth).
- Addressing health literacy, language needs, and cultural preferences.
- Providing education on preventive services, chronic condition management, and self-care.
- Supporting medication reconciliation and adherence.
- Connecting members and caregivers to CBOs for food, housing, transportation, and caregiver support.

Reinforcing provider treatment plans and facilitating communication across care settings.

Role of the Care Manager

Care Managers play a central role in coordinating and integrating services for members. Key responsibilities include:

- Coordinating quality services and timely interventions to increase efficiency and effectiveness of care.
- Developing and implementing ICPs that reflect the member’s preferences, goals, and needs, and updating them regularly as the member’s health status changes.
- Promoting health, independence, and optimal functioning in the most proactive, effective, and least restrictive way possible.
- Collaborating and communicating with the PCP, specialists, and other providers regarding completed clinical assessments and care plans.
- Educating and involving the member and family in care coordination to support engagement and self-management.
- Coordinating access to benefits and services across the healthcare continuum, including LTSS, behavioral health, and community resources.
- Supporting care transitions between providers and care settings, including timely notification to Contra Costa Care Plus (HMO D-SNP)
- Facilitating ICT meetings and updating care plan goals and interventions based on ICT recommendations and member progress.

- Promoting multidisciplinary care that integrates clinical, behavioral, and rehabilitative services.
- Collaborating with other case managers who are part of the member's ICT to ensure cohesive, non-duplicative services.

Role of Providers in Care Management

- Providers play an essential role by:
- Actively participating in ICTs and contributing to ICP development and updates.
- Communicating promptly with CCHP about hospitalizations, discharges, or significant changes in member condition.
- Collaborating with care managers on treatment adherence, follow-up care, and referrals.
- Engaging members and caregivers in goal setting and decision-making.

High-Risk and Complex Case Management

Care managers use claims, encounters, EHR, pharmacy, and social service referrals to identify members who may benefit from higher-level care management.

Complex Case Management (CCM)

CCM serves members with advanced clinical needs requiring intensive oversight. These members often have multiple chronic conditions, frequent hospitalizations, polypharmacy (≥ 15 medications), or are transplant candidates/recipients.

Members may be referred to CCM if they meet one or more of the following criteria:

1. Poorly Controlled Disease States
Members with chronic conditions demonstrating inadequate control, as evidenced by:
 - Two or more hospitalizations within the past 12 months, with at least one hospitalization related to a chronic condition.
 - Three or more emergency department (ED) visits in the past six months, with at least one visit related to a chronic condition.
2. Polypharmacy
Members taking 15 or more prescribed medications, indicating complex pharmacologic management needs.
3. Transplant Status
Members who are transplant candidates or recipients requiring intensive monitoring and care coordination.

Program Components:

- **Comprehensive Assessment:** In-depth evaluation of medical, behavioral, functional, and social needs to guide care planning and interventions.
- **Individualized Care Planning:** Comprehensive ICPs integrating medical, behavioral, and LTSS needs.
- **Service Coordination:** Ensures continuity across providers, care settings, and disciplines.
- **High-Risk Monitoring:** Proactive monitoring to reduce hospital readmissions, ED visits, and adverse events.
- **Transitions Support:** Management of hospitalizations, post-acute care, and home/community transitions.
- **Provider Collaboration:** Direct communication with PCPs, specialists, and ICT members.
- **Member & Caregiver Engagement:** Education, support for self-management, and participation in ICP development.

California Integrated Care Management (CICM)

CICM provides care coordination for D-SNP members with complex medical, behavioral, and social needs. CICM targets vulnerable members who require intensive support, including those experiencing homelessness, at risk for avoidable hospital or ED use, with SMI/SUD needs, post-incarceration, transitioning from LTC, pregnant/postpartum with disparities, or with dementia.

Program Components:

- **Individualized Care Planning:** ICPs tailored to clinical and social needs.
- **Service Coordination:** Connection to healthcare, behavioral health, LTSS, housing, and social services.
- **In-Person Engagement:** Direct support in homes, shelters, nursing facilities, or community settings.
- **High-Risk Monitoring:** Oversight to reduce hospitalizations and ED visits.
- **Health Equity Focus:** Proactive support for populations with identified disparities.

Collaboration with CBOs:

- Direct coordination with CCHP Care Plus (HMO D-SNP) care managers is required when CBOs provide care management to ensure integrated, non-duplicative services aligned with the ICP.

Program Goals:

- Support members in the least restrictive, most appropriate setting.
- Reduce avoidable hospitalizations and ED utilization.
- Improve member engagement, health equity, and quality of life.

- Strengthen collaboration between providers, CBOs, and care teams.
- Promote continuity of care through interdisciplinary teamwork.

Member and Caregiver Engagement

Members and caregivers are central to Care Management:

- Active participation in ICP development and updates.
- Education in preferred language and format.
- Support navigating the health system and accessing resources.
- Feedback through surveys, grievances, and the Community Advisory Committee (CAC).

Care Management Referral and Contact Pathways

Questions or Concerns:

Providers may also contact Care Management directly at 1-**925-313-6887** for any questions, clarifications, or concerns regarding members, referrals, or services.

How to Refer a Member:

- Electronic Referral: Through Epic Care Link or fax to Care Management at 925-252-2609.
- Phone Referral: Call (925) 313-6887 to speak with staff or leave a message.
- Provider Portal: Submit via the “Case Management Referral” or “California Integrated Care Management Referral” section.

Provider Collaboration:

- Care managers update providers on referral outcomes, member engagement, and next steps.
- Providers are encouraged to participate in ICTs as appropriate.

Plan Directed Care

When a Provider or a non-contracted provider furnishes non-covered services to a Member that the Member believes are covered, federal law prohibits holding the Member financially liable for the service. The Provider is responsible for ensuring that the services rendered are covered services and, if applicable, the covered services are pre-authorized prior to rendering such services. In these circumstances, the service may be referred to as “Plan Directed Care.”

A Member will generally be deemed to believe the service is covered unless the Member received a denied authorization request. Therefore, CCHP requires the

following:

- Providers should not refer to out-of-network providers without prior authorization
- If a Provider knows or believes an item or service furnish by an out-of-network provider will not be covered, the Member or Provider must request a prior authorization request. In the case of a Member who routinely receives the same non-covered service, one denied authorization request received at the beginning of the course of service may be used, as long as it is clear that the Member understands that the services will never be covered by CCHP.

If a Provider fails to follow these authorization requirements, CCHP may decline to pay the claim, and the Provider will be held financially responsible for services received by the Member. Refer to CMS's Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections Section 160 Beneficiary Protections Related to Plan-Directed Care at [Regulations and Guidance | CMS](#).

****PLEASE NOTE—A PROVIDER MUST NEVER USE AN ABN WITH A Care Plus (HMO D-SNP) Member ****

Continuity of Care for Medicare Primary and Specialty Providers

Under the Department of Health Care Services' (DHCS) CalAIM D-SNP Policy Guide, upon Member request, or request by other authorized representative as noted below, and as required by applicable Laws, rules, and guidance, CCHP's Care Plus (HMO D-SNP) must offer continuity of care with out-of-network Medicare providers to all Members if all of the following circumstances exist:

- A Member has an existing relationship with a primary or specialty care provider. An existing relationship means the Member has seen an out-of-network PCP or a Specialty Care Provider, at least once, during the 12 months prior to the date of their initial enrollment in D-SNP for a non-emergency visit;
- The out-of-network provider is willing to accept, at a minimum, payment from
- CCHP based on the current Medicare fee schedule, as applicable; and
- The out-of-network provider does not have any documented quality of care concerns that would cause CCHP to exclude the provider from its network
- Each continuity of care request must be completed within:
- Thirty (30) calendar days from the date CCHP receives the request;
- Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or

- Three (3) calendar days if there is risk of harm to the Member

For more information on Continuity of Care requirements please refer to the CalAIM D- SNP Policy Guide at <https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide-2026.pdf>.

Section 15 – Quality and Health Equity

CCHP is committed to the delivery of high-quality and equitable health care services to our culturally and linguistically diverse members. CCHP's Quality Improvement and Health Equity Program is designed to measure, monitor, evaluate, and enhance the quality and safety of health care services, ensuring not only the equitable delivery of healthcare, but also promoting and achieving equitable health outcomes for all members. The overarching quality and health equity goals at CCHP are to:

- Achieve better health outcomes for members by closing gaps in care that are informed by evidence-based practice guidelines.
- Provide a robust population health management strategy to address the needs of members across the continuum of care services.
- Promote health equity and reduce disparities in care through a coordinated strategy with members, providers, and the community.
- Ensure patient safety by ensuring adequate and timely identification and investigation of issues.
- Improve the member experience of care, including timely access to care that is convenient and culturally competent.
- Avoid unnecessary utilization in the ED and hospital by investing in preventive care and coordinating care across settings.
- Stabilize or reduce health care costs by targeting the right resources to the patients who need them most.
- Optimize the provider experience through meaningful collaboration and reducing administrative barriers.

The Quality Program scope includes the provision of clinical care (medical and behavioral health) and service for all Medi-Cal and Commercial members. In partnership with CCHP departments, provider networks and facilities, community-based organizations, and Contra Costa Health Departments, the Quality Program encompasses all aspects of care and service.

The Quality Council (QC) and Equity Council are the principal committees for directing and overseeing Quality, Patient Safety, and Health Equity operations and activities for CCHP, including but not limited to, clinical and service-related performance improvement projects, access to care studies for medical and behavioral health, member grievances, potential quality issues, case management, utilization management, and oversight of delegated entities for Quality, Utilization Management, and Behavioral Health.

CCHP has a comprehensive Quality and Health Equity Program Description and

Work Plan that are revised each year with the input from various committees including CCHP's Quality Council. They can be found on the Contra Costa Health Plan website: [Quality Improvement and Health Equity | Contra Costa Health](#).

Quality Improvement Initiatives

The Quality Program utilizes the Model for Improvement and PDSA cycles to continuously evaluate and improve care and services for our members. CCHP contracted providers provide input into the specific quality improvement, disease management, health education, and cultural and linguistic initiatives. Input is obtained through provider meetings, trainings, and joint operations meetings.

The Quality Department uses data and provider input to propose priorities to CCHP's Quality Council, a multi-specialty group of clinicians that represent our provider network, for review and approval.

CCHP has at least two active DHCS statewide performance improvement projects and, if needed, smaller mandated pilot projects for measures below the state's minimum performance level. Additionally, CCHP identifies additional performance improvements in the work plan based on an analysis of quality data. Annually, CCHP reviews quality metric data, assesses measurement areas that need improved, and develops improvement projects to be added to the work plan.

On an at minimum of monthly basis, CCHP reviews quality metric data and may modify the work plan to add additional performance improvement projects. CCHP identifies areas where there is a decline in performance level or CCHP is under the desired quality target. Quality staff conduct a root cause analysis and develop a plan to implement a performance improvement project, reaching out to provider to coordinate on quality improvement activities.

Population Health Management

Understanding the diverse needs of our community is essential to providing effective healthcare services. Our Population Health Management strategy guides our efforts in identifying the health needs and characteristics of our members, with a focus on addressing health disparities. This strategy, along with our Population Needs Assessment, informs our quality improvement initiatives and helps us tailor programs to better serve our population. The work of population health is to maximize health by co-creating services with members and providers which deliver primary and secondary evidence-based interventions for the prevention and management of illness in our assigned population. Population health aims to utilize data to risk stratify members based on need and direct to services.

CCHP has developed and is implementing new programs that keep the well

healthy, provide self-management resources to members with well controlled chronic conditions, provide case management services to our members with poorly controlled chronic disease, and provide enhanced care management services to our high utilizing members.

Case Management Services, like Enhanced Case Management for the most at-need, Complex Case Management, and Transitional Case Management are designed to provide services to the most at-need patients according to risk stratification. Basic population health management services are designed to provide health education, wellness, and preventive services to all members.

Health Education

Contra Costa Health Plan is committed to improving the health of our members and their families by providing resources that meet their needs. We have partnered StayWell, an NCQA certified organization to ensure a dynamic health education website that includes health education articles, videos, interactive tools, and links to community resources. The health education website can be found at healthed.cchealth.org.

If you would like printed material, phone assistance, or are interested in additional information, please contact:

Health Education Specialist

Phone: 1-925-608-7815 – E-mail: HealthEducation@cchealth.org.

We would like to encourage all providers to access our health education website section and become familiar with the newest resources.

Members will find health education tools on many health topics such as:

- Nutrition and healthy recipes
- A variety of Physical activities
- Asthma, diabetes, heart health, hypertension.
- Children’s health, prenatal care, breastfeeding.
- Videos on several health topics.
- Community Resources, the latest newsletter and more.

To access the website, go to: healthed.cchealth.org. CCHP’s Health Education Department can assist providers in locating a variety of Health Education modalities that are culturally appropriate in either network for your diverse member population. Examples include:

- Health Coaching groups

- Health education materials and information
- One-on-one health education

See list of community resources and classes on our website at the link below:

- cchealth.org/health-insurance/my-contra-costa-health-plan/health-education/health-education-classes

For additional questions, please call 1-925-608-7815 or 1-925-313-6019.

HEDIS Healthcare Quality Measurement

HEDIS® (Healthcare Effectiveness Data and Information Set) provides a comprehensive set of standardized performance measures that help us ensure the quality of care we deliver. Contra Costa Health Plan uses HEDIS measures to evaluate our performance in key areas such as preventive care, chronic disease management, and member satisfaction. CCHP is responsible for calculating and reporting measure sets to regulators including the DHCS, DMHC, and NCQA.

Aggregate quality measurements are shared with CCHP providers annually through the quarterly Provider Bulletin or in a separate correspondence. Additionally, primary care providers can performance results for their provider group in the provider portal. Additionally, member level gap in care reports are shared with providers. In contracting with CCHP, a provider agrees to allow the health plan to access medical record data for the assigned CCHP members.

Value-Based Payments

CCHP is dedicated to aligning provider incentives with the quality of care delivered. Our Value-Based Payment Pay for Performance Program rewards primary care provider groups for achieving high standards in patient care and outcomes. More details on the program are available on the CCHP website: [Quality Improvement and Health Equity | Contra Costa Health](#)

NCQA Accreditation

CCHP's Medi-Cal line of business has been accredited by NCQA since March 2014, recognizing excellence in health plan operations. Accreditation is awarded for three years, and CCHP was last accredited in March 2023.

Delegation Program & Oversight

Contra Costa Health Plan holds a Knox-Keene license to provide managed health care coverage to members, a contract with the California Department of Health

Care Services (DHCS), the California Department of Managed Health Care (DMHC), and Centers for Medicare & Medicaid Services (CMS). Contra Costa Health Plan may contract with providers and vendors and delegate certain administrative duties (“Delegated Activities”), referred collectively as Delegates. Delegated Activities may involve one or a combination of functions including pharmacy benefit administration, utilization management, provider credentialing and re-credentialing, quality management and improvement, member experience, population health management, network management, and claims processing.

Contra Costa Health Plan shall ensure that Delegates perform Delegated Activities according to its obligations in its contracts between Contra Costa Health Plan and Delegate in accordance with guidance and regulations from California Department of Health Care Services (DHCS), California Department of Managed Health Care (DMHC), Centers for Medicare & Medicaid Services (CMS), associated regulatory guidance, and the National Committee for Quality Assurance (NCQA).

Contra Costa Health Plan oversees the Delegated Activities through regular audits and monitoring reports, and Delegation Oversight Committee meetings. If issues are identified, Delegates are required to implement Corrective Action Plans (CAPs) to correct the deficiency.

Delegate is responsible for oversight of any activities that are sub-delegated. Contra Costa Health Plan retains authority to approve any sub-delegation and request or conduct oversight activities of subdelegates.

Contra Costa Health Plan retains final authority to provide any delegation, and may revoke in whole or in part, delegation of any function or activity at any time if delegate does not perform in accordance with contractual obligations, State and Federal regulations, or NCQA standards.

The Delegation Program includes:

1. Reports
 - Description: Contra Costa Health Plan requires Delegate to provide monitoring reports on a regular basis to demonstrate performance at expected levels for each Delegated Activity.
 - Expectation: The reports that are required of Delegates are identified in a list provided on an annual basis specific to each Delegated Activity. The list identifies the type and frequency of required reports. Delegates are also required to provide any additional data and/or reports requested by Contra Costa Health Plan necessary to monitor activities related to Corrective Action Plan.
2. Dashboard
 - Description: Contra Costa Health Plan maintains and utilizes a

- ‘Delegation Oversight Dashboard’ to track and trend key performance metrics of Delegates on a quarterly basis. The results are shared and discussed internally at Delegation Oversight Committee meetings.
- Expectation: The expectation is that Delegates will provide data in a timely manner and participate in discussions regarding the key performance metrics when called upon.
3. File Reviews
 - Description: On-going performance of Delegated Activities is evaluated through routine monitoring of reports, an annual audit, and by performing file reviews as required for effective oversight.
 - Expectation: Delegates shall comply with file review requests and requirements.
 4. Communication regarding delegated activities/requirements
 - Description: Delegated Activities are to be performed in accordance with the most current State and Federal regulatory requirements, NCQA accreditation standards, and Contra Costa Health Plan policies and procedures.
 - Expectation: When accreditation standards and/or regulatory requirements change, Contra Costa Health Plan notifies Delegates in writing and Delegates shall take all necessary steps to demonstrate compliance within required timeframes. When there is conflicting guidance from NCQA standards and State or Federal regulatory requirements, the more stringent standard or requirement shall apply.
 5. Annual audit requirements
 - Description: Contra Costa Health Plan monitors Delegate performance by examination of reports, and an annual review, through a review of policies, procedures, program descriptions, evaluations, reports and file review, as necessary for the specific Delegated Activity.
 - Expectation: Delegate will provide required documentation within ten business days of requests. Onsite or remote audits will be scheduled at mutually convenient times no less than every twelve months.
 6. Audit results/Corrective Action Plans (CAPs)
 - Description: A summary of audit results, including observations and findings, will be provided to Delegate upon completion of the annual audit.
 - Expectation: Delegates will review the initial audit results and provide responses within the requested timeframe. Contra Costa Health Plan shall review Delegate responses and provide final audit results within 30 calendar days of receipt of the Delegate response. If no response is received from Delegate within the required timeframes, the initial

audit results will be considered final. The Delegate will develop a Corrective Action Plan (CAP) in response to audit findings within ten business days for approval by Contra Costa Health Plan. Once approved, Delegates will implement the correction(s) within 30 calendar days or otherwise mutually agreed upon date if the situation cannot be corrected to the satisfaction of the Contra Costa Health Plan. Contra Costa Health Plan can request further CAPs, temporarily suspend Delegated Activities, or terminate all or part of the Delegated Activities.

- If Delegate does not take corrective action, or fails to meet improvement goals, Contra Costa Health Plan reserves the right to revise the Delegation Agreement and scope or revoke the Delegation Agreement altogether and cease contracting for services.
7. Additional remedies for Non-compliance
- Description: In addition, or in the alternative to any other remedy, Contra Costa Health Plan may impose Sanctions against Delegates that are reasonably necessary to address Delegate's failure to comply with Delegated Activities, with or without a CAP in place.
 - Expectation: Sanctions may only be imposed following written notice to the Delegate of an identified deficiency and a sixty-day period for Delegate to cure such deficiency. Sanctions available to Contra Costa Health Plan to address specific identified deficiencies include:
 - i. Enrollment freeze – auto assignment, member selection, or both.
 - ii. De-delegation of delegated functions (with necessary and commensurate reduction in capitation payment).
 - iii. The ability to require Delegate to engage and pay for an external auditor, or other consultant for Delegate to correct the identified deficiency(ies); and/or
 - iv. Pass through of financial penalties assessed by regulatory agencies.

Delegation Audits

CCHP is responsible for assuring that quality care and services are administered to CCHP members when services are delegated to contracted providers. CCHP may fully or partially delegate care and/or services to contracted providers. Delegation arrangements are part of the contracting process.

Delegated quality monitoring status is granted to contracted providers upon successful demonstration of the required scope of quality monitoring activities. CCHP monitors delegation via routine reporting and/or on-site audits of delegated providers on an annual basis. The frequency of audits may be more often if needed

and if identified as part of a corrective action plan. Audit tools are based on NCQA standards in addition to State and Federal requirements.

Delegates' NCQA Accreditation may be considered when reviewing specific standards. CCHP may fully or partially delegate any of the following functions to contracted providers:

- Appeals
- Claims Processing
- Credentialing
- Cultural Linguistics
- Disenrollment
- Grievances
- Health Education
- Marketing
- Member Rights
- Population Health Management
- Provider/Facility Contracting
- Quality Improvement
- Utilization Management

The QM Director and/or designee coordinates the audit process for CCHP. Several CCHP staff members are involved in reviewing appropriate information according to their expertise.

Audit/report findings and corrective action plans are reported to the CCHP Medical Director and Quality Council, and as appropriate, Peer Review and Credentialing Committees.

Potential Quality Issues

To ensure that CCHP members receive high-quality care and services, CCHP investigates all referred potential quality issues (PQIs). A Potential Quality Issue (PQI) is defined as a suspected deviation from expected provider or system performance, clinical care, or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists.

A PQI can originate from a variety of sources including, member grievances, appeals, utilization review, claims and encounter data, care coordination, case management, medical records audits, facility site reviews, or member/provider surveys.

PQIs can be referred by members, CCHP staff, contracted or non-contracted providers, pharmacies, hospitals, skilled nursing facilities, ancillary providers, or DME/medical supply providers, and community members. All PQIs are investigated and reviewed by the PQI Committee. Contracted providers shall cooperate in responding to PQI inquiries including any relevant medical records.

The PQI Committee will evaluate all available documentation, including the provider response, and assign a severity level to the issue. Based on their findings, the Committee may recommend corrective actions. This may include a formal Corrective Action Plan (CAP) to prevent future occurrences. CAPs require detailed documentation to verify that the identified issue has been addressed. All PQIs are monitored and analyzed to identify any recurring patterns of quality issues.

To report a PQI, complete the PQI Reporting form on the CCHP website. The form can be found at <https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/quality-department>. Once completed, the form can be emailed to QualityConcerns@cchealth.org.

Reporting Of Provider Preventable Conditions

By Federal law, a provider must report the occurrence of any Provider Preventable Condition (PPC) that did not exist in any Medi-Cal member prior to the provider initiating treatment. 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.

A provider must report the occurrence regardless of whether the provider seeks Medi-Cal reimbursement for services to treat the PPC. Reporting a PPC for a Medi-Cal beneficiary does not preclude the reporting of adverse events, pursuant to Health and Safety Code (H&S Code), Section 1279.1, to the California Department of Public Health (CDPH).

A provider reports a PPC by completing the form found at:
<https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx>.

Instructions are found here:

http://www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx

Providers must submit the form within five days of discovering the event and confirming that the member is a Medi-Cal beneficiary. The provider must also send a copy of the information to the CCHP: Fax to 1-925-313-6870.

Health Care Acquired Conditions (For Any Inpatient Hospital Settings in Medicaid)

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement (excluding pregnant women and children under 21 years of age)
- Falls/trauma that result in the following:
 - Fracture
 - Dislocation
 - Intracranial injury
 - Crushing injury
 - Burn
 - Electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
 - Diabetic ketoacidosis
 - Nonketotic hyperosmolar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity
- Stage III or IV pressure ulcers
- Surgical site infection
 - Mediastinitis following coronary artery bypass graft (CABG)
 - Surgical site infections following:
 - Bariatric surgery
 - Laparoscopic gastric bypass
 - Gastroenterostomy
 - Laparoscopic gastric restrict surgery
 - Orthopedic procedures for spine, neck, shoulder, and elbow
 - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection
- Other Provider Preventable Conditions (For Any Health Care Setting)
- Wrong surgical or other invasive procedure performed on a member
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong member

Facility Site Review

CCHP requires all PCPs and OB/GYNs acting as PCPs to undergo a full scope

Facility Site Review (FSR) initially as part of the credentialing and contracting process and every three years thereafter as part of the re-credentialing process. The FSR is CCHP's method of evaluating provider offices to ensure that regulatory health and safety standards are met prior to the provision of medical services to plan members.

The FSR is conducted by a Facility Site Review Registered Nurse (RN) who is trained and certified by the state of California to conduct the review using the tool compiled by the California Department of Health Care Services Medi-Cal Managed Care Division. The FSR Nurse will provide practitioners with a copy of the FSR tool in preparation for the review and will provide technical assistance to help providers meet the review standards and requirements. The FSR tool can be accessed on our website at [FSR Tool | Contra Costa Health](#).

The full scope FSR includes a facility/site survey (FSR) and a medical record review survey (MRR). Any noted deficiencies are reported in a Corrective Action Plan (CAP) and returned to the provider.

Depending on the score of the FSR and the need for intense Corrective Action, the Credentialing process may be temporarily withheld at the discretion of the Peer Review and Credentialing Committee (PRCC).

At the same time as the FSR and MRR, CCHP performs a survey for Physical Accessibility at all PCP, OB/GYN, and High-Volume Specialist sites every three years. All Ancillary Providers that join the network will have a Physical Accessibility survey performed at the time they join and anytime they make changes to the physical site. This information is accessible to members via our provider directories and our on-line provider directory. Physical Accessibility is not scored and will not be subject to CAPs.

CCHP utilizes a modified FSR tool to survey organizational providers that are not either accredited or have a current CMS survey. This includes skilled nursing facilities, free standing surgery centers and dialysis infusion centers.

CCHP collaborates with other Medi-Cal Managed care plans to share FSRs and avoid duplication of audits in providers' offices whenever possible.

[Corrective Action Plan for Deficiencies On The FSR](#)

The Corrective Action Plan (CAP) is written specific to the noted deficiencies found during the FSR and MRR. It identifies modifications needed at provider offices to existing procedures or the development of new processes to meet standards and guidelines. A corrective action plan (CAP) is required for a total score on the FSR

portion of less than 90%, OR for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control.

The MRR score is based on a review standard of 10-30 records per primary care physician (PCP) office (dependent on number of PCPs in an office). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section that scores less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.

A specific time frame for compliance will be noted on the CAP, and any needed follow-up will be initiated by the FSR RN responsible for Facility Site Review and reported to the CCHP Peer Review and Credentialing Committee.

Non-Compliance Or Failure on The FSR

Providers who do not comply with the FSR or the CAP timelines will be deemed as non-compliant and subject to administrative actions on the part of CCHP, including suspension or termination from the network. Providers who do not obtain a minimum passing score of 80% on the FSR for both the facility site and medical record review will need to complete a CAP according to the timelines. Member assignment cannot be made until the CAP is approved and all corrections are documented.

Quality, Health Equity, and Patient Safety Contacts

- For any questions or concerns related to quality improvement, health equity, or population health, please contact us at cchp.quality@cchealth.org.
- For questions or concerns related to patient safety, please contact QualityConcerns@cchealth.org.

Section 16 – Preventive Health Services

Clinical Practice Guidelines

Contra Costa Health Plan is committed to supporting our providers with evidence-based clinical practice guidelines to ensure high-quality care and optimal patient outcomes. These guidelines cover a range of clinical areas and are regularly updated to reflect the latest research and best practices. Providers are encouraged to use these guidelines to inform their clinical decision-making and enhance patient care. All Clinical Practice Guidelines are reviewed and approved by CCHP's Quality Council. To view CCHP Clinical Practice Guidelines, please visit: [Clinical Guidelines | Contra Costa Health](#)

Preventive Care Guidelines

CCHP expects PCPs to follow the most current US Preventive Health Task Force (USPSTF) guidelines for preventive health services. Preventive Services require no co-payment by the member. CCHP requires providers to follow all USPSTF A and B level recommendations, which are listed here:

<https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

CCHP's preventive guidelines can be found at <https://www.cchealth.org/health-insurance/information-for-providers/clinical-guidelines>

Screening and Care Coordination for New and Returning Members

To screen and risk-tier new CCHP Medi-Cal members and identify those with significant medical and health needs, all members receive a Health Information Form/Member Evaluation screening tool (HIF/MET) as part of their new member welcome packet. Seniors and Persons with Disabilities and those receiving Long Term Support Services (LTSS) screening will receive a Health Risk Assessment to identify health needs and appropriate services for linkage. Depending on screening and assessment answers, members may be referred to a case manager or community health worker to provide follow-up. High risk members are re-screened on an annual basis.

Initial Health Appointment (IHA)

For Medi-Cal members, PCPs are required to provide an Initial Health Appointment (IHA). The IHA is a comprehensive assessment that is started during the member's initial visit(s) with his or her primary care provider within 120 days of enrollment.

The purpose of the IHA is to assess and set the baseline for managing the acute, chronic and preventive health needs of the member. The IHA should include the following three parts:

- A history of the Member's physical and mental health
- An identification of risks
- An assessment of need for preventive screens or services using the most current US Preventive Services Task Force A & B recommendations, available here: [US Preventive Services Task Force A & B recommendations](#).
- Health Education
- The diagnosis and plan for treatment of any diseases

The member may be exempt from the IHA through documentation in the medical record by the member's PCP.

Exemption reasons include:

- All elements of the IHA have been completed within 12 months of the member's effective date of enrollment, and the provider has reviewed/updated the member's medical record.
- If the provider can incorporate relevant information from the member's existing medical record and has received a physical exam within 12 months of the member's effective date of enrollment
- The member loses his or her eligibility prior to performance of the IHA.
- The member refuses the IHA, and the provider documents the refusal in the medical record.
- The member is unresponsive to outreach attempts. All outreach attempts should be documented in the member's medical chart.

The purpose of the IHA is to assess and set the baseline for managing the acute, chronic and preventive health needs of the member. The IHA should include the following three parts:

- A history of the Member's physical and mental health
- An identification of risks
- An assessment of need for preventive screens or services using the most current US Preventive Services Task Force A & B recommendations, available here: [A and B Recommendations | United States Preventive Services Taskforce](#).
- Health Education
- The diagnosis and plan for treatment of any diseases

Blood Lead Screening

Ensuring that all children receive timely blood lead tests is a key aspect of

preventive care. According to California lead guidelines for Medicaid children, these tests are crucial for detecting and preventing lead exposure. CCHPs encourage providers to follow these guidelines and ensure screenings are completed.

1. Providers must provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance must be provided to the parent or guardian at each well visit, starting at 6 months of age and continuing until 72 months of age.
2. All CCHP Medi-Cal children are considered high-risk, and a risk screening is insufficient. Providers must order or perform blood lead screening tests on all child members in accordance with the following:
 - a. At 12 months and at 24 months of age.
 - b. When the network provider performing a well visit becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
 - c. When the network provider performing a well visit becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
 - d. At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
 - e. If requested by the parent or guardian.
3. Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

Providers are not required to perform a blood lead screening test if either of the following applies:

1. In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
2. If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

If a blood lead screening is not performed, providers are responsible for documenting the reason(s) in the child member's medical record. In cases where consent has been withheld, the provider must document this by obtaining a signed statement of voluntary refusal. If the provider is unable to obtain a statement of voluntary refusal, the provider must document the reason it was not obtained.

Primary Care Providers can obtain a list of all children due for blood lead screening on the CCHP Provider Portal, which updates daily. Additionally, CCHP has resources regarding blood lead screening on [Quality Improvement and Health Equity | Contra Costa Health](#).

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

PCPs shall provide SABIRT (Alcohol and Drugs Screening, Assessment, Brief Intervention and Referral to Treatment) services for members 11 years of age and older, including pregnant women. Alcohol and drug screening, including brief behavioral interventions, done in the primary care setting can address and mitigate risky behaviors and offer treatment options where probable alcohol use disorder (AUD) or substance abuse disorder (SUD) is demonstrated. Providers must comply with all applicable laws and regulations related to privacy of SUD medical records, as well as state law regarding the right of minors over 12 years of age to consent to treatment, including, without limitation, Title 42 Code of Federal Regulations (CFR) section 2.1 et seq., 42 CFR Section 2.14, and Family Code Section 6929.

PCPs are required to screen members for alcohol and drug use within 120 days of enrollment and more often as clinically needed. When a screening is positive, a validated assessment tool should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Where brief assessments uncover unhealthy alcohol use, the member must receive behavioral counseling interventions, typically one (1) to three (3) sessions of fifteen minutes each offered in person, over the telephone, or by telehealth modalities. Further need for mental health and/or substance use disorders services must be referred by the PCP to a licensed mental health care provider via the Mental Health Access line.

CCHP provides an incentive for completion of the alcohol screening and brief intervention for CPT codes G0442 (for alcohol misuse screening), H0049 (for drug misuse screening), and H0050 (for alcohol and drug services, brief intervention).

Children's Presumptive Eligibility (CPE)

Children's Presumptive Eligibility (CPE) allows Qualified Providers to grant immediate, temporary Medi-Cal coverage for low-income children pending their formal Medi-Cal application. CPE is designed for California residents who do not have Medi-Cal and meet all other eligibility requirements. Once enrolled, the child qualifies for paid doctor's visits (including sick care), prescription medicines,

dental care, mental health care, vision care including glasses, hospital services, x-rays, lab tests and specialty care for the month of enrollment and the month after. Enrolling children into CPE is very simple. It consists of a quick eligibility screening based on age and the amount of money the child's family earns. The parent/guardian then completes a one-page application that is entered into the internet. A temporary Medi-Cal number is issued within minutes. The provider is not responsible for verifying Immigration status or information on the pre-enrollment form.

Providers can obtain additional information about becoming a CPE provider by going to the CPE website at <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/cpe>.

Section 17 – Special Needs Services

Tuberculosis Program

The following process is in place with Public Health with a Memorandum of Understanding:

- Physician will be oriented within 10 days of contract/credentialing about how to report members with suspected or confirmed TB disease to Contra Costa Public Health Tuberculosis Control Program. The Confidential Morbidity Report (CMR) form is available in Appendix D.
- Physicians, Clinical Lab directors and other providers are required by law to report confirmed and suspected cases of TB to Public Health within one working day of the diagnosis of TB or suspected TB. Providers should complete a Confidential Morbidity Report (CMR). This form is available in Appendix D. After completing the form, fax it to Contra Costa Public Health (CCHP) at 1-925-313-6465.
- When the report is received by the Contra Costa Public Health Tuberculosis Control Program, physician will be contacted to provide records, x-rays and treatment plan to Public Health TB Control Program. Member is contacted, interviewed, and if the diagnosis will be confirmed, member will be assigned a Public Health Nurse Case Manager. The TB Control Program will facilitate Directly Observed Therapy if necessary. DOT staff is culturally, ethnically and gender diverse.
- The TB Control Program will share information with the provider about the member including medication adherence. The TB Control Program will provide information to CCHP about TB members upon request.
- For questions about TB reporting, diagnosis, management of members with LTBI confirmed or suspected TB disease or any medical consultation providers should call 1-925-313-6740.

Children With Special Needs – California Children’s Services (CCS)

California Children’s Services (CCS) offers medical coverage and case management services to children for catastrophic or chronic illness on a financial sliding scale. When a CCHP Medi-Cal child has a CCS condition, the medical services related to the CCS condition are covered by CCS. CCHP will cover eligible medical services until CCS eligibility is determined and will cover services that are not related to the CCS condition.

Submitting a completed Prior Authorization Form through the ccLink Provider Portal to CCHP when requesting services assures that the request will be evaluated by the Utilization Review Team and referred to CCS for ongoing medical supervision if the

condition is eligible. The physician's office can also send a direct referral by fax to CCS. In either instance, copies of medical documentation must accompany the referral.

A listing of CCS eligible providers can be found on the CCS website here:

<https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx>

CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Plan's network, and only from the date of referral.

1. As a provider you should perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;
2. Initial referrals of members with CCS-eligible conditions are to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.
3. As a provider you should continue to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed. Once eligibility for the CCS program is established for a Member, CCHP will continue to provide all Medically Necessary Covered Services that are not authorized by CCS and will ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.
4. If the local CCS program does not approve eligibility, CCHP remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, CCHP remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

The PCP is responsible for performing an appropriate baseline health assessment and diagnostic evaluation for children who are identified with conditions that may be CCS eligible. Referrals sent to CCHP are reviewed by Utilization Management Unit for completeness of clinical information before a referral is submitted to CCS. Early identification of possible CCS eligible conditions is an important step to timely specialty care with a CCS provider. Once CCS determines that a child has a CCS medically eligible condition, the provider can fax prior authorization requests related to the CCS, to the local CCS Office.

California Children's Services (CCS)

Fax: 1-925-372-5113

Section 18 – Medical Records

Requirements

- CCHP will delegate the responsibility of maintaining medical records to contracted Providers.
- Provider is responsible for appointing an on-site medical records staff member with the responsibility of maintaining and securing medical records at each Provider site.
- All PCP offices will maintain policies and procedures consistent with requirements for the maintenance of member medical records.
- Medical records must be kept protected and confidential in accordance with State and Federal laws.
- An individual medical record will be created for each member treated by a PCP and will be designed to create a format for maintaining a member's medical information in a consistent, logical, legible and uniform manner.
- The medical record will reflect continuity of care for any emergency treatment rendered in a Hospital, Emergency Room, or Urgent Care setting and include provisions for follow-up or continued treatment. Physicians will document referrals to specialists, treatments rendered, or recommendations made, and follow-up care to be instituted. Provider will also maintain pathology and lab reports. Abnormal results shall be noted.
- Provider will obtain appropriate written consent for treatment prior to actual procedure performance, including invasive procedures and the human sterilization consent procedures required by Title 22, CCR, and Section 51305.1 through 51305.6, if applicable. This will also include consent for release of medical records.
- The expressed written consent of the member or legal representative is necessary for release of medical records to another party outside of the provider. In special circumstances for treatment of sensitive services such as sexually transmitted disease, HIV, and family planning, members have the right to sign a limited Release of Information form that prohibits the release of medical records but does allow release of sufficient information for billing purposes.

PCPs Will Comply with The Following:

1. Providers will maintain procedures for storage and filing of medical records including collection, processing, maintenance, storage, retrieval identification, and distribution.

2. Providers will maintain a record-keeping system to make the individual medical record available for each member visit or contact.
3. Member ID will be noted on each page of the medical record.
4. Members will be linked to their individual medical records through an assigned unique identifier for filing purposes and to distinguish that record from any other Member's record.
5. Medical records will be protected, confidential and maintained in a secure area not readily accessible to unauthorized parties. Providers will limit medical records access to physicians and associated staff.
6. Medical records will be maintained in a legible, current, detailed, organized and comprehensive manner. This will be reviewed during FSR.
7. All CCHP records related to the quality of covered services and delivery of care will be retained for a period of five years from the end of the Department of Health Care Services' fiscal year in which IPA's contract is in effect.
8. Providers will establish a uniform medical records organization format and maintain all medical records in a consistent and comprehensive manner.

Documentation

Medical records documentation will include the following:

1. Each medical record entry will contain all pertinent information related to the member contact including complaints, examination results, medical impression, treatments, member condition, test results and proposed follow-up.
2. Providers will maintain a complete and comprehensive medical record for each member. The record will include all provider services rendered including examinations, member contacts tests, procedures, ancillary services, off-site treatments, emergency room records, hospital admission/discharge information, informed consents, and correspondence regarding the member's medical condition such as consultation records, specialist reports, and referrals.
3. Each entry or member contact noted in a member's medical record will be dated and signed by the provider of service and/or ancillary staff, if applicable, including the title of the person making the chart entry.
4. All therapies, procedures, and medications administered to a member will include the signature and date of the person providing the procedures, next to the original order for that therapy, procedure, or medication.
5. The PCP will include a problem list, record of immunization, and record of health maintenance or preventive services rendered. Any member allergies or adverse reactions will be prominently noted.

6. Adult medical records will contain information regarding execution of advanced directives such as a living will or Durable Power of Attorney for Health Care. Such information will be prominently noted.
7. The member's primary language will be noted with documentation of a request for or refusal of interpreter services.

An initial preventive health screening will be performed for all members to assess the member's current medical condition, institute any necessary treatments, and outline preventive health care programs. Specific notations will be made concerning use of cigarettes, alcohol, and substance abuse for members aged twelve (12) or older. Included with the notation will be health education or counseling and anticipated guidance regarding such use.

For services referred to specialty providers, the specialist is responsible for faxing all clinical documentation back to the referring provider. For CCRMC Providers, please fax to Medical Records at 1-925-370-5239. For CPN Providers, please check with the individual provider for the best way to communicate this information.

Section 19 – HIPAA

Confidentiality

All providers, their subcontractors and affiliates are expected to treat Protected Health Information (PHI) and Personally Identifiable Information (PII) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as all other applicable laws governing member confidentiality.

Expectations Include but Are Not Limited To:

- Implementation of appropriate administrative safeguards including policies and procedures
- Ensuring staff members are appropriately trained in confidentiality policies and procedures, including appropriate use and disclosure, minimum necessary rules and penalties for noncompliance
- Implementation of safeguards for physical security in offices, including safeguarding member records, files and all communication pertaining to members
- Implementation of the appropriate computer security safeguards, ensuring ONLY appropriate and authorized access to confidential information
- Ensuring technical safeguards are in place for electronic transmissions of confidential data
- Reporting to CCHP within 24 hours of discovery, any possible or real breach or unauthorized disclosure of PHI to compliance@cchealth.org

Some Examples of Good Confidentiality Practices:

- Never discuss a person's medical care in a public area, including hallways and break rooms, or in employee-only areas when a member of the public is present
- Never give out a person's status or information to unauthorized person(s)
- Never include health information, Social Security Number or any information that can identify a specific individual in unencrypted e-mails
- Never access information in any form that you do not need to perform your job duties. For example, accessing a neighbor's medical record out of curiosity and/or concern
- Confirm contact information prior to sending confidential faxes. Confirm receipt if necessary (Pre-programmed numbers are highly recommended).
- Immediately route all confidential material inadvertently faxed, e-mailed, or sent to the wrong location to the appropriate department/person. Call sender to correct information.

Recommended Security Practices Include:

- Do not bring software or disks from home to download onto a work computer. Disks can carry viruses that can infect your system
- Do not download software from the Internet, as you can't be sure of its integrity.
- Do not open e-mail attachments you aren't expecting, even if it's from someone you know. Some virus programs access your friends' address books and send you attachments that sound friendly but are really viruses.
- Keep your password(s) confidential and secure - See below
- Do not use another individual's user ID/password
- Report any violations of security policies and procedures to your immediate supervisor
- Use virus protection software regularly

Password Do's and Don'ts

Almost 90% of computer network security incidents can be traced to poor or mismanaged passwords. Following several basic rules for passwords is critical in preventing misuse:

- Don't share your password with anyone
- Don't write your password down
- Don't embed your password in a login script or assign it to a function key
- Don't use your name, your spouse's name or your children's name as a password
- Do follow the basic rules for constructing good passwords. A good password is at least eight (8) digits long and includes at least one number and/or punctuation character. Good passwords are words that are not found in the dictionary
- Do choose a password that you can remember. Combine two meaningful words with punctuation or select a phrase and use the first letter from each word. If your system accepts long passwords, you may want to use a "pass phrase", which is a phrase that you can remember easily but that someone else cannot guess (e.g., 49ersAre#1)
- Do change your password often

Penalties For HIPAA Violations

Under the criminal provisions of the HIPAA privacy regulation, a person may be punished for knowingly and willfully obtaining, disclosing or using individually identifiable health information. Although the Office of Civil Rights does not enforce

the criminal standards, they will notify the Department of Justice of a suspected criminal violation. The penalties that may be imposed are as follows:

- \$50,000 fine and/or one (1) year imprisonment for wrongful disclosure offenses
- \$100,000 fine and/or five (5) years imprisonment if the offense was committed under false pretenses
- \$250,000 fine and/or ten (10) years imprisonment if the offense is committed with intent to sell transfer or use individually identifiable health information for commercial advantage, personal gain or malicious harm.
- 42 U.S. Code § 1320d–6 states, in part, that any person is guilty of public offense who:
 - Uses or causes to be used a unique health identifier
 - Obtains individually identifiable health information relating to an individual
 - Discloses individually identifiable health information to another person

Section 20 – Provider Trainings

Required Trainings

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Training

In 1967, Congress expanded the Medicaid benefit for children with the creation of the EPSDT benefit. The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in full-scope Medicaid.

Under DHCS requirements, all Medi-Cal Managed Care Health Plans must ensure network providers have received training on EPSDT services for Members less than 21 years of age at least once every two years. To promote a more uniform and shared understanding of the benefit, as well as to reduce duplicative trainings for Providers contracted with multiple managed care plans, CCHP utilizes the provider training program developed by DHCS. CCHP Network Providers must attest to completing the training at least once every two years.

The training can be accessed at: [Other Training Resources | website for Contra Costa Health](#)

Attestation for the training can be done here: [Training Attestation | Contra Costa Health](#)

Additional information may be found at: <https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx>

Diversity, Equity and Inclusion (DEI) Training

In accordance with DHCS APL 24-016 and other regulations, all CCHP Network Providers are required to complete initial DEI training by December 2025 or within 90 days of start day, and retake training during times of re-credentialing or contract renewals.

CCHP Provider DEI Training can be accessed here: [Other Training Resources | website for Contra Costa Health](#)

Attestation for the DEI training can be done here: <https://hsdmobile.cchealth.org/cchpprex/DEIAttestation.aspx>

If you have already taken a similar training for another Health Plan, please send us

the documentation, along with the name of the training and the other Health Plan's name, and we will accept it as completion of the training. If you have any questions, please contact Provider Relations at 1-925-608-9400.

Model of Care Training

All providers serving Contra Costa Health Care Plus (HMO D-SNP) members are required to complete annual Model of Care training. The training materials and attestation form are available on the health plan's [website](#). Completion of the attestation is required to demonstrate compliance with CMS requirements.

Optional Trainings

Additional Cultural Competency Training Resources on Our Website

Contracted CCHP providers must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

Provider Tool Kit - Better Communication Better Care

This provider resource was developed by ICE - Industry Collaboration Effort as a helpful tool to care for Diverse Populations. By downloading this toolkit, you will find a variety of useful resources such as:

- Communicating with diverse members and addressing health literacy issues
- Tips for working with interpreters and language issues/common sentences in multiple languages
- Pain management and sensitive services across cultures
- Laws and standards regarding languages issues and cultural competency web resources

Download the tool kit on our website:

<https://www.cchealth.org/home/showpublisheddocument/1639/638241044607370000>

On-Line Cultural Competency Trainings with CMEs

Providers can receive up to nine (9) CME credits, free of charge by taking this online cultural competency course from Think Cultural Health. The following information refers to the course:

- "Think Cultural Health" provides free web-based training A Physicians Practical Guide to Culturally Competent Care supported through the Office of Minority Health at the United States Department of Health and

- Human Services
- Register at the web site below to start earning up to 9 free CME credits (Physicians and Physician Assistants) or 9 contact hours (Nurse Practitioners), while exploring engaging cases and learning about cultural competency in health care.
 - Go to: <https://cccm.thinkculturalhealth.hhs.gov>

We encourage you to go visit the CCHP website at [Other Training Resources | Contra Costa Health](#), click on heading “How to Communicate with Diverse Populations” and view the latest articles and training resources.

Quarterly Provider Network Trainings

The CCHP Medical Director and Health Education staff co-chair and facilitate quarterly Provider Network Trainings for all CPN and CCRMC providers. These trainings serve as a forum for providers to learn about CCHP programs and functions, standards and regulatory requirements and new initiatives.

All training meeting materials are available on CCHP’s website <https://www.cchealth.org/health-insurance/information-for-providers/trainings/provider-network-trainings>.

Topics include but are not limited to, the following: Initial Health Appointment, USPSTF Recommendations, updates on healthcare legislation, annual HEDIS rates, new programs, pharmacy and benefit updates, our member grievance policy and process, UM authorization process and enhancements, claims and guest speakers from the community. The guest speakers include: The Immunization Program Manager, California Children’s Services, Regional Center of the East Bay and Children & Family Services.

Section 21 – Care Plus (D-SNP HMO) Risk Adjustment Management Program

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's Membership based on medical conditions and demographic information.

This process helps ensure Contra Costa Health Plan receive accurate payment for services provided to Care Plus (HMO D-SNP) Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is Risk Adjustment Important?

Contra Costa Health Plan relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency
- Recognize and address current and potential health conditions early
- Identify Members for Care Management referral
- Ensure adequate resources for the acuity levels of Contra Costa Health Plan Members
- Have the resources to deliver the highest quality of care to Contra Costa Health Plan Members

Your Role as a Provider

As a Provider your complete and accurate documentation in a Member's medical record and submitted claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity as this will ensure Contra Costa Health Plan receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Contra Costa Health Plan and reviewed with the Member

- Be compliant with CMS correct coding initiative
- Use the correct ICD-10 code by coding the condition to the highest level of specificity
- Only use diagnosis codes confirmed during a Provider visit with a Member. The visit may be face-to-face, or telehealth, depending on State or CMS requirements
- Contain a treatment plan and progress notes
- Contain the Member's name and date of service
- Have the Provider's signature and credentials

RADV Audits

As part of the regulatory process, state and/or federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Contra Costa Health Plan is appropriate and accurate. All claims/encounters submitted to Contra Costa Health Plan are subject to state and/or federal and internal health plan auditing. If Contra Costa Health Plan is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Section 22 – Frequently Asked Questions

What is Contra Costa Health Plan (CCHP)?

CCHP is an HMO and Medi-Cal Managed Care health plan that has been serving the health care needs of people in Contra Costa County for over forty-five (45) years.

Who are CCHP Members?

CCHP serves over 200,000 health plan members in Contra Costa County and continues to be at the forefront in offering comprehensive, quality health coverage. CCHP serves Medi-Cal recipients as well as County Employees. CCHP is the largest single provider of Child Health and Disability Program (CHDP) services and care for mothers and children in Contra Costa County.

Does CCHP use Providers from The Community?

Yes. Most of the members in CCHP have the choice of receiving care from County Health Centers or from primary care and specialty care providers contracted with CCHP in their community.

Where are Members of CCHP Hospitalized?

Our members can be hospitalized at our contracted facilities (located on our on-line search engine [Health Insurance | Contra Costa Health \(cchealth.org\)](https://www.cchealth.org) however, based upon medical necessity, CCHP will allow hospitalization outside of the contracted network (with authorization) to meet the needs of the member.

Who Takes Care of Hospitalized Members?

When members are admitted to a hospital, typically the hospital staff cares for them. Community Providers are usually not expected to care for members while hospitalized, but when discharged, the member's ongoing care is assumed by their Primary Care Provider (PCP).

How are Members Assigned to Primary Care Providers?

Assignment of members to PCPs is accomplished through CCHP assignment and/or member choice. When CCHP assigns a PCP to a member, consideration is given to community of care, the member's location and expressed language and other preferences. Members may change their PCP assignment by calling Member Services at 1-877-661-6230, option 2.

What is The Turn Around for Payment On Claims?

Clean claims are usually paid within a few weeks after receipt of the claim. CCHP has up to forty-five (45) business days to reimburse clean claims for Medi-Cal members.

How Do I Refer a Member to a Specialty Care Provider?

CCHP maintains a comprehensive listing of contracted Specialty Care Providers that PCP's may refer to or obtain authorization for services for members. All credentialed and contracted providers are listed in our printed member and online Provider Directory. The online Provider Directory can be accessed 24/7 at the following internet address: <https://www.cchealth.org/health-insurance>.

Are There Resources Within CCHP That Would Help Me Manage a Member's Medical Care?

CCHP has a twenty-four (24) hour Advice Nurse line (1-877-661-6230, option 1) available to all health plan members and a Case Management system to facilitate access to ongoing care. Also, there are other valuable member support programs such as asthma management, diabetes management, prenatal nurse follow-up, and referrals for mental health services. (Please note: Medi-Cal members may self-refer for mental health services through the County's Access Line at 1-888-678-7277).

What Pharmacy Coverage Should Members Expect?

CCHP contracts with a Pharmacy Benefit Manager (PBM) that subcontracts with local pharmacies to fill prescriptions. Most but not all of our members have a prescription benefit through CCHP.

Providers must use the CCHP Preferred Drug List (formulary) when prescribing for members with drug coverage. The PDL can be accessed at on our website <https://www.cchealth.org/health-insurance>. The formulary is updated quarterly.

How Do I Confirm That Members Are Eligible CCHP Members and Have Been Assigned to My Panel?

Providers can access real-time member eligibility and assignment information through the ccLink Provider Portal. To request access to the ccLink Provider Portal, complete and submit the application located on our website <https://www.cchealth.org/health-insurance>. If you have any questions regarding the application process or access to the ccLink Provider Portal, please contact the

CCHP Portal Support team by e-mail CCHPPortalSupport@cchealth.org or by phone at 1-925-313-7108.

Eligibility and PCP assignment can also be confirmed by calling the 24/7 Eligibility line at 1-877-800-7423, option 1.

If I Want to Refer Other Providers to CCHP to Become a CCHP Provider, How Do I Do That?

All CCHP contracted providers must be credentialed prior to contracting and providing services to members. To obtain a credentialing application, contact the Provider Relations Credentialing Unit at 1-925-608-9400 or by e-mail CCHPCredentialing@cchealth.org.

Appendices

Appendix	Title
A	<p>Abuse Reporting Forms</p> <ul style="list-style-type: none"> • Child Abuse Instructions • Child Abuse Report • Domestic Violence Legal Requirements for Reporting • Elder Abuse
B	<p>Advanced Health Care Directive</p> <ul style="list-style-type: none"> • English/Spanish
C	<p>Claims (Not applicable to the Regional Medical Center network)</p> <ul style="list-style-type: none"> • Corrected Claim Submission Guideline • Appeal and Dispute Form
D	Confidential Morbidity Report
E	Fraud/ Waste and Abuse Training for Providers
F	<p>Pharmacy</p> <ul style="list-style-type: none"> • Medication- Prior Authorization Request • Request for Formulary Review
G	<p>Member Services</p> <ul style="list-style-type: none"> • Member Grievance and Appeal Form English/Spanish • Member Consent for Provider to File an Appeal English/Spanish
H	<p>Prior Authorization Request (PA) Form Minor Consent Form Transportation-NEMT Disclosure of UM Criteria or Guidelines Request From Physician Certification Statement</p>
I	Provider and Member Call Centers
J	Provider Complaint Form
K	Seniors and Persons with Disabilities Cultural Sensitivity Training

L	<p>WIC Referrals</p> <ul style="list-style-type: none"> • Pregnant Postpartum/BreastfeedingWoman • Pediatric Referral
M	<p>CPN PCP Orientation CPN Specialist Orientation CPN Urgent Care Orientation CPN Organizational Provider Orientation CCRMC Orientation CPN Community Health Worker (CHW) Orientation CPN Skilled Nursing Facilities Orientation</p>
N	Face to Face Interpreter Request Form
	Video Virtual Interpreter or ASL Request Form

Contra Costa Health Plan Contact Information

CCHP Department	Phone Number	Fax Number	Email Address or Website URL
Advice Nurse Unit	1-877-661-6230, Option 1 Care Plus: 1-844-729-8410 (TTY 711)		1-925-313-6397
	1-925-957-7542, Priority Line		
Behavioral Health Department	1-877-661-6230, Option 4	1-925-313-6196	cchpbhd@cchealth.org
	1-888-678-7277, Mental Health Access Line		
CalAIM Programs (ECM, Community Supports)	1-925-313-6887	1-925-252-2609	CCHPCalAIM@cchealth.org
			CCHPCalAIMReferrals@cchealth.org
Case Management	1-925-313-6887	1-925-252-2609	CCHP.CaseManagement@cchealth.org
Claims	1-877-800-7423, Option 5, Monday-Friday 8 am - 12 pm Care Plus: 1-877-800-7423		Claimstatus@cchealth.org
Clinical Quality Auditing		1-925-608-9453	QualityConcerns@cchealth.org
Compliance HIPAA Reporting	1-800-659-4611, Privacy		Compliance@cchealth.org

	Hotline		
Facility Site Review			CCHPfsr@cchealth.org
Fraud Waste Abuse Reporting	1-800-304-9490, FWA Hotline		Compliance@cchealth.org
Health Education	1-925-608-9781	1-925-313-6870	HealthEducation@cchealth.org
Interpreter & Translation Services	1-877-800-7423, Option 4		CCHP.Quality@cchealth.org
Use email for other interpreter requests or document translations	1-866-874-3972, Telephonic Interpreter Services		
Member Eligibility and PCP Assignment	1-877-800-7423, Option 1		https://cclinkproviderportal.cchealth.org/
Member Services	1-877-800-7423, Option 7 Care Plus: 1-844-729-8411 (TTY 711)		
Pharmacy	1-877-800-7423, Option 2 Care Plus: 1-855-287-9128 (TTY 711)	1-925-313-6412	
Provider Portal Support ccLink application, access, or questions	1-925-957-7272, Technical Support, Reset Password 1-925-608-8222, Escalations	1-925-252-2600	CCHPportalsupport@cchealth.org
Provider Portal: ccLink Provider			https://cclinkproviderportal.cchealth.org/

Portal Web-based eligibility checks			
Provider Portal: ccLink Portal Application			ccLink Provider Agreement
Provider Relations	1-877-800-7423, Option 6 Care Plus: 1-877-800-7423	1-925-608-9411	ProviderRelations@cchealth.org
Provider Relations: Contracting	1-877-800-7423, Option 6	1-925-608-9411	cchpcontracts@cchealth.org
Provider Relations: Credentialing	1-877-800-7423, Option 6	1-925-608-9411	cchpcredentialing@cchealth.org
Provider Relations: Network Management	1-877-800-7423, Option 6	1-925-608-9411	networkmanagementteam@cchealth.org
Quality Concerns, Potential Quality Issues		1-925-608-9453	Qualityconcerns@cchealth.org
Quality, Health Equity, Population Health	1-925-608-9781	1-925-313-6870	CCHP.Quality@cchealth.org
Sales & Enrollment	Care Plus: 1-844-729-8412		-
Utilization Management For general inquiries and updates, do NOT email authorization requests	1-877-800-7423, Option 3		CCHPauthorizations@cchealth.org
			Auth-Umsupport@cchealth.org Urgent issues, escalations
Utilization Management Fax Numbers, Medi-Cal Member Authorization	Out of Area (Hospital) Face Sheet	1-925-313-6645	-
	Mental Health (only)	1-925-313-6196	

	if not yet on portal)		
Utilization Management Fax Numbers, Commercial Member Authorization	Confidential Mental Health (only if not on portal)	1-925-313-6645	