The purpose of the guidelines presented in this Manual is to assist the Provider with information about Contra Costa Health Plan processes. It will assist with referrals for health services, 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 925-313-9500 or e-mail: ProviderRelations@cchealth.org or fax 925-646-9907.

All information contained in this manual can be accessed on our website at www.cchealth.org/healthplan.
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Section 1 - WELCOME TO THE CONTRA COSTA HEALTH PLAN (CCHP)

MISSION STATEMENT

Contra Costa Health Plan provides managed care health insurance with its safety net community and county provider partners at an affordable price for diverse populations. We offer Patient-Centered care to assure coordinated, comprehensive, compassionate and quality care.

ABOUT CCHP

CCHP is accredited for our Medi-Cal product by the National Committee for Quality Assurance (NCQA). Regulatory oversight is through our contracts with the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). As a Federally Qualified HMO, the Contra Costa Health Plan (CCHP) enrolls employer groups (public and private), In Home Support Services (IHSS), Medi-Cal members that include Seniors and Persons with Disabilities and Chronic Conditions, Medi-Cal Expansion, Families and Low-Income Children’s Programs. We also manage the care of low income, uninsured County children eligible under the County’s Basic Health Care Program. 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. In order to influence policies to meet the needs of health plan members, the Board appoints eleven individuals to serve on the CCHP Advisory Board, known as the Managed Care Commission (MCC).

The Board of Supervisors establishes the mission and goals of CCHP; the Director of Health Services has the responsibility for meeting these goals. The HMO Chief Executive Officer, who reports to the Director of Health Services and to the Board of Supervisors, is responsible for the overall administration and management of CCHP; the Medical Director is a Physician who is responsible for the overall clinical operations of CCHP. The MCC acts as a liaison between CCHP, the Board of Supervisors and the community.

CCHP is one of seven major divisions 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 Ambulatory Care Centers (10 sites), Alcohol and Other Drugs, Mental Health, Public Health, Environmental Health and Finance Divisions in order 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 healthcare services;
- to ensure the provision of preventive health care;
- 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 their benefit package, members choose or are assigned to one of three 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 practitioners, physician assistants, nurses, specialists, and ancillary providers providing care in their private offices in the community and at our contracted hospitals.
- **Kaiser Permanente Network (KP).** The Kaiser Network is a member choice option for Medi-Cal members only. There are restrictions related to assignment to the KP Network. For more information call Member Services at 877-800-7423 (option 7).

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 does not allow providers to contract for specific product lines. Contracted providers agree to serve members enrolled in CCHP regardless of benefit plan and agree to accept Medi-Cal, Seniors and Persons with Disabilities and Chronic Conditions (SPD’s) members and County Employees.
Section 2 – 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 of coverage or financially encouraged to make decisions that result in underutilization.

Normal Business hours for the Authorization and Utilization Management (UM) Department are Monday through Friday from 8:00am to 5:00pm, excluding weekends and holidays. When making outbound or returning calls, staff identifies themselves by their name, title and organization. Members can reach the UM Department by calling the Member Call Center at 1-877-661-6230, option 4. Providers can reach the UM Department by calling the Provider Call Center at 1-877-800-7423, option 3.

Afterhours and during weekends, both callers have two options. For non-urgent matters, the caller can leave a message at the above number. Messages are addressed the next business day. 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 has limited authority to approve medically necessary services on behalf of the UM Department and is able to reach a backline at the UM Department for assistance. As necessary, the AN Unit has access to the UM Manager and Medical Director. 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 11-Cultural and Linguistic Services for detailed information. Language services information is also available at our website www.cchealth.org/healthplan.

Providers can request, free of charge, copies of clinical guidelines used for decision-making. When requested services are denied or modified, providers have the opportunity to discuss the UM decision. 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.

REFERRAL FROM REGIONAL MEDICAL CENTER/HEALTH CENTER PROVIDERS

Referrals from the Regional Medical Center Network (RMC) are submitted electronically to CCHP UM/Authorization through ccLink. CCHP reviews and authorizes the service. A faxed authorization letter will be sent to the Specialist, a copy to the member being referred and to the requesting Provider. The RMC Provider and/or Care Coordinator is responsible for sending all required documentation to the CPN specialist. The Specialist is responsible for faxing all clinical documentation back to the referring RMC Provider to be included in the member’s medical record at Fax 925-370-5239. RMC Members can self-referral to Behavioral Health and Sensitive Service providers in the CPN network. No prior authorization is required.
PRIOR AUTHORIZATION

The electronic No Authorization Required interactive list is located on our website at https://cchealth.org/healthplan/providers. This list can be searched by CPT code and should be checked periodically for updated versions. When the service is on the Interactive No Authorization Required List, we will honor that a Prior Auth request is not required. Any issues or problems you encounter, please reach out directly to the Authorization Department at CCHPauthorizations@cchealth.org. Please ensure any Protected Health Information (PHI) is encrypted.

Please note that emergency treatment may be rendered without authorization by any contracted or non-contracted provider. Please note that an asterisk (*) by any of the services listed below indicates that the service is not available for all benefit plans. You may call Member Services at 1-877-661-6230, Option 2 to ascertain if the services are covered for your patient.

Services requiring health plan prior authorization includes, but not be limited to:

- Acupuncture (Medi-Cal members)**
- Audiology (Medi-Cal members)**
- Chemo/Radiation Therapy (not related to cancer)
- Child Development Center (Autism, Behavior and Child Development Center), Craniofacial Clinic, Healthy Eating Active Living (HEAL) (Children’s Hospital Oakland)
- Chiropractor (Medi-Cal members)**
- Dialysis
- DME and Oxygen
- NCS, ENG
- Experimental/Investigational Services
- Follow Up Visits beyond 6 visits unless otherwise indicated
- Genetic or DNA Testing
- Hearing Aids
- Home Health Services including hospice* & home infusion therapy
- Inpatient Admissions including OB, Acute Rehab, SNF & Hospice
- PET Scans, Total Body Scan
- Non-Contracted Providers-Emergency services do not require prior authorization from CCHP.
- Non-emergency transportation**
- Non-network follow up visits
- Non-reusable medical supplies
- Mental Health Psychiatry for Organ Transplant and Transgender Evaluation services
- Ophthalmology
- Out-of-Area Services
- Outpatient Surgery Center and Facility based procedures
- Podiatry (Medi-Cal members)**
- Prosthetics, Orthotics, Appliances and Braces
- RAST or MAST Testing
- Rehabilitation Services*** including physical, occupational, speech therapy and cardiac pulmonary rehabilitation (Excludes Developmental Delay Diagnosis)
- Special Programs and Subspecialty Providers: Pain Management, Urogynecological services, Weight Loss, Gastric Bypass Surgery and Sleep Studies
• Tertiary Care Centers, e.g. UCSF, UC Davis, Sutter West Bay, Stanford, Lucile Packard
• Tuberculosis Treatment (referral only)
• Vision Services***

*For Medi-Cal members, prior authorization is not required but notification of admittance to hospice care is required.

**Unaccompanied Minors require a signed Minor Consent form with the Prior Auth request.

*** limited to two (2) visits per month in combination for Acupuncture, Audiology, Chiropractic, Occupational and Speech Therapy services. Vision services limited to routine eye exam and eyeglasses once every 24 months; contact lens when required for medical conditions such as aphakia, aniridia and keratoconus. The following Medi-Cal members are eligible for chiropractic services:

• Children under age 21
• Pregnant women through the end of the month that includes 60-days following the end of a pregnancy;
• Residents in a skilled nursing facility, intermediate care facility, or subacute care facility.
• All members when services are provided at hospital outpatient departments, Federally Qualified Health Centers or Rural Health Centers.

A special worksheet is required for the following services:

• Bone Growth Stimulator
• Gastric Bypass Surgery
• Incontinence Supplies (creams and washes are excluded when supplies are covered) (Medi-Cal only)
• Manual Wheelchair
• Motorized Wheelchair/Power Operated Vehicle
• TENS Unit

Call the Authorization Unit for applicable worksheet
Phone: 1-877-800-7423 (option 3)

SUBMISSION OF PRIOR AUTH REQUEST

Prior Authorizations should be submitted to CCHP Authorizations Unit through cclink. Always indicate whether the authorization request is URGENT or ROUTINE.

• A request is considered urgent when the member faces an “imminent and serious threat” to his or her health and the standard timeframe of 5 business days for the decision-making process:
  1. Would be detrimental to the enrollee’s life or health, or
  2. Could jeopardize the enrollee’s ability to regain maximum function.

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

If a request does not meet the above guidelines, please document the reason that it does not meet the guidelines in the text notes. Urgent Requests will be reviewed for “Urgency.” Please note that Urgent Requests may take up to 72 hours to process.
REVIEW OF PRIOR 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 and/or failed
- Specialist findings, recommendations and treatments

EXCLUDED SERVICES REQUIRING MEDI-CAL MEMBER DISENROLLMENT

CCHP has multiple product lines, each with their own benefit structure. Our Medi-Cal members have excluded (carved-out) services that Fee-For-Service (FFS) Medi-Cal will cover. CCHP will continue to cover and ensure that all medically necessary services are provided to our members who must disenroll and receive care through the FFS program. Our Utilization Management (UM) team will assist with these types of requests. Contact the UM or Member Services Department for assistance.

Excluded or limited Medi-Cal services include:

- Major Organ Transplants (excludes corneal and kidney)
- Waiver Programs
- California Children Services (CCS) Eligible Conditions

MEDI-CAL EXCLUDED SERVICES DESCRIPTION

MAJOR ORGAN TRANSPLANTS

Please contact the CCHP UM Department when a CCHP member is identified as a potential major organ transplant candidate. If the member is CCHP Medi-Cal, special handling is required.

Major organ transplant procedures (except for Kidney and Corneal transplants) are covered by FFS Medi-Cal and are considered an excluded service.

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 in order 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.
CALIFORNIA CHILDRENS SERVICES 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). PCP’s are responsible for ongoing medically necessary diagnostic, preventive treatment and services not covered by CCS.
SECTION 3 – PROVIDER APPEAL AND CLAIM DISPUTE

Providers and facilities may submit an appeal of an unfavorable determination made by CCHP for a prospective, concurrent or retroactive request for service or hospitalization of an enrollee. Providers or facilities may also submit a claim dispute for disagreements on claim denial, underpayment, overpayment, payment rates, or other billing or reimbursement issues.

The appealing party must submit a written appeal request within 365 days from the receipt of a service or claim denial or modification, or in case of inaction, the expiration of the applicable claim/authorization filing period. Timelines for Medi-Cal or Commercial members are subject to change.

All requests should be accompanied by supporting documents such as clinical records (hard copy or on an encrypted disc) to support the appeal. All appeals are required to be sent in by Certified Mail or Encrypted Email due to HIPAA regulations.

Failure to submit an appeal within the specified timeframe may result in the denial of an appeal request. No punitive action is taken against a provider who submits an appeal. If a provider submits an appeal on behalf of a member, the appeal must be accompanied by written member consent.

Consent forms are located here: https://cchealth.org/healthplan/for providers/forms and resources/member consent

Provider appeal and dispute form and instruction are located here: https://cchealth.org/healthplan/providers/

Submit the completed form via secure, encrypted email to Appeals@cchealth.org or mail form to:

Contra Costa Health Plan
Attn: AGD Department
595 Center Avenue, Suite 100
Martinez, CA 94553
Section 4 – CASE MANAGEMENT

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:

- Multiple Comprehensive Case Management Programs
- Health Risk Assessments and Care Coordination for our newly enrolled Medi-Cal members.
- Comprehensive Perinatal Services Program for pregnant members receiving OB care with a community provider
- Hospital Transitions Programs

CASE MANAGEMENT PROGRAM

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. Since complex case management is considered an opt-out program, all eligible members have the right to participate or decline participation.

The goal of complex case management is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The primary goals of the program are to:

- 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

Case Managers coordinate 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.

In order to make a referral to the program you may do one of the following:

- Complete the referral form (Refer to Appendix C) and fax it to the CM Program.
- Make a telephone referral. Leave a message including times you may be reached, and a case management staff member will return your call promptly.

Case Management
Phone: 925-313-6887
Fax: 925-313-6462
COMPREHENSIVE PERINATAL SERVICES PROGRAM

CCHP believes that every baby should have a healthy start in life. Our expectation of our perinatal providers is that each member receives services following Comprehensive Perinatal Services Program (CPSP) Guidelines. This includes:

- Initial assessment, trimester reassessments, post-partum assessment, interventions and follow-up services in:
  - Obstetrics
  - Nutrition (assessment, education, intervention and referrals)
  - Health Education (needs assessment, information and linkage to community educational resources)
  - Psychosocial Services (support including crisis intervention, community resources, transportation needs, or any psychosocial problem affecting her care)
- Individual Case Coordination
- Prenatal Vitamin/Mineral Supplements
- Referrals to Related Services

BABY WATCH PROGRAM

The Baby Watch program is part of CCHP Perinatal Case Management program. The goal of the Baby Watch incentive program is to promote good prenatal care with the goal of reducing the incidence of low birth weight babies and infant morbidity.

Certain pregnant CCHP members are eligible for the incentive program. In order to receive an incentive, eligible members need to do the following:

- Receive their first prenatal visit in the first trimester of pregnancy
- Return for a post-partum follow up visit within six (6) weeks of delivery

For more information about Baby Watch or to refer a CCHP member, please call:

Baby Watch Program
Phone: 925-313-6852

HEALTH-RISK ASSESSMENTS AND CARE COORDINATION FOR NEW AND RETURNING MEMBERS

Under CCHP Care Management Department direction and oversight, our contracted provider Eliza will place automated calls to perform a combined Health Information / Health Risk Assessment (HRA) for all new members and yearly for returning members. The goal of the assessment is to identify members that are high-risk and/or at-risk and enroll them with case management and other appropriate services. This solution will target members from Contra Costa’s Medicaid population in order to gain a better view into medical and health needs. It will also satisfy the requirements for Long Term Supportive Services by DHCS as well as requirements set forth in APL 17-013. Any questions about the HRA may be addressed to the team by contacting the Care Management unit at 925-313-6887.
HOSPITAL TRANSITION PROGRAMS

- Contra Costa Health Plan (CCHP) Hospital Transition Coordination Program facilitates the transition of CCHP clients admitted to the hospital back to their assigned PCP. The program consists of a designated phone line at CCHP which is answered by a specially trained RN. Services include identifying a member’s assigned PCP and coordinating the transition of discharged patients back into primary care. Additionally, the RN will assist in coordinating specialty appointments, facilitating getting medical records to the appropriate provider to maximize appointment productivity, connecting patients to outside resources, and providing linkages to financial counselors for health coverage. Through this program we will not only enhance continuity of care between our health systems, but also reduce unnecessary ED visits and hospital readmissions. Our Hospital Transitions Coordination Program RN is available from 8am-5pm Monday-Friday.

  Hospital Transition Nurse
  Phone: 925-313-6885
  877-800-7423, Option 3, then Option 3

- Contra Costa Health Plan (CCHP) Hospital Transition Outreach Program is an effort to contact CCHP clients that are frequent utilizers of the Emergency Department, those that had a visit to the ED that was determined to be avoidable or those that are readmitted within 90 days of a hospital discharge. The members are identified by multiple reports. Each member receives either a call or a letter from the Transition Outreach RN. The PCPs are also notified that CCHP reaches out to members for this purpose. The goal is to decrease ED utilization and readmissions, as well as, offering case management assistance and services to meet their medical needs.

- Additional outreach programs include the polypharmacy report and opiate use. Those members either have 15 + prescriptions per month or receive narcotic prescriptions from 3 or more pharmacies and/or 3 or more providers. Members who are on the polypharmacy report receive a letter offering case management services. PCPs are notified of members that are on the narcotic report.

- The goal is to ensure PCPs are aware of all medications prescribed to their members for care coordination purposes; as well as to engage those members with complicated medical conditions to offer case management assistance and services to meet their medical needs.

Palliative Care Services for Medi-Cal Members

As of January 1st 2018 - Palliative Care Services is a covered benefit for Medi-Cal members. Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Members who are chronically ill and have a life expectancy greater than 6 months are eligible for Palliative Care services. 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 may not be concurrently enrolled in Hospice and Palliative Care.
Eligibility Criteria:
- Member has an advanced illness
- Member’s life expectancy is greater than one year and not in hospice
- Member has received the appropriate patient desired medical therapy, but it is no longer effective

Disease Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF):
   a. 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
   b. Member has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD):
   a. 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
   b. Member needs a 24-hour oxygen requirement of greater than or equal to three liters per minute

3. Advanced Cancer:
   a. Member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   b. 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).

4. Liver Disease:
   a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
   b. Member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   c. Member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

CCHP's Palliative Care providers include clinicians who have Palliative Care training and/or certification to conduct palliative consultations or assessments such as; PCP’s if Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) or Nurse Practitioner if a PCP, a Registered Nurse (RN), Licensed Vocational Nurse (LVN), and a Social Worker. Chaplain Services are recommended from the community to be part of the Palliative Care Team. Chaplain services are not a paid service under the Medi-Cal Benefit structure. CCHP has Palliative Care contracts with Hospice of the East Bay and Noble Hospice Care.
Section 5 – Transportation

Non-Medical Transportation is a benefit provided to all Contra Costa Health Plan Medi-Cal members who do not have access to get to their medically necessary appointments, including dental, mental health and AODS. This transportation benefit is member driven and is scheduled and facilitated entirely within the Home and Community Based Service Unit. Member input is vital/required to ensure accuracy of information and successful completion of transportation logistics. This benefit is easily accessible through the health plan’s non-medical transportation 800 number. Members can call 1-855-222-1218 to schedule transportation. This benefit is separate and in addition to Non-Emergent Medical Transportation / Emergent Medical Transportation benefits.

Non-Emergency Medical Transportation (NEMT) services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250.

Contra Costa Health Plan (CCHP) is required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member’s medical needs. CCHP is required to provide medically appropriate NEMT services when the member’s medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services.

Unless otherwise provided by law, CCHP must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, CCHP may arrange NEMT for a minor who is unaccompanied by a parent or a guardian and provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor’s service. CCHP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor. The form is available on our website at cchealth.org/health plan/for providers in the Provider Manual appendices Appendix M.

CCHP is required to provider NEMT for the following:

1. NEMT ambulance services for:
   • Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
   • Transfers from an acute care facility to another acute care facility.
   • Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
   • Transport for members with chronic conditions who require oxygen if monitoring is required.
2. Gurney services when the member’s medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:

- Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

3. Wheelchair van services when the member’s medical and physical condition does not meet the need for litter van services, but meets any of the following:

- Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below):

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring.

4. NEMT by air only under the following conditions:

- When transportation by air is necessary because of the member’s medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms

CCHP is required to use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. All NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member’s limitations and provide specific physical and medical limitations that preclude the member’s ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).
- Certification Statement: Prescribing physician’s statement certifying that medical necessity was used to determine the type of transportation being requested.
The PCS form is required with the prior authorization request. The form is available on our website at [www.cchealth.org/healthplan/pdf/provider/Appendix-M-Physician-Certification-Statement-for-NEMT.pdf](http://www.cchealth.org/healthplan/pdf/provider/Appendix-M-Physician-Certification-Statement-for-NEMT.pdf).

The Department of Health Care Services (DHCS) requires a parent or guardian to give consent for a minor child (17 and under) to travel on Non-Emergency Medical Transportation (NEMT) unaccompanied. The purpose of the consent form for NEMT is for a Parent/Guardian to consent that the minor will be unaccompanied and Contra Costa Health Plan (CCHP) is not liable for any issues/problems that may occur. Non-emergency Transportation companies are not allowed to transport unaccompanied minors without this form completed.

Please have the Parent/Guardian complete the form and attach to the Prior Authorization request for Non-Emergency Transportation. When submitting a Prior Authorization for Non-Emergency Transportation for a minor child that may be unaccompanied, the signed consent form must be included with the request. The form can be found on our website at [www.cchealth.org/healthplan/pdf/provider/Appendix-M-Transportation-Minor-Form.pdf](http://www.cchealth.org/healthplan/pdf/provider/Appendix-M-Transportation-Minor-Form.pdf).

If you have any questions about the PCS or Minor Consent form contact the authorization unit by e-mail at CCHPauthorizations@cchealth.org or at 1-877-800-7423, Option 3.

**INDIAN HEALTHCARE PROVIDERS**

If an Indian Healthcare Provider rendered NMT services after October 10, 2018, to an American Indian beneficiary enrolled in CCHP, the claim can be sent to CCHP for reimbursement. Indian Healthcare Providers are not required to contract with CCHP or one of our subcontractors.
Section 6 – PHARMACY SERVICES

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).

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:

1. A printable PDL is available online at [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan)
2. Epocrates also hosts the CCHP formulary.

CCHP’s pharmacy network consists of two national pharmacy chains, Walgreens and Rite Aid, and many independently owned pharmacies in Contra Costa County. If you need help finding a pharmacy for your patients, use the search engine available at the above website or call CCHP Pharmacy services for assistance.

HOURS OF OPERATION

- CCHP Pharmacy Authorization Unit is available to answer questions from providers from 8:00 am – 5:00 pm, Monday through Friday.
- After hours – Unless the dispensing pharmacist determines that the member cannot wait, requests for drugs requiring prior authorization will not be processed until the next business day.
- Our Pharmacy Benefits Manager, PerformRx, also handles provider calls. They are available from 9am-9pm, Monday through Friday and Saturday from 9am-1pm. The PerformRx Network Management unit can be reached at 1-800-555-5690.
- In the event that an urgently needed medication that requires prior authorization is needed, an emergency fill procedure may be utilized.
- The 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. Please note, that this does not eliminate the need for a prior authorization and only applies to specific medication classes.
- 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 submit a Medication Prior Authorization through cclink to request a non-preferred drug or for an amount above our plan’s quantity limits. CCHP requires prior authorization for a non-preferred medication before the provision of a prescription of such medication to the member. Providing samples of a non-preferred drug for use is a violation of CCHP policy and is not considered continuation of therapy for authorization review purposes.

Prior authorizations are usually good 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 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, member, and/or pharmacy (via fax and/or mail) within 24 hours of receipt of a valid prior authorization request.

PROVIDER MEDICATION APPEALS

Medication appeals are made directly to CCHP. Members need to contact the Member Services Department and providers should contact the Authorization/Utilization Management Department. There are appeals processes and time standards for Medi-Cal and Commercial members. For questions regarding the appeals process call:

CCHP Pharmacy Services:
Phone: 1-877-800-7423 (option 2)
Or fax provider appeal documents to the CCHP pharmacy unit at: 925-313-6412

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 on our website www.cchealth.org/healthplan under the topic Forms and Resources and in Appendix I)
Section 7 – ADVICE NURSE

The Advice Nurse Telephone Triage Program (URAC accredited) 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 patients 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
- Verifying member eligibility and addressing benefit related questions after hours

To access the Advice Nurse Telephone Triage Program call:

Advice Nurse Program Phone
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. Acceptable dispositions are usually in a range of being seen within 8 to 24 hours. Once the decision has been made, and the patient 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 patient is directed to call the facility to schedule the appointment or can walk into any of our contracted facilities. 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 patients were seen and to follow up on the patient’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 patient’s satisfaction as they are seen for their urgent medical needs in a timely manner.

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.

**TELEPHONE CONSULTATION CLINIC**

The Telephone Consultation Clinic (TCC) program allows for patients 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 patient 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 patients and all others handled by CCHP. With appointments difficult to come by, some of the common concerns patients have are able to be managed by providers speaking with patients over the phone. This initial contact helps to streamline the patient care process, allowing for patient 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 patients in regards to at-home care, or further assessment of symptoms.
- **Lab work:** Often, TCC can assist in ordering lab work for patients ahead of a clinic visit, allowing patients 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 patient or pharmacy is unclear on medication directions, unable to fill based on insurance limitations, or a patient is reacting to their current medication, TCC providers may be able to provide assistance when PCPs are unavailable.
- **Medication refills:** TCC is also able to assist with medication refills for patients having a difficult time getting in to 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 patient. 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.
Patients who suffer from chronic UTIs and BV may also be given a prescription prior to completing lab results, dependent on patient 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 patient 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 patient into one of the on-hold clinic appointments. This is particularly useful for patients 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 patient 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

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

Telephone Triage Protocols - Adult and Pediatric After-Hours Version 2015 - David A. Thompson and Barton D. Schmitt, M.D

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.
GENERAL GUIDELINES- MENTAL HEALTH

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 Health Plan benefits. CCHP covers mild to moderate mental health issues. Moderate to severe issues are covered through County Mental Health.

In our Federally Qualified Health Centers (FQHC, ie. CCRMC, Lifelong) practices, PCPs can refer a member to their embedded mental health providers for mild to moderate mental health issues. The mental health provider must utilize the Mental Health screening tools for Adults and Children to document acuity of issue. Forms can be found on the website at https://cchealth.org/healthplan/providers/ or available in Appendix K.

If the mental health provider has availability, they can then provide the service. If the FQHC mental health provider does not have availability, the member may self-refer or be referred to the Mental Health Access Line (see number below). If the member is identified as having a moderate to severe mental health issue at any time, they are referred to County Mental Health, also through the Access Line.

Medi-Cal members:

☐ Can self-refer or be referred by their primary care physician (PCP) to the CCHP Mental Health Network by calling the Mental Health Access Line (see below). If available, PCPs at Federally Qualified Health Centers (FQHCs) can refer mild to moderate issues to the credentialed mental health providers embedded at their center. When the member calls, an assessment will be performed and if appropriate, a referral made.

    Mental Health Access Line Phone:
    1-888-678-7277

☐ Inpatient Specialty Mental Health Services for Medi-Cal members are carved out to the County Mental Health Department.

Commercial members:

☐ All mental health services for commercial members require prior authorization from CCHP.
☐ Providers must have written confirmation of authorization prior to rendering services. Unauthorized services are subject to payment denial.
☐ Requests for additional visits must include current symptoms and diagnosis to support continuing treatment.
☐ Members in mental health treatment must see their PCP at least annually.
☐ Updated clinical information is required for authorization of additional visits beyond the initial authorization.
For questions regarding member benefits call:

Member Services
Phone: 1–877-800-7423 (option 7)

To access Mental Health Services, members must call the CCHP Mental Health Authorization Unit. All messages left for the Utilization Management (UM) nurse are confidential.

Mental Health Authorization Unit
Phone: 1–877-800-7423 (option 3) or 925-313-6683

**ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC)**

When an issue with alcohol use is identified in a member, the PCP must perform the Alcohol Misuse Screening and Counseling (AMSC) using the Audit or Audit C Tools. (See website [www.cchealth.org/healthplan Forms and Resources](http://www.cchealth.org/healthplan Forms and Resources).) 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. 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. It is recommended that at least one provider per clinic or practice receive 4-hour AMSC training and submit an attestation to CCHP. Trainings can be found on the SBIRT website at [https://sbirt.clinicalencounters.com/](https://sbirt.clinicalencounters.com/)

**ACCESS FOR COMMERCIAL MEMBERS TO PSYCHOTHERAPY AND PSYCHIATRY SERVICES**

**PSYCHOTHERAPY**

A member may directly request psychotherapy services from the CCHP Mental Health Authorization Unit by contacting the UM Nurse for initial authorization and referral at the number listed above.

The UM Nurse will triage the needs of the member and direct the member to a Mental Health Specialist or inform the member to contact his/her (PCP) to rule out any underlying physical condition that may contribute to Mental Health symptoms. If the member is directed to a Mental Health Specialist, a provider will be assigned and initial visits authorized.

**PSYCHIATRY**

A referral from the member’s assigned PCP or Specialist is required for psychiatry services. The PCP or specialist will provide the UM Nurse with clinical information for review. Upon completion of the review, the UM Nurse will assign the member to a psychiatrist, if appropriate, and authorize an initial and three follow up visits.
BEHAVIORAL HEALTH TREATMENT- COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

CCHP ensures that Behavioral Health Treatment (BHT) services are provided to Medi-Cal and Commercial members under 21 years of age that meet the eligibility criteria for services when medically necessary, based upon recommendation of a licensed physician or a licensed psychologist. 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 (CCRMC and CPN) who suspect autism or other behavioral diagnoses should submit a referral request to Autism Behavior and Child Development Center (ABCD) at CCRMC to rule out autism. See Section 13, page 2 for referral instructions. The member will be screened by the ABCD Center, and a Comprehensive Diagnostic Evaluation will be performed as needed.

☐ After diagnosis is confirmed, if Applied Behavior Analysis, speech or other modalities are ordered, CCHP Authorization Unit will contact appropriate providers and authorize services.

☐ For individuals diagnosed with ASD who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, CCHP will refer to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services, respectively.
Section 9 – SENSITIVE SERVICES

ABORTION, CONTRACEPTION, HIV, AND STD’s

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 with regard to 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 Phone:
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 is 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:
East County: 925-427-8811
West County: 510-374-3324
Central County: 925-646-1680
Section 10 – 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 added new health education topics, videos, interactive tools, and links to community resources on our website. If you would like printed material, phone assistance, or are interested in additional information, please contact:

Elisa Hernandez, Senior Health Education Specialist  
Phone: 925-313-6019  
Or  
E-Mail: Elisa.Hernandez@cchealth.org.

Health Education Services are available for members through CCRMC (for members in that network) and through the Health Plan directly. We would like to encourage all providers to access our health education website section and become familiar with the newest resources. To access the website go to www.cchealth.org/healthplan/health-ed.php

CCHP’s Health Education Department can assist providers in locating a variety of Health Education modalities that are culturally appropriate for your diverse patient population. Examples include:

- Health education classes and support groups
- Health education materials and information
- One-on-one health education and dietician services

HEALTH EDUCATION ONE-ON-ONE APPOINTMENTS

Appointments with patient educators or dieticians are available at the county clinics for health problems requiring an individual approach. Some examples are: smoking cessation, diabetes management, high cholesterol, asthma management, weight management, stress management, birth control options, and more. Services are provided at CCRMC clinics. These services are for members served in the CCRMC network.

QUARTERLY PRIMARY CARE PROVIDER MEETINGS

The CCHP Medical Director and Health Education staff co-chair and facilitate quarterly Provider Meetings for all CPN and CCRMC primary care providers. These meetings serve as a forum for providers to learn about CCHP programs and functions, standards and regulatory requirements and new initiatives. All meeting materials are available on CCHP’s website https://cchealth.org/healthplan/provider-meetings.php.

Topics include but are not limited to, the following: Initial Health Assessment, 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.
**CHILDBIRTH PREPARATION CLASSES**

CCRMCL providers can refer pregnant members to CCRMC’s Healthy Start Program for childbirth preparation classes. For more details call Healthy Start:

- Martinez Health Center 925-370-5495
- Pittsburg Health Center 925-431-2345
- West County Health Center 510-231-9469

**OTHER RESOURCES**

California Smokers’ Help Line (Phone Counseling):
- English 1-800-662-8887
- Spanish 1-800-456-6386
- Mandarin & Cantonese 1-800-838-8917
- Vietnamese 1-800-778-8440
- Hearing Impaired 1-800-933-4833

American Lung Association Helpline 1-800-LUNGUSA

Chewing Tobacco
- English 1-800-844-2439
- Korean 1-800-556-5564
- Hearing Impaired 1-800-933-4833
- Teen’s 1-800-662-8887

Smoking Cessation website: [http://www.nobutts.org/county-listing](http://www.nobutts.org/county-listing)


(choose option car seat inspection)

Services are offered in English and Spanish
Section 11 – CULTURAL AND LINGUISTIC SERVICES

By law, Contra Costa Health Plan (CCHP) must ensure members have access to free interpreter services when English is not their primary language. Interpreter services must be available 24-hours a day, 7-days a week for medical encounters. CCHP provides access to interpretation 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.

INTERPRETER SERVICES

REGIONAL MEDICAL CENTER NETWORK

The RMC Network and clinics have procedures on how to use interpreter services, provide American Sign Language or alternative resources for members who have communication limitations such as people who are deaf or hearing impaired. RMC Network providers should be referred to the clinic coordinator/manager for specific procedures.

CULTURAL COMPETENCY REQUIRED TRAINING

Under Final Rule, 42CFR 438.10, h/1/vii, the California State Department of Health Care Services (DHCS) now requires all health plans to list in their on-line and hard copy directories if a contracted provider has completed Cultural Competency training.

To meet this requirement, CCHP is offering brief (no more than 30 minutes) training, free and easily accessible on our website called “Connecting to your Patients”. We have included an attestation at the end of the training to verify the training has been completed. Please go to cchealth.org/healthplan/ For Providers/Training Resources/How to Communicate with Diverse Populations/ Cultural Competency Training for Healthcare Providers or go to this link: http://cchealth.org/healthplan/pdf/provider/Cultural-Competency-Training.pdf.

When you complete the training, please click on the Attest button, and then Submit. This sends the attestation directly to Provider Relations Credentialing Unit. Credentialing staff will review the attestation and update your listing in our database to reflect you have completed the training.
Here are more details about the short training. "Connecting with your Patients" is an excellent Power Point training you can review at your leisure developed by ICE – Industry Collaboration Effort.

This training will assist providers and their staff to:

- Understand culture and cultural competence Strive towards clear communication
- Better understanding lesbian, gay, bisexual and transgender (LGBT) communities
- Address health care for refugees and immigrants
- Reflect on strategies to support seniors and people with disabilities

Click this link for the power point slides: [http://cchealth.org/healthplan/pdf/provider/Cultural-Competency-Training.pdf](http://cchealth.org/healthplan/pdf/provider/Cultural-Competency-Training.pdf)

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 925-313-9500.

**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 patients 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

ON-LINE CULTURAL COMPETENCY TRAINING WITH CME’S

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 http://cchealth.org/healthplan/provider-training.php and view the latest articles and training resource as we are expanding this section for our providers.
Section 12 – MEMBER SERVICES DEPARTMENT

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 J)

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
Phone: 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 go online to fill out the grievance form https://cchealth.org/healthplan/cchp/. Or you may advise the member to call Member Services at 1-877-661-6230 (option 2) to help resolve the member’s issue. The member may also go to the CCHP office to talk to 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.
TIMEFRAMES 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: http://www.cchealth.org/healthplan

MEMBER APPEALS FOR DENIED SERVICES

If a member believes that 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.

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

Providers can file an Appeal on behalf of their patient if they have the written consent of the member (https://cchealth.org/healthplan/forproviders/forms and resources/Member Consent).
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 make a decision 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

The following section details information provided to members regarding their rights as members of CCHP. Providers are encouraged to assist members with their grievances and no punitive action will be taken against a provider who supports a member through the appeals process. Also providers may not take any negative action against a member who files a complaint or grievance against the provider. You may also refer to Appendix J and our website at www.cchealth.org/healthplan.

Member rights and responsibilities include, but are not limited to, the following:

- The right to receive care with respect regardless of race, religion, education, sex, cultural background, physical or mental handicaps, or financial status.
- The right to receive appropriate accessible culturally sensitive medical services.
- The right to choose a Primary Care Physician in CCHP’s network, who has the responsibility to provide, coordinate and supervise care.
- The right to be seen for appointments within a reasonable period of time.
- The right to participate with practitioners in making health care decisions including the right to refuse treatment, to the extent permitted by law.
- The right to receive courteous response to all questions from Contra Costa Health Plan and its Health Partners.
- The right to voice complaints or appeals about Contra Costa Health Plan or the care it provides orally or in writing; and to disenroll.
- The right to health plan information which includes, but is not limited to: benefits and exclusions, after hours and emergency care, referrals to specialty providers and services, procedures regarding choosing and changing providers; and types of changes in services.
• Medi-Cal recipients have the right to seek family planning services from a Medi-Cal provider outside the network without a referral or authorization if the member elects to do so.
• The right to formulate advanced directives.
• The right to confidentiality concerning medical care.
• The right to be advised as to the reason for the presence of any individual while care is being provided.
• The right to access personal medical record.
• The right to have access to emergency services outside of the Plan’s provider network.
• Medi-Cal recipients have the right to request a fair hearing.
• The right to interpreter services.
• The right to access Federally Qualified Health Centers and Indian Health Services Facilities.
• The right to access minor consent services.
• The right to receive written Member informing materials in alternative formats, including Braille, large size print and audio format upon request.
• The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
• The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member’s condition and ability to understand.
• The right to freely exercise these rights without adversely affecting how the Member is treated by the health plan, providers or the state.
• The right to candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage
• A right to be treated with respect and recognition of their dignity and their right to privacy.
• The right to make recommendations regarding the Contra Costa Health Plan’s Member’s Rights and Responsibility policy.
• The right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

Member responsibilities include, but are not limited to:
• The responsibility to provide complete and accurate information about past and present medical illnesses including medications and other related matters.
• The responsibility to follow the treatment plan and instructions agreed upon with your health care providers.
• The responsibility to ask questions regarding condition and treatment plans until clearly understood.
• The responsibility to keep scheduled appointments or to call at least 24 hours in advance to cancel.
• The responsibility to call in advance for prescription refills.
• The responsibility to be courteous and cooperative to people who provide health care services.
• The responsibility to actively participate in their health and the health of the member’s family. This means taking care of problems before they become serious, following provider’s instructions, taking all medications as prescribed, and participating in health programs that keep one well.
The responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the best degree possible.

The responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

The responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

Commercial and Medi-Cal Members

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-HMO-2219 and a TDD line 1-877-688-9891 for the hearing and speech impaired. The department's website http://www.hmohelp.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 1-800-952-5253 (TDD call 1-800-952-8349) or write to:

Medi-Cal Fair Hearing Rights:
California Department of Social Services
Services State Hearing Division
• Box 944243, Mail Service 9-17-37
Sacramento, CA 94244-2420

Expedited Medi-Cal Fair Hearings:
California Department of Social
Services Expedited Fair Hearings Unit
744 P Street, Mail Service 9-17-37
Sacramento, CA 95814

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 Web Site http://www.hmohelp.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 http://www.dmhcc.ca.gov/dmhcc_consumer/pd/pd_imr.asp

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)
Section 13– QUALITY MANAGEMENT PROGRAM

The goal of CCHP’s Quality Management Program (QMP) is to ensure that high quality, appropriate health care and related services meet or exceed members’ and other stakeholders’ expectations. The Program’s mission is carried out in accordance with CCHP’s organizational mission to provide affordable, high quality, accessible health care with integrity and compassion to all that use our programs.

The scope of CCHP’s Quality activities include the quality of clinical care and the quality of service for all services including, but not limited to, preventive, primary, specialty, emergency, and ancillary care services. The scope of activities reflects CCHP’s population in terms of age groups, disease categories and special risk status, and includes, but is not limited to, services provided in institutional settings, inpatient settings, ambulatory care, home care, and mental health.

CCHP has a comprehensive Quality Management Program Description and Work Plan that is revised each year with the input from various committees including CCHP’s Quality Council.

QUALITY IMPROVEMENT INITIATIVES

Specific quality improvement, disease management, health education/promotion, and cultural and linguistic initiatives will be determined through collaborative processes including CCHP/CCHS clinical and administrative management staff. Providers are expected to cooperate with Quality Improvement activities.

Quality Improvement Projects may include:

- Reducing Health Disparities
- Improving Diabetes Care
- Reducing Pediatric Obesity
- Improving Blood Pressure Control
- Improving Nephropathy Screening and Treatment for Diabetics
- Improving Asthma Care

We have also begun a Population Health Management program which is implementing targeted interventions based on analysis of our population. So far, areas of focus have included asthma, diabetes, opiates, and members with multiple chronic illnesses, in addition to preventive reminders for the general population.

HEDIS HEALTHCARE QUALITY MEASUREMENT

CCHP’s Quality Management Department is responsible for calculating and reporting a set of HEDIS (Healthcare Effectiveness Data and Information Set) measures as required by the State. The results of these measures are reported to CCHP’s providers annually through the quarterly Provider Bulletin or in a separate mailing. In contracting with CCHP, a provider agrees to allow the health plan to use the provider’s performance data.
**NCQA ACCREDITATION**

CCHP’s Medi-Cal line of business has been accredited by NCQA since March 2014. This is the gold standard in health plan recognition, demonstrating a high level of excellence in our operations.

Accreditation status is good for three years; CCHP was again awarded Accreditation in February 2017 and again in March 2020.

**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
- 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.
ACCESS STANDARDS

The following table contains CCHP’s access standards. These standards will be monitored utilizing a variety of methods.

The following are examples of access monitoring methods used by CCHP: Member Satisfaction Surveys, Member Grievances, Facility Site Reviews, Provider Surveys, Appointment Reports, Advice Nurse Reports, Delegation Oversight Monitoring, and DMHC’s Provider Appointment Access Survey. Monitoring member complaints and reviewing member satisfaction survey results will be used to monitor and measure wait time standards for telephone responsiveness and provider in-office wait time, as well as for obtaining appointments. Data on telephone and office wait times are also gathered in provider surveys. Access data will be presented to Quality Council regularly for evaluation and determination of any action needing to be taken.

<table>
<thead>
<tr>
<th>ACCESS TOPIC</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>URGENT CARE APPOINTMENTS FOR SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION</td>
<td>48 hours</td>
</tr>
<tr>
<td>URGENT CARE APPOINTMENTS FOR SERVICES THAT REQUIRE PRIOR</td>
<td>96 hours</td>
</tr>
<tr>
<td>NON URGENT CARE APPOINTMENTS FOR PRIMARY CARE</td>
<td>10 business days</td>
</tr>
<tr>
<td>NON URGENT CARE APPOINTMENTS FOR SPECIALIST</td>
<td>15 business days</td>
</tr>
<tr>
<td>NON URGENT APPOINTMENTS FOR ANCILLARY SERVICES FOR THE DIAGNOSIS OR TREATMENT</td>
<td>15 business days</td>
</tr>
<tr>
<td>OF INJURY, ILLNESS, OR OTHER HEALTH CONDITION.</td>
<td></td>
</tr>
<tr>
<td>EMERGENCY CARE</td>
<td>Immediate</td>
</tr>
<tr>
<td>FIRST PREGNATAL VISIT</td>
<td>10 business days</td>
</tr>
<tr>
<td>MENTAL HEALTH (NON-PHYSICIAN PROVIDER)-ROUTINE</td>
<td>10 business days</td>
</tr>
<tr>
<td>MENTAL HEALTH- URGENT</td>
<td>48 hours</td>
</tr>
<tr>
<td>MENTAL HEALTH-EMERGENCY</td>
<td>Immediate</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>TELEPHONE WAIT TIME for PLAN and PRACTICE TO ANSWER</th>
<th>10 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE CALL BACK WAIT TIME</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

WAITING TIME IN PROVIDER OFFICE

The amount of time a member waits in a provider office and exam room must be reasonable according to the urgency of the individual’s condition. In most cases, it is reasonable for a member to wait 45 minutes or less from the scheduled appointment time until the provider enters the exam room.

| INITIAL HEALTH ASSESSMENT (Medi-Cal only)             | Within 120 calendar days of enrollment |
| RISK ASSESSMENT (Medi-Cal SPDs only)                  | 45 calendar days                      |
| SKILLED NURSING                                      | 7 days                                |

**SHORTENING OR EXPANDING TIMEFRAMES**

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.

Interpreter services are available at all CCHP points of contact where members may reasonably need such services. Interpreter services can be accessed by calling 1-866-874-3972 and provide the 6 digit client ID 298935. Refer to Provider Manual Section 11 Cultural and Linguistics Services for instructions on how to obtain interpreter services including face to face or in person interpreters, American Sign Language or to make a California Relay Service call.

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 patients. 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.
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 patient prior to the provider initiating treatment. A provider must report the occurrence regardless of whether or not 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 patient is a Medi-Cal beneficiary. The provider must also send a copy of the information to the member’s health plan: Fax to (925) 313-6870.

Health Care Acquired Conditions (For Any Inpatient Hospital Settings in Medicaid)
• Any unintended foreign object retained after surgery
• A clinically significant air embolism
• An incidence of blood incompatibility
• A stage III or stage IV pressure ulcer that developed during the patient’s stay in the hospital
• A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock
• A catheter-associated urinary tract infection
• Vascular catheter-associated infection
• Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity
• A surgical site infection following Coronary artery bypass graft (CABG), mediastinitis.
• Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery
• Orthopedic procedures; including spine, neck, shoulder, elbow
• Cardiac implantable electronic device procedures
• Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement with pediatric and obstetric exceptions
• Iatrogenic pneumothorax with venous catheterization
• A vascular catheter-associated infection

Other Provider Preventable Conditions (For Any Health Care Setting)
• Wrong surgical or other invasive procedure performed on a patient
• Surgical or other invasive procedure performed on the wrong body part
• Surgical or other invasive procedure performed on the wrong patient
Section 14 – PREVENTIVE HEALTH SERVICES

CCHP expects PCPs to follow the most current US Preventive Health Task Force (USPSTF) guidelines for preventive health services. CCHP requires providers to follow all USPSTF A and B level recommendations, which are listed here:
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Preventive Services require no copayment by the member.

CCHP’s preventive guidelines can be found at http://cchealth.org/healthplan/clinical-guidelines.php.

Initial Health Assessment (IHA)

PCPs are required to provide primary care services including follow-up and referral for specialty care as appropriate. For Medi-Cal members, PCPs are required to provide an Initial Health Assessment (IHA). The IHA is a comprehensive assessment that is completed during the member’s initial visit(s) with his or her primary care provider within 120 days, unless the PCP believes the member should be exempt from the IHA. Exemption and the reason member is exempt must be documented in the medical record. 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 is able to 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. There is an available field on the SHA form for refusal.)
- The member misses the scheduled appointment and two additional documented attempts to reschedule are unsuccessful.

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 two parts:

- History and Physical, sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include the following elements:
  - Member’s history of present illness
  - Member’s past medical history
  - Member’s social/mental health history
  - Review of the member’s organ systems
Individual Health Education Behavioral Assessment

An essential part of the IHA is the completion of the Individual Health Education Behavioral Assessment (IHEBA), also known as the Staying Healthy Assessment (SHA). The IHEBA must be documented in the member’s medical record and reviewed annually and re-administered at age-appropriate intervals by PCPs. The provider must sign and date the SHA whenever administered and discussed. Updated SHA forms with expanded age categories including 0–6 months, 7–12 months, 1–2 years, 3–4 years, 5–8 years, 9–11 years, 12–17 years and adults. See [http://cchealth.org/healthplan/providers/](http://cchealth.org/healthplan/providers/), under Forms and Resources, Staying Healthy Assessment.

**ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC)**

Annually, PCP’s are required to complete the Alcohol Misuse and Screening form for Medi-Cal members who misuse alcohol and if necessary perform a brief 15 minute intervention. 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.

**CHILD HEALTH AND DISABILITY PREVENTION**

CCHP encourages Providers to maintain certification with the Child Health and Disability Prevention Program (CHDP), and we expect the same standards in care to be provided to our members.

Children requiring CHDP care coordination should be referred to the CHDP program using the CHDP Care Coordination form. Referral forms should be filled out and returned to the CHDP Program via one of the following methods:

Confidential Fax:  925-372-5118  
Secure email:   chdp@cchealth.org  
Mail:   CHDP Program, 2500 Bates Ave.  Suite B Concord, CA 94520

Referral forms can be downloaded from the CCHS website at [https://cchealth.org/chdp/provider.php](https://cchealth.org/chdp/provider.php)

For questions about the CHDP Program and provider enrollment, contact them by email at chdp@cchealth.org or by phone at 925-313-6150.
Section 15 – 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 patients with suspected or confirmed TB disease to Contra Costa Public Health Tuberculosis Control Program. The Confidential Morbidity Report (CMR) form is available on the website including instructions and additional information required at [http://cchealth.org/tb/providers.php](http://cchealth.org/tb/providers.php).

- 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 on the website including instructions and additional information required at [http://cchealth.org/tb/providers.php](http://cchealth.org/tb/providers.php). After completing the form, fax it to Contra Costa Public Health (CCHP) at 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. Patient is contacted, interviewed, and if the diagnosis will be confirmed, patient 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 patient including medication adherence. The TB Control Program will provide information to CCHP about TB patients upon request.

- For questions about TB reporting, diagnosis, management of patients with LTBI confirmed or suspected TB disease or any medical consultation providers should call 925-313-6740.

**CHILDREN WITH SPECIAL NEEDS (CCS)**

California Children’s Services (CCS) offers medical coverage 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. However, CCHP will continue to cover eligible medical services that are not related to the CCS condition. Submitting a completed Prior Authorization Form (PA001) 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 medical facilities is posted in each provider manual; additionally a listing of CCS eligible physicians is available to community providers through CCHP.

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 eligible condition, the provider can fax prior authorization requests related to the CCS, to the local CCS Office.

California Children’s Services (CCS)
Fax: 925-313-6115

**DEVELOPMENTAL DELAY**

Behavioral Health Treatment for autism is a covered benefit for children (both Medi-Cal and Commercial members) diagnosed through a comprehensive assessment as having autism spectrum disorder ages 0 up to 21. Referrals to evaluate a child for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) can be sent to the Autism Behavior and Child Development Clinic (ABCD)

ABCD
Phone: 925-370-5025
Fax: 925-370-5277

For all referrals, leave child’s name, date of birth, parent’s name, call back number, address, and reason for referral. If you suspect autism, it is helpful to note that on the original referral, in order to obtain services more rapidly. Always send a copy of any referral to CCHP.

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 office can refer their member directly to the center:

Regional Center of the East Bay
Phone: 510-618-6195
Website: [www.rceb.org](http://www.rceb.org)

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 and Authorization Unit, who in turn, will forward to the school district for processing.
Section 16 – MEDICAL RECORDS

REQUIREMENTS

- CCHP will delegate the responsibility of maintaining medical records to contracted Providers (i.e. CCRMC).
- 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 the human sterilization consent procedures required by Title 22, CCR, and Section 51305.1 through 51305.6, if applicable.
- 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.

PCP’S WILL COMPLY WITH THE FOLLOWING:

1. Providers will maintain procedures for storage and filing of medical record including: collection, processing, maintenance, storage, retrieval identification, and distribution.
   - Providers will maintain a record-keeping system to make the individual medical record available for each member visit or contact.
   - Member ID will be noted on each page of the medical record.
   - 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.

2. 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.
3. Medical records will be maintained in a legible, current, detailed, organized and comprehensive manner. This will be reviewed during FSR.

4. 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.

5. Providers will establish a uniform medical records organization format and maintain all medical records in a consistent and comprehensivemanner.

**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 age twelve (12) or older. Included with the notation will be health education or counseling and anticipated guidance regarding such use.
Section 17 – HIPAA

CONFIDENTIALITY

All providers, their subcontractors and affiliates are expected to treat Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as all other applicable laws governing patient confidentiality.

Expectations Include But Are Not Limited To:

- Implementation of appropriate 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 PHI in offices, including safeguarding patient records, files and all communication pertaining to patients
- Implementation of the appropriate computer security safeguards, ensuring ONLY appropriate and authorized access to confidential information
- Ensuring secure electronic transmissions of confidential data
- Reporting any possible or real breach or unauthorized disclosure of PHI to the CCHP

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 HIPAA, 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.

California Penal Code Section 502 states, in part, that any person is guilty of public offense who:

- Knowingly access and without permission alter, damage, delete, destroy, or otherwise uses any data, computer, computer system or computer network in order to either a) devise or execute any scheme or artifice to defraud, deceive, or extort, or b) wrongfully control or obtain money, property or data
- Knowingly access and without permission take, copy, or make use of any data from a computer, computer system, computer network, or take or copy any supporting documentation, whether existing or residing internal or external to a computer, computer system, or computer network
- Knowingly accesses and without permission add, alter, damage, delete or destroy any data, computer software, or computer programs which reside or exist internal or external to a computer, computer system, or computer network
- Knowingly and without permission disrupt or cause the disruption of computer services or deny or cause the denial of computer services to an authorized user of a computer, computer system, or computer network
- Knowingly introduces any computer contaminant into any computer, computer system, or computer network
Section 18 – 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. Patients seeking treatment are for single visits. Patients 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.
Section 19 – PROVIDER RELATIONS DEPARTMENT

The Provider Relations Department is responsible for the centralization of the following services to CCRMC Providers:

- Facility Site Reviews
- Provider Complaints
- Provider Directory on-line and hard copy
- Provider Bulletin

**FACILITY SITE REVIEW**

CCHP requires all PCP and OB/GYN offices and clinics to undergo a full scope Facility Site Review (FSR) every three years. 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 the Provider Relations (PR) Nurse who is a Registered Nurse (RN) trained and certified by the state of California to conduct the review, and using the tool compiled by the California Department of Health Care Services Medi-Cal Managed Care Division. The PR 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.

(Tool can also be located on our website at www.cchealth.org/healthplan)

The full scope FSR includes a facility/site survey and a medical record review survey. Any noted deficiencies are reported in a Corrective Action Plan (CAP) and returned to the provider.

at the same time as the FSR and MRR, CCHP performs a survey for Physical Accessibility at all PCP and OB/GYN sites. This information will be made accessible to members via our provider directories and our on-line search engine (OSE). 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 and stand-alone surgery centers.

**CORRECTIVE ACTION PLAN FOR DEFICIENCIES ON THE FSR**

The Corrective Action Plan (CAP) is written specific to the noted deficiencies found during the FSR. It identifies modifications needed at provider offices to existing procedures or the development of new processes to meet standards and guidelines.

A specific time frame for compliance will be noted on the CAP and any needed follow-up will be initiated by the PR RN responsible for Facility Site Review and reported to Quality Council ON-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. 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.
**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 Directory located at [www.cchealth.org/healthplan](http://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.

**PROVIDER ROLES AND RESPONSIBILITIES – NEW PROVIDER ORIENTATION**

The CCHP Quality Management Department is responsible for orienting new providers to CCHP within ten (10) days of being placed active in the CCHP network. This orientation is performed through a link sent to the new provider at the time of onboarding to a power point and provider manual. The Provider Manual is available on our website at [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan). The Provider Manual is updated with new materials as changes occur. By request, a hard copy can be mailed to an existing provider. For the most recent edition, check the website.

The Power Point and Manual review the following:

- PCP and Specialty Provider Roles and Responsibilities
- Managed Care
- Seniors and Persons with Disabilities (SPD’s) Cultural Awareness and Sensitivity Training (Refer to Appendix P)
- Case Management Services (Refer to Appendix C)
- 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)
- Advice Nurse Services
- California Children Services
- 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
- Cultural Competency Training
- Facility Site Review (if applicable)
- Formulary
- Fraud, Waste and Abuse (Refer to Appendix H)
- Grievance, Complaints and Appeal Procedures and forms
- Independent Medical Review (IMR)
- Initial Comprehensive Health Assessments (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 IHA appointments.
- Interpreter Services
- Member Accessible Clinical Telephone Triage
• Member Assignment Process
• Member Rights
• Mental Health-AMSC—Alcohol Misuse Screening and Counseling, Mental Health services, including referrals for Applied Behavior Analysis
• Non-Physician Medical Practitioner Supervisor and 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 guidelines.
• Provider hours-Offers hours of operation that are no less than the hours of operation offered to other patients or comparable to Medi-Cal Fee-For-Service.
• 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. (Refer to Appendix E)
• WIC- (Refer to Appendix Q)
  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.

**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.
REGULATORY REQUIREMENTS

• CCHP may not prohibit providers from providing advice to patients 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 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, recredentialed 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 patients; or (ii) if provider had previously not accepted new patients, but provider is currently accepting new patients. If Provider is not accepting new patients, 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 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; facility site reviews, interactions with CCHP staff, CPN physicians or concerns regarding CCHP policies and procedures. The complaint form can be found at the following link. https://cchealth.org/healthplan/pdf/provider/Appendix-O-Provider-Complaint-Form.pdf All Provider Complaints are required to be submitted on the Provider Complaint Form (located on our website www.cchealth.org/healthplan under the topic Forms and Resources) 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. Medically related complaints will be referred to the Quality Management nurse 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 Complaint form by mail, e-mail, fax or by calling:

Contra Costa Health Plan  
Attn: Provider Relations  
595 Center Avenue Suite 100  
Martinez, California 94553 
Telephone: 1 877-800-7423 (option 6) or 925-313-9500 
Fax: 925-646-9907  
E-Mail: ProviderRelations@cchealth.org

Appeals are complaints expressed in writing requesting a review of a denied service. See Utilization Management (Section 2) 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, or disruptive and/or threatening behavior, but not for health status or diagnosis. To discharge a member from a provider’s practice:

Provider should notify the member in writing and a phone call why 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 if they have any questions.

The new provider is identified and appraised of the situation. IT assigns the member to the new provider.

PROVIDER DIRECTORIES

All credentialed and contracted providers are listed in our printed member directories, and our Online Provider Directory, available 24 hours a day, seven days a week at the following internet address: www.cchealth.org/healthplan. Searches provide 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 or 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 patients 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 Search by 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

ccLink is a communication tool between the Community Provider Network (CPN) and Contra Costa Health Plan and the Specialty Care Providers and Primary Care Providers at Contra Costa Regional Medical Center (CCRMC) and Health Centers. ccLink Provider Portal is based on best practices from other medical centers and health plans.

ccLink allows on-line access to CCHP member information and provides real-time eligibility inquiries about CCHP members. It allows a provider to submit and check the status of any required referral and to attach documentation to a referral being sent to CCHP for evaluation of an authorization.

You can also facilitate communication and streamline patient care across locations and disciplines.
FRAUD, WASTE AND ABUSE

On January 1, 2009, The Centers for Medicare and Medicaid Services (CMS) requirements for Fraud, Waste and Abuse (FWA) training for all contracted entities became effective.

The requirements can be found in 42 C.F.R. 422.503 (b) (4) (VI) and 42 C.F.R. 423.504 (b) (4) (VI). A copy of the training materials is included in Appendix H and is available on our website located at www.cchealth.org/heathplan.

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.

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. 100  
Martinez, CA 94553  
Phone: 925-313-9500  
Fax: 925-646-9907  
E-mail: ProviderRelations@cchealth.org

FWA may also be reported to the Office of Inspector General at: 1-800-HHSTIPS
For cases involving Medicare prescription drugs, to the Health Integrity Unit at: 1-877-772-3379
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 www.cchealth.org/healthplan under facilities) 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, but when discharged, the member’s on-going 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 (press 2).

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 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 www.cchealth.org/healthplan.

The formulary is updated quarterly.

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 925-313-9500 or by e-mail Providerrelations@cchealth.org.
# Appendices

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