PROVIDER MANUAL

2022

INTRODUCTION TO MEDI-CAL, CALOPTIMA AND CHOC HEALTH ALLIANCE

Medi-Cal

Medi-Cal is California's version of the federal Medicaid program for low-income families, children and persons with disabilities. Medi-Cal provides a core set of health benefits, including primary and specialty care, hospital services, immunizations, pregnancy-related services and nursing home care.

Medi-Cal Managed Care Program

The Department of Health Care Services (DHCS) contracts with a managed care health plan to administer services through established networks of organized systems of care, which emphasize primary and preventive care. These plans have networks of providers, including doctors, pharmacies, clinics, labs, and hospitals. Members must use the providers in their network when care is needed.

Website: www.medi-cal.ca.gov

CalOptima

CalOptima is a county organized health system (COHS) that administers health insurance programs for low-income children, adults, seniors and persons with disabilities in Orange County. As a Medi-Cal managed care health plan, CalOptima is funded by the state based on periodic fixed payments for each recipient enrolled in Medi-Cal.

Website: www.caloptima.org

CHOC Health Alliance (CHA)

CHA is a Physician Hospital Consortium (PHC) that coordinates medical services for Orange County's pediatric and young adult Medi-Cal recipients from birth to 21 years of age. CHA is comprised of CHOC Children's Hospital of Orange County and the CHOC Physicians Network (CPN), an independent organization of contracted primary care physicians, specialists, ancillary providers and allied health professionals.

Website: www.chochealthalliance.com

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Disclaimer: This manual is revised periodically. For the most recent version, please visit the CHA website at www.chochealthalliance.com. In the event of a conflict or inconsistency between a provider's contract and this manual, the terms of the contract take precedence.

SECTION A: CONTACT INFORMATION

A1: CHOC Health Alliance

Resources	**Contact Information**
Administrative Offices	(714) 565-5100
Member Services Available 24/7	(800) 424-2462
Member Services Hearing Impaired TTY / TDD	(800) 735-2922 English (800) 855-3000 Spanish
Provider Services Monday – Friday: 8 am-5 pm	(800) 387-1103
Provider Relations	providerrelations@choc.org
Claims Department	(800) 387-1103, **Option 1**
Claim and Payment Appeals Provider Dispute Resolution (PDR)	(800) 387-1103, **Option 1**
Prior Authorization Department	(800) 387-1103, **Option 2**
Website	www.chochealthalliance.com
Provider Portal (EZ-NET)	https://eznet.rchsd.org

SECTION A2: CALOPTIMA

Resources	Contact Information
General Information	(714) 246-8500
Main Location	505 City Parkway West Orange, CA 92868
Customer Service	(888) 587-8088
Provider Resource Line	(714) 246-8600
Website	www.caloptima.org
Behavioral Health	(855) 877-3885

SECTION A3: OTHER PROGRAMS AND SERVICES

Resources	Contact Information
Denti-Cal	(800) 322-6384
Medi-Cal Rx Customer Service *Pharmacy Benefit*	(800) 977-2273
Vision Service Plan (VSP)	(800) 615-1883
Vaccines for Children	(877) 243-8832
Regional Center of Orange County (RCOC)	(714) 796-5100
Orange County California Children's Services (CCS)	(714) 347-0300
Orange County Mental Health Plan	(800) 723-8641
Help Me Grow	(866) 476-9025

SECTION B: TOOLS AND RESOURCES

Section B1: Provider Relations (PR)

Provider Relations (PR) serves as a liaison between CHA and the provider community. Please feel free to reach out to them for any assistance you may need, including, but not limited to:

- Demographic changes
- Provider additions and terminations
- Authorization status
- Payment inquiries
- Member disenrollment
- Quality improvement and patient satisfaction
- Provider Incentive Program
- Provider and staff training

Contact your dedicated PR representative or email the PR team at providerrelations@choc.org.

Section B2: Website

Access CHA resources on our website at www.chochealthalliance.com. Resources include, but are not limited to:

- Provider portal link and registration form
- Provider training
- Prior Authorization, Provider Dispute Resolution (PDR) and other forms
- Best Practices and HEDIS® tools
- Claims and payment information

Section B3: Provider Portal

EZ-NET Services

EZ-NET is CHA's secure provider portal. To access your account, visit https://eznet.rchsd.org. Use EZ-NET to:

- Verify member eligibility and member's aid code
- Submit authorizations
- Check authorization status
- View claim status

Registration and Support

To register for an EZ-NET account:

- Visit www.chochealthalliance.com
- Download and complete the EZ-NET User Request form
- Fax the completed form to (858) 309-6279
- Once access is granted, a notification with instructions will be emailed to the new user

For access and training, contact Provider Relations at providerrelations@choc.org.

SECTION C: MEMBER SERVICES

C1: Member Eligibility

Providers must verify a member's eligibility on each date of service and prior to rendering services. If a member is not eligible, you may not receive payment for services provided on that date.

Verifying eligibility

Providers have multiple options for verifying a member's eligibility:

Eligibility Verification Systems	
Medi-Cal	Website: www.medi-cal.ca.gov Phone (AEVS): (800) 456-2387
CalOptima	Website: www.caloptima.org (see "CalOptima Link") Phone (IVR): (800) 463-0935
CHOC Health Alliance (CHA)	Provider Portal (EZ-NET): https://eznet.rchsd.org Phone: (800) 387-1103

C2: Primary Care Provider (PCP) Assignment

PCP Selection

New members can select a PCP at the time of enrollment by calling CHA Member Services at (800) 424-2462. If no choice is made, CHA auto-assigns the member using an algorithm that considers the members place of residence, primary spoken language, and other similar factors.

PCP Change

Members can change their PCP at any time by calling CHA Member Services at (800) 424-2462. The member, member's parent or legal guardian must make the PCP change request. The provider or office staff cannot make the request on behalf of the member.

Member Disenrollment

If the member-provider relationship is no longer positive and collaborative, the PCP can request the member's disenrollment (i.e. removal) from their panel.

- Member Disenrollment Criteria:
    - Non-compliance: Member repeatedly does not follow the recommended treatment and/or established office policies (missed appointments policy, etc.)
    - Disruptive behavior: Member or member's legal guardian exhibits threatening or inappropriate behavior towards the provider, staff or other patients
- What to Do Next:
    - Mail, fax or email a letter to Provider Relations stating detailed information on the reason(s) for requesting disenrollment
    - Mail a certified letter to the member stating the reason(s) for disenrollment
    - If the request fits the criteria, CHA will notify the member to select a new PCP

Until the change is complete, the current PCP must provide continued medical treatment or urgent care services to the member, for up to 30 days.

SECTION D: SERVICES COVERED BY CALOPTIMA

D1: Behavioral Health Services

CalOptima manages behavioral health treatment and outpatient mental health services for mild to moderate conditions. Severe cases may be referred to the Orange County Health Care Agency for specialized services.

Service	Access	Details
Outpatient Mental Health Services	CalOptima Behavioral Health: (855) 877-3885	• Treatment of mild to moderate mental health conditions • No prior authorization needed to start treatment
Behavioral Health Treatment (BHT)	CalOptima Behavioral Health: (855) 877-3885	• Treatment of autism spectrum disorder (ASD) • Services include applied behavioral analysis (ABA) and other evidence-based services • No prior authorization needed
Mental Health Services (Severe Cases)	Orange County Health Care Agency (HCA): (800) 723-8641	• Treatment of severe health mental conditions • Services directly through the Orange County Mental Health Plan (MHP) • Recommendation from a licensed provider is required

SECTION E: SERVICES COVERED BY MEDI-CAL

E1: Pharmacy Services

The Medi-Cal outpatient pharmacy benefit transitioned from CalOptima to Medi-Cal Fee-For-Service under a program called Medi-Cal Rx. DHCS is working with a contractor, Magellan Rx, to provide Medi-Cal Rx services. For more information on approved medications, pharmacy locations and member benefits, please visit the Medi-Cal Rx website https://medi-calrx.dhcs.ca.gov/home/ or contact Medi-Cal Rx Customer Service Center at (800) 977-2273.

SECTION F: CLAIMS

F1: Claim Submission Requirements

CHA Contracted Provider

Providers must submit claims and encounters to CHA for ALL services.

Medi-Cal Guidelines

Electronic and paper claims must follow Medi-Cal billing guidelines. For more information, visit www.medi-cal.ca.gov.

Timely Filing

File a claim on an electronic or paper form within **90 calendar days** of the date of service, unless otherwise specified by your contract. Failure to follow these guidelines may result in denial and nonpayment. (Non-contracted providers are subject to Medi-Cal billing guidelines.)

F2: Electronic Claim Submission

File claims and encounters electronically with one of our contracted vendors. To register for an account, contact Office Ally or Change Healthcare.

Vendor	Payer ID	Contact	Website
Office Ally	CHOC1	(866) 575-4120	www.officeally.com
Change Healthcare	33065 or SCH01	(866) 363-3361	www.changehealthcare.com

F3: Paper Claim Submission

If you must send a paper claim, mail it to the following address:

Via Mail:	Rady Children's Hospital – San Diego Attn: CHOC/CPN – Claims P.O. Box 1598 Orange, CA 92856
Via Physical Delivery:	Rady Children's Hospital – San Diego Attn: CHOC/CPN – Claims 5898 Copley Dr., Suite 307 San Diego, CA 92111

F4: Claim Status and Processing Time

Processing Time

The standard processing time for a claim is 30 business days from the date CHA receives the claim.

Status Updates

To check claim status:

- **Online**: Go to EZNet at https://eznet.rchsd.org/
- **Phone**: Contact the Claims Department at (800) 387-1103, Option 1

F5: California Children's Services (CCS) in the Whole Child Model (WCM)

Claim Requirements:

- Submit all claims to CHA for CCS services in the WCM
- Only include CCS diagnosis codes on claims for CCS services
- Prior authorization numbers must be included on claims

F6: Corrected Claims

What is a corrected claim?

A corrected claim is a resubmission of an existing claim. The corrected claim tells CHA that you are rebilling a previously submitted claim with the correct codes and/or modifiers, with the goal of payment.

Corrected Claim Submission

- Make the changes to the CPT, ICD-10, modifiers, etc. on a new paper form
- Stamp "corrected claim" on the document
- Mail the corrected claim to:

Via Mail:	Rady Children's Hospital – San Diego Attn: CHOC/CPN – Claims P.O. Box 1598 Orange, CA 92856
Via Physical Delivery:	Rady Children's Hospital – San Diego Attn: CHOC/CPN – Claims 5898 Copley Dr., Suite 307 San Diego, CA 92111

F7: Provider Complaint Process

CHA and CalOptima maintain a multi-level complaint process to review and resolve provider disputes for claims payment.

Provider Dispute Resolution (PDR)

A PDR is a provider's written request to CHA challenging or appealing a payment or denial of a claim. Disputes must be received within 365 calendar days from CHA's action that led to the dispute (or the most recent action if there are multiple actions).

- PDR Submission
    - Download the Provider Dispute Resolution request form at www.chochealthalliance.com
    - Fill out the form and attach supporting documentation

- Mail the completed form and documents to:

Via Mail:
Rady Children's Hospital
Attn: CHOC/CPN – Claims
3020 Children's Way, Mail Code 5144
San Diego, CA 92123

Via Physical Delivery:
Rady Children's Hospital – San Diego
Attn: CHOC/CPN – Claims
5898 Copley Dr., Suite 307
San Diego, CA 92111

- Receipt, Review and Resolution
  - CHA will acknowledge receipt by mail within 15 calendar days. If you do not receive an acknowledgment letter, contact CHA Provider Services at 800-387-1103.
  - CHA then reviews the PDR request to determine whether to uphold or to overturn the initial decision.
  - Once the decision is made, CHA will issue a dispute determination letter by mail within 45 days.

Second-Level Appeal

Providers who disagree with CHA's decision, may file a second-level appeal with the CalOptima Grievance and Appeals Resolution Services (GARS).

For additional resources on how to file a second-level appeal, visit www.caloptima.org/ForProviders/Resources/ProviderComplaintProcess.

SECTION G: PAYMENT

G1: Payment Disclaimer

Reimbursement for services is dependent on:

- Authorization of services
- Member eligibility
- Medical necessity
- Provider's contract

G2: Payment Models

What is Capitation?

Capitation is the fixed payment amount that a provider receives per-member-per-month (PMPM). It covers a defined scope of services (by procedure code) and varies based on a member's age and gender. Capitated services in CHA include:

- Most routine primary care services (e.g., sick visits)
- Most laboratory services (e.g., blood tests)

What is Fee-For-Service (FFS)?

Fee-For-Service (FFS) is the payment amount that a provider receives for Medi-Cal covered services not included under capitation. Services paid FFS include:

- Child Health and Disability Prevention (CHDP) services
- Certain "carve-out" primary care services (e.g. x-rays and minor surgical procedures)
- All services rendered to members with a Seniors and Persons with Disabilities (SPD) aid code
- Services rendered by Specialists, Ancillary Providers, and Hospitals

CHA pays providers according to the current Medi-Cal fee schedule. For more information visit, http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp.

G3: Coordination of Benefits (COB)

Coordination of benefits (COB) is required when a member is covered by one or more health insurers in addition to CHA. CHA is the payer of last resort and should be billed after all others.

Billing CHA and Other Health Coverage:

- First, file the claim with the primary insurer.
- If the primary insurer issues a partial payment or denial, submit a claim with a copy of the Explanation of Benefits (EOB), including the payment details, to CHA.
- If appropriate, CHA will pay the remaining balance up to the Medi-Call allowable amount.

G4: Member Billing

Federal and state law **prohibits** providers from charging or collecting payment from Medi-Cal eligible members for covered services, which includes, but is not limited to:

- Copayments, coinsurance or deductibles required by the member's other health coverage
- Pending or disputed claims
- Missed, canceled, or same day appointments
- Completing paperwork or forms related to the delivery of medical care, including but not limited to:
    - Immunization cards
    - Sports physical forms, or history of physical forms required by school
    - Disability forms
    - Forms related to Medi-Cal eligibility
- Other fees acquired while providing covered services to a Medi-Cal member

G5: Payment Vendor:

ECHO Health/Change Healthcare

The easiest and quickest way to receive payment from CHA is to register with our contracted vendor and choose a preferred payment method. Please see details for registration below:

- Visit the Provider Payments Portal at www.providerpayments.com. This portal is available for all methods of payment and offers detailed payment information, such as the Explanation of Provider Payment (EPP).
- Call ECHO Health at (888) 834-3511. Be sure to select a method of payment for both capitation and fee-for-service.

G6: Payment Methods

Electronic Funds Transfer (EFT)

Payments transmitted directly from CHA to the provider's bank account.

Virtual Card

Payments issued on a one-time-use virtual credit card. Standard merchant fees may apply.

Paper Check

Payments issued on a paper check and mailed to the provider's designated address.

G7: Support

Inquiry Type	Contact
General questions	CHA Provider Services: (800) 387-1103
Electronic Funds Transfer (EFT)	ECHO Health Customer Service: (888) 834-3511
Virtual card	ECHO Health Card Services: (877) 260-3681

SECTION G: REFERRALS AND AUTHORIZATIONS

H1: Services Requiring Prior Authorization

What is a direct referral?

A member may be sent to another contracted CHA practitioner for **consultation** without prior authorization from CHA, with the exception of Podiatry and Ophthalmology Specialists.

What is a prior authorization?

Services that require prior approval by CHA before those services are rendered.

If approved, the authorization stays active for a specified date range and may expire. For extension requests, complicated cases or any questions, contact CHA Provider Services at (800) 387-1103.

Services requiring prior authorization

For the most up-to-date information, download the CHA Quick Reference Guide available on our website - www.chochealthalliance.com.

Specialist Services	
• Hospital-based procedures & surgeries • Ophthalmology services (exclude E&M)	• Podiatry services • All office-based services (excludes E&M)

Other Services	
• Out of network providers • Inpatient services • Acupuncture • Chiropractic Services • Dialysis • Dr. Riba's Health Club • Durable Medical Equipment (DME) • Genetic Testing • Hearing Aids/ Cochlear Implants	• Home Health/Hospice/Palliative Care • Infusion • Injectable drugs, Chemotherapy • Medical and Incontinence supplies • Non-emergency medical transportation • Orthotics and Prosthetics • Surgical Procedures • Therapy services (Physical, Occupational, Speech)

H2: Requesting Prior Authorization

How to Submit Prior Authorizations

- Electronic Submission
  - Go to https://eznet.rchsd.org/EZ-NET60/Login.aspx
  - Sign in to your EZ-NET account
  - Under the Auth/Referrals tab, click Auth Submission
  - Fill out each section, attach relevant medical records and submit
- Fax Submission
  - Visit www.chochealthalliance.com to download and print the CHA Prior Authorization Form. Fax the completed form to (855) 867-0868.

Prior Authorizations for CCS Services in the WCM

CHA will process and approve authorizations for both CCS and Medi-Cal services. To simplify this process for providers:

- CHA created Condition-Specific Authorization Groups (CSAGS) for common CCS diagnoses
- Providers are only required to submit a single authorization request for these medical diagnoses
- CHA will follow existing prior authorization guidelines for all services, whether under CCS or Medi-Cal

Authorization Processing Time:

- Urgent Authorizations: within 72 hours
- Routine Authorizations: within 5 business days
- Retro-Authorizations: within 30 calendar days

Authorization Denial and Reconsideration

Providers may request reconsideration of a denial by submitting a formal appeal to CHA. Contact CHA Provider Services at (800) 387-1103 for more information.

Providers may contact a physician reviewer to discuss adverse determinations. The name of the reviewing physician and contact information is included in the authorization denial or may be obtained by contacting CHA Member Services at (800) 424-2462.

SECTION I: MODEL OF CARE

I1: Overview

The Model of Care programs address a special population of members living with chronic illness, or developmental, physical, and/or cognitive challenges. Medi-Cal members are identified as eligible for these programs through an aid code(s) assignment by CalOptima.

The Patient Care Coordinator is dedicated to helping members in our Case Management Program, Senior and Persons with Disabilities (SPD) Program, and Whole Child Model (WCM) Program. The Patient Care Coordinators work closely with health care providers, case managers and agencies throughout Orange County to help guide members through the healthcare system. They help members obtain proper care, timely referral to services, and connect them with health and community resources.

SECTION J: CALIFORNIA CHILDREN'S SERVICES AND WHOLE CHILD MODEL

J1: California Children's Services (CCS)

What is CCS?

CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.

What medical conditions are eligible?

Eligible conditions include severe physical disabilities resulting from congenital defects or those acquired through disease, accident or abnormal development. Examples include cerebral palsy, cystic fibrosis, cancer, heart conditions and orthopedic disorders.

Who determines eligibility?

The Orange County Health Care Agency determines CCS eligibility. Please note, CCS eligibility is separate from Medi-Cal eligibility.

For more information on eligibility, visit the Orange County Health Agency's CCS website - www.ochealthinfo.com/phs/about/ccs.

How can I become a CCS paneled provider?

Providers can apply to be CCS paneled through DHCS. Paneling instructions can be found at www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx.

J2: Whole Child Model (WCM)

What is the WCM?

The WCM is a program that aims to help CCS children and their families get better care coordination, access to care, and health results. WCM integrates services traditionally covered separately by CCS and Medi-Cal into one health plan. In Orange County, both CCS and Medi-Cal services will be managed by CalOptima and its health networks, like CHA, beginning July 1, 2019.

J3: WCM Services

Prior Authorizations

Prior authorizations for CCS services are the responsibility of each member's assigned health network in WCM. For CHA members, CHA will process and approve authorizations for both CCS and Medi-Cal services. To simplify this process for providers:

- CHA created Condition-Specific Authorization Groups (CSAGS) for common CCS diagnoses
- Providers are only required to submit a single authorization request for these medical diagnoses
- CHA will follow existing prior authorization guidelines for all other services, whether under CCS or Medi-Cal

J4: Billing and Payment

Providers submit all claims to CHA for CCS services in the WCM.

- Providers should only include CCS diagnosis codes on claims if treating a CCS condition.
- Prior authorization numbers are required on claims for processing.
- CHA follows the DHCS payment methodology for CCS-paneled providers.

SECTION K: SPD PROGRAM

K1: What is the SPD Program?

The Seniors and Persons with Disabilities (SPD) program addresses a special population of members living with chronic illness, or developmental, physical, and/or cognitive challenges.

K2: How are Members Classified as SPD?

- Department of Health Care Services (DHCS) assigns an aid code(s) to each Medi-Cal member; these codes are used to identify SPD members
- CalOptima contacts each SPD member to complete a health needs assessment
- Based on the assessment, CalOptima assigns a level of complexity (Basic, Care Coordination, or Complex Case Management)
- CalOptima sends the case to CHA's SPD program for assignment to a Patient Care Coordinator (PCC). PCCs provide ongoing assistance to the member and member's family (i.e. "concierge" services)

K3: Program Services

- Help to connect SPD members to services needed
- An Individual Care Plan (ICP) driven by parent concerns and medical recommendations, facilitated by a CHA nurse
- ICPs are sent to each member's PCP. The PCP reviews the ICT's medical recommendations and provides any additional input within 72 hours of receipt.
- CHA holds Interdisciplinary Care Team (ICT) meetings based on the ICP. PCPs are encouraged to attend Interdisciplinary Care Team (ICT) meetings via phone or in-person when possible.

SECTION L: CARE MANAGEMENT SERVICES

L1: Care Management and Coordination

The Care Management Team at CHOC Health Alliance is comprised of Nurses, Social Workers, Physicians and Patient Care Coordinators who work to facilitate care coordination to our members and families. The team provides assessment, evaluation , planning , facilitation, and advocacy to promote the best possible outcomes for our member. Once the care management referral is received our staff assigns the member to a level of case management services based on their specific needs and case complexity.

L2: Referrals for Care Coordination and Case Management

Who qualifies for services?

Case Management is an "opt in" program available to any member or family struggling to cope with medical, social, or emotional challenges related to an acute or chronic illness. All CHA members qualify, newborn to 21 years of age.

Referral Submissions

- **Fax or Email**: Fill out the Care Coordination/Case Management Request form and fax to (714) 628-9119 or email the form to CHACM@choc.org.
    - To access the request form, visit the CHA website at www.chochealthalliance.com
    - Include the member's relevant clinical records along with the form

L3: Contacting a Case Manager

Once a case is open, the referring provider will be notified by the assigned case manager. We encourage you to communicate with your member's case manager whenever necessary.

L4: When is a Case Closed?

The case is closed once the member achieves their goals, loses eligibility, ages out of CHA or stops participating.

SECTION M: COMPLIANCE

M1: Medi-Cal Enrollment

The Department of Health Care Services (DHCS) requires all CalOptima providers participating in Medi-Cal to enroll in the Medi-Cal program. This a statewide requirement affecting all contracted CalOptima providers.

Visit http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp to begin the provider enrollment process directly with DHCS.

M2: Credentialing

Initial Credentialing

Prior to participating in the CHA network, providers must become credentialed and approved by the CHA Credentialing and Performance Committee. Physicians, physician assistants, nurse practitioners and ancillary providers are responsible for the completion of CHA's credentialing application along with all required attachments.

Re-credentialing

Re-credentialing occurs every 36 months. A few months before the deadline, you will receive a pre-populated application from CHA's Credentialing Department. You are required to:

- Complete the application and verify that the pre-populated information is correct.
- Send the application to CHA's Credentialing Department for review.

For questions, please email chacredentialing@choc.org.

M3: Compliance Training Requirements

CalOptima requires all contracted providers and staff to complete annual training for the following areas. For more information, visit www.chochealthalliance.com or email providerrelations@choc.org.

- Fraud, Waste and Abuse
- Cultural Competency, including Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex and Asexual (LGBTQIA+) cultural competent training, as well as cultural and linguistic requirements
- SPD Awareness and Sensitivity

M4: Fraud Waste and Abuse (FWA)

What is Fraud, Waste and Abuse?

- **Fraud**: When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program
- **Waste**: Inefficiencies that result in unnecessary costs, which are considered a misuse of resources
- **Abuse**: When health care providers perform actions that directly or indirectly result in unnecessary costs to any health care program

In summary, fraud requires intent to deceive, while waste and abuse implies no knowledge of intent or wrongdoing.

How To Report Suspected Health Care Fraud

Suspected fraud or abuse should be reported to CalOptima immediately.

- Complete the Suspected Fraud or Abuse Referral form and attach all supporting documents, making sure all items are clear and legible. To obtain a copy of the form, please access the Providers section of the CalOptima website.

- Email the form and supporting documents to fraud@caloptima.org or fax the form and all supporting documents to CalOptima's Office of Compliance at 714-481-6457.

CalOptima's Special Investigations Unit (SIU) will investigate cases to determine if potential fraud or abuse exists, refer potential fraud and abuse cases to the appropriate entity, and document the process for each case. CalOptima may coordinate an independent internal investigation with other CalOptima departments and FDRs, health networks, or any other delegated entity, including procuring the services of contracted investigators, as needed.

CalOptima will report, as appropriate, to all local, state and federal entities.

M5: Cultural Competency

What is cultural competence?

- Acceptance and respect for differences
- Ongoing development of cultural knowledge and resources
- Understanding of how culture and language may influence health

M6: SPD Awareness

Contracted providers and staff agree to:

- Serve all members with compassion and respect
- Ensure communications, physical spaces, services and programs are accessible to people with special needs, including visual, hearing, cognitive and physical disabilities
- Be the member's partner in health care

SECTION N: ACCESS AND AVAILABILITY

N1: Appointment Access Standards

Providers are responsible to be available during regular business hours and have coverage after-hours.

Emergency and Urgent Care Services

Type of Care	Standard
Emergency Services	Immediately, 24/7
Urgent Care Services	Offered within 24 hours of request

Primary Care Services

Type of Care	Standard
Urgent Appointment	Offered within 48 hours of request
Routine Appointment	Offered within 10 business days of request
Physical Exams and Wellness Visits	Offered within 30 calendar days of request
Initial Health Assessment (IHA) Staying Health Assessment (SHA)	Offered within 120 calendar days of CalOptima enrollment

Specialty and Ancillary Care

Type of Care	Standard
Urgent Appointment	Offered within 96 hours of request
Non-Urgent Specialty Care	Offered within 15 business days of request
First Prenatal Visit	Offered within 10 business days of request
Non-Urgent Ancillary Services	Offered within 15 business days of request

N2: Telephone Access Standards

During Business Hours

Description	Standard
In-coming calls	Answer phone calls within 30 seconds
Returning general phone calls	Return phone calls within 24 hours
Returning urgent messages	Return urgent phones calls within 30 minutes
Emergency phone calls	Refer members to the nearest emergency room
In-coming calls	Answer phone calls within 30 seconds

After Business Hours

Description	Standard
After-hours access	PCP or designee must be available 24/7 to respond to emergent calls
Live attendant	If an emergency, instruct the member to call 911 or go to the nearest ER
Recorded message	Recorded messages must include: “if you feel that this is an emergency, hang up and dial 911 or go to the nearest ER.”

N3: Cultural and Linguistic Standards

Description	Standard
Oral Interpretation	Oral interpretation including, but not limited to, sign language, shall be made available to members at key points of contact through an interpreter in person (upon a member's request) or by telephone, 24 hours a day and seven days a week.
Written Translation	All written materials to members shall be available in threshold languages as determined by CalOptima
Alternative Forms of Communication	Informational and educational information for members in alterative formats will be available at no cost in the threshold languages in at least 14 point font, audio format, or braille upon request, or as needed within 21 business days of request or within a timely manner for the format requested
Telecommunications Device for the Deaf	Telecommunications Device for the Deaf (TDD) or California Relay Services (CRS) and auxiliary aids shall be available to members with hearing, speech or sight impairments at no cost, 24 hours a fay and seven days a week. The TDD/TTY line is (800) 735-2922
Cultural Sensitivity	Practitioners and staff shall encourage members to express their spiritual beliefs and cultural practices, be familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrate these beliefs into treatment plans.

SECTION O: PEDIATRIC PREVENTIVE SERVICES

O1: Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The federally mandated EPSDT Program provides comprehensive and preventive health care services for children under age 21. EPSDT is key to ensuring that children and adolescents receive preventive, dental, mental health, developmental, and specialty services.

- **Early**: Assessing and identifying problems early
- **Periodic**: Checking children's health at periodic, age-intervals
- **Screening**: Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
- **Diagnostic**: Performing diagnostic tests to follow up when a risk is identified
- **Treatment**: Control, correct or reduce health problems found

O2: Child Health and Disability Prevention (CHDP)

The CHDP program oversees the screening and follow-up components of the federally mandated EPSDT program for Medi-Cal eligible children and youth. PCPs are required to ensure that all age and risk appropriate preventive services are provided, including, but not limited to:

- Immunizations following Federal and California State Standards
- Education of the importance of CHDP services
- Referrals for those with developmental disabilities for appropriate services
- Document each CHDP assessment in the medical record (paper or electronic)
- Report CHDP visits by recording the applicable current procedural terminology (CPT) preventive codes when submitting claims and encounters

O3: CHDP FAQs

Q: Which Periodicity Schedule should providers follow?

A: CHA will reimburse providers according to Bright Futures Periodicity Schedule, developed by the American Academy of Pediatrics (AAP).

Q: Is an authorization necessary before rendering CHDP services?

A: No, an authorization is not required.

Q: Will a provider be paid if an examination is performed is prior to its "due date"?

A: CHA will reimburse for services performed prior to the "due date."

SECTION P: REQUIRED HEALTH ASSESSMENTS

P1: Initial Health Assessment (IHA)

What is the IHA?

The IHA consists of a:

- Comprehensive health history
- Assessment of health education needs
- Physical assessment
- Specific evaluation including, tests, immunizations, counseling, follow-up and treatments

PCPs must perform the IHA within 120 calendar days of a member's enrollment in CalOptima.

P2: Staying Healthy Assessment (SHA)

What is the SHA?

The SHA consists of seven (7) age-specific questionnaires available on our website – www.chochealthalliance.com and the DHCS website - www.dhcs.ca.gov.

The SHA assists PCPs in:

- Identifying and tracking individual health risks and behaviors
- Targeting health education
- Counseling interventions
- Providing referrals and follow-up

For any questions, please contact providerrelations@choc.org.

SECTION P: HEDIS® PERFORMANCE

Q1: What is HEDIS®?

HEDIS® consists of a set of performance measures used by health plans that compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction

Q2: CHA and HEDIS® Performance

Why is HEDIS Important?

HEDIS® ensures we are offering quality preventive care and service to our members. By proactively managing patients' care, you can effectively monitor their health and identify issues that may arise with their care.

We work with our providers to continuously improve performance on HEDIS® scores. Contact PR to review your performance and find opportunities for improvement.

For more information and resources, contact PR at providerrelations@choc.org or visit www.chochealthalliance.com.

SECTION R: LONG-TERM SERVICES AND SUPPORTS

R1: Overview

CalOptima administers the following Long-Term Support Services (LTSS):

- Long-term care (LTC) as a Medi-Cal managed care plan benefit
- Community-Based Adult Services (CBAS) as a Medi-Cal managed care benefit
- Multipurpose Senior Services Program (MSSP) as a Medi-Cal managed care plan benefit
- IHSS: For Initial referrals only for In-Home Supportive Services (IHSS)

Who should be referred for LTSS? Members who:

- Need social support
- Need assistance with activities of daily living
- Qualify for a nursing home but want to stay at home
- Need caregiver support
- Have issues with current LTSS services
- Indicate they need more support
- Have a history of repeated hospitalization
- Request non-medical help

R2: Community-Based Adult Services (CBAS)

CalOptima is responsible for determining CBAS eligibility and medical necessity criteria. CalOptima may receive an inquiry for CBAS from a variety of sources, including: CBAS center, a member or member's authorized representative, a member's primary care provider (PCP) or specialist, a member's case manager or personal care coordinator. CalOptima may also initiate an evaluation based on the results of the member's initial risk stratification or health risk assessment results. For members

assigned to CalOptima and health networks, CalOptima's Long-Term Support Services staff shall process all CBAS benefit inquiries and CBAS authorizations requests.

Community-Based Adult Services (CBAS) offers services to frail older adults or adults with disabilities, to restore or maintain their capacity for self-care and delay moving into an institutionalized setting. CBAS services include:

- An individual assessment
- Professional nursing services
- Therapeutic activities
- Social services
- Personal care
- One meal per day
- Physical, occupational and speech therapies as needed
- Mental health services as needed
- Nutrition services as needed
- Transportation to and from the member's residence and CBAS center as needed

In order to quality for CBAS, members must meet the following eligibility requirements for the CBAS program:

- Must be enrolled in CalOptima in the Medi-Cal
- Must be at least 18 years of age or older
- Meet Nursing Facility-A (NF-A) level of care or above or
- Have an organic, acquired or traumatic brain injury or chronic mental health condition or
- Have moderate to severe cognitive disorder such as Alzheimer's disease or other dementia or
- Have mild cognitive impairment or
- Have developmental disabilities that meet Regional Center criteria and eligibility

CalOptima LTSS staff or contracted registered nurse will perform a face-to-face)F2F) assessment of the member within 30 calendar days of receipt of the initial eligibility inquiry. CalOptima shall not require an initial F2F review when adequate documentation is available to make a determination that a member is eligible to receive CBAS. CalOptima LTSS clinical staff shall make CBAS eligibility and medical necessity determinations based on available clinical documentation. These include:

- History and physical
- Laboratory results
- Diagnostic reports
- Medication profiles
- Facility discharge summary
- PCP or specialist progress notes

Grievances and Appeals

If a member does not meet CBAS eligibility and medical necessity criteria, CalOptima will deny the request and notify the member of the denial decision in writing through use of the Notice of Action or Integrated Notice of Denial that addresses members' right to file an appeal or grievance under state and federal law.

CBAS Authorization Process

CBAS centers must submit the following documentation via facsimile to the CalOptima LTSS department:

- The completed CalOptima CBAS Authorization Request Forms (ARF) to include the following information:
    - A start and end date
    - Total number of days requested per week
    - Total number of days requested in a six-month period
    - The member's individualized plan of care
- An authorization is required initially before a member attends CBAS and every six months thereafter.

R3: In-Home Supportive Services (IHSS)

The objective of the IHSS program is to allow eligible individuals to live safely at home in the least restrictive living environment.

Responsibilities of the Social Services Agency

The Social Services Agency (SSA) is responsible for performing the tasks related to the administration of the IHSS program.

The SSA is responsible for verifying and processing IHSS applications. Once the IHSS application intake process is completed, the IHSS social worker shall conduct an in-home, face-to-face assessment and make a determination whether to approve, modify or deny the application, including determination of authorized hours.

Responsibilities of IHSS PA

IHSS PA is responsible for the following:

- IHSS provider enrollment
- Provider orientation
- Retention of enrollment documentation
- Assistance to IHSS recipients in finding IHSS-eligible providers
- Conducting criminal background checks of all potential IHSS providers
- Acting as an employer of record for IHSS individual providers serving IHSS recipients
- Performance of quality assurance activities
- Provision of administrative support for IHSS advisory committee

Interdisciplinary Care Team (ICT)

Based on the member's identified needs, CalOptima or CHA will offer an ICT to all high-risk members to discuss a plan of care.

- CalOptima or CHA shall coordinate with the county SSA IHSS social worker to participate in the member's interdisciplinary care team conference, when appropriate.

- With the member's or member's authorized representative's consent, the SSA IHSS social worker and IHSS provider may participate in the ICT meeting
- The member's consent and the ICT's recommendations shall be recorded in the member's electronic medical record.

R4: Contact Information

For more information from CalOptima for CBAS or IHSS services (initial referrals only), contact Long-Term Support Services at 714-246-8444.

In order to apply for In-Home Supportive Services (IHSS), members may call Orange County In-Home Supportive Services (IHSS) at 714-825-3000, Monday through Friday, from 8 a.m. to 5 p.m. A social worker will speak to the member about the help they may need and what costs, if any, the member may be required to pay for the services. The social worker will visit the member's home and conduct a needs assessment.

SECTION S: QUALITY OF CARE ISSUES

S1: Reporting Potential Quality of Care Issues

CalOptima monitors the quality of care provided to members by its health networks and providers. As a part of this monitoring effort, CalOptima has a process for identifying and receiving reports of potential quality of care issues. CalOptima performs case reviews, investigate potential quality of care issues and determine the severity of issues. Based upon these investigations, CalOptima determine the appropriate follow-up action required for individual cases. CalOptima also aggregates potential quality of care issues data to help identify problems within the provider network.

What Constitutes Potential Quality of Care Issues

Potential quality of care issues may include any of the following types of cases:

- A clinical issue or judgement that affects a member's care and has the potential for an adverse effect. This may include
    - Delay in care or treatment, or delay in referral for testing or to a specialist that adversely affected the member's health
    - Unnecessary prolonged treatment, complications or readmission
    - Patient management of lack of treatment results in significantly diminished health status, impairment, disability or death
    - An unexpected occurrence involving death or serious physical or psychological injury

Members, providers, practitioners, health networks, and CalOptima staff may each report potential quality of care issues

S2: How to Report a Potential Quality of Care Issue

The quality of care issue should be directed to:

CalOptima

Attention: Quality Improvement

505 City Parkway West

Orange, CA 92868

Or qualityofcare@caloptima.org

Please include the member's name, CIN, provider's full name, and a description of the issue or concern.

What Happens Once a Potential Quality of Care Issues Complaint is Filed?

CalOptima will request that CHA gather medical records and the providers response to the complaint. CalOptima shall conduct a case review of the member's medical records and provider's response and evaluate the issue.

CalOptima's physician reviewer will determine if a quality of care issue has occurred. If a quality issue exists, CalOptima's Credentialing and Peer Review Subcommittee may request corrective action.

Will the Provider or Party Filing the Complaint Hear About Resolution?

The reporting provider will not be informed of the outcome of the complaint. Only those directly involved in the case will be knowledgeable of the outcome.

SECTION T: MEMBER HEALTH EDUCATION PROGRAMS

T1: Referrals for Health and Wellness Services

Health and Wellness services are provided at no cost by CalOptima Population Health Management (PHM). These are covered benefits for eligible CHA members. CalOptima provides organized programs, services, and education to assist Members in improving their health and managing illness.

CalOptima's health and wellness topics include, but are not limited to:

- Asthma
- Cholesterol
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Depression
- Fitness or exercise
- Heart disease
- High Blood Pressure
- Injury Prevention
- Preventive screenings
- Nutrition
- Pregnancy
- Tobacco cessation
- Weight control

CalOptima has a program for members with chronic conditions, e.g. asthma and diabetes. Members meeting certain clinical criteria are identified and automatically enrolled into the disease management program. Newly identified members receive an introductory letter informing them of their eligibility to participate in the program, along with instructions on how to opt out of the program if they so choose.

CalOptima stratified the identified members into two risk categories based upon the severity of their condition and utilization characteristics. These risk levels determine the type of intervention that the disease management program applies:

- High Risk – Members receive 1:1 telephonic counseling on condition self-management, coaching on medication adherence and lifestyle changes, required tests and shots, depression assessment, and reminder letters, in addition to low-risk services

- Low Risk – Members receive educational mailings, disease-specific newsletter publications with articles on health management and resources, such as community classes

T2: Referring Members Who Would Benefit from Health and Wellness Services and Opt Out Option

Providers can help identify members who would likely benefit from receiving health and wellness services. These are members who require adherence and maintenance to manage their chronic conditions.

Referring a Member

To refer a member, providers may complete a Health and Wellness Referral Form under Resources in the Providers section of the CalOptima website https://www.caloptima.org and fax it to: 714-338-3127. Members can self-refer to CalOptima's programs by calling 714-246-8895.

Opting Out of the Health and Wellness Services

Some identified members may receive health education materials about their chronic conditions. If a member would like to opt out of the program, ask the member to call CalOptima Population Health Management at 714-246-8895.

SECTION U: HIPAA PRIVACY

U1: About HIPAA Privacy

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires CHA and its providers to protect the security and privacy of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights, including the right to file a privacy complaint.

PHI is any individually identifiable health information, including demographic information, PHI includes a member's name, address, phone number, medical information, Social Security number, card identification number, date of birth, financial information, etc.

CHA supports the efforts of its providers to comply with HIPAA requirements. Because patient information is critical to carrying out health care operations and payment, CHA and its providers need to work together to comply with HIPAA requirements in terms of protecting patient privacy rights, safeguarding PHI and providing patients with access to their own PHI upon request.

U2: Reporting a Breach of PHI

A breach is an unauthorized access, use or disclosure of Protected Health Information (PHI) that violates either federal or state laws (HIPAA Privacy Rule and State Information Practices Act of 1977) or PHI that is reasonable believed to have been acquired by an unauthorized person. A breach may be paper, verbal, or electronic.

If you would like information regarding what constitutes a breach of PHI, visit the U.S. Department of Health & Human Services' website at www.hhs.gov/hipaa.

If a provider becomes aware that a breach of PHI has occurred affecting any CHA member, whether caused by CalOptima, CHA, a delegated entity or an FDR, the provider should notify CHA and CalOptima immediately upon discovery. To report a breach to CHA, call 877-388-8588 or email compliancehotline@choc.org. To report a breach to CalOptima, call 888-587-8088 and ask for the Privacy Officer, or email privacy@caloptima.org.

SECTION V: NETWORK CERTIFICATION REQUIREMENTS

V1: Overview

Managed Care Plans are required to annually submit documentation to DCHS to demonstrate adequacy of their networks for the upcoming calendar year. DHCS reviews all MCP network submissions and provides assurance of CalOptima's compliance with the Annual Network Certification (ANC) requirements to the Centers for Medicare & Medicaid Services before the calendar year begins.

CalOptima must complete and submit accurate data and information to DHCS that reflects the entire makeup of all network providers that are reviewed for ANC requirements.

V2: Subcontracted Network Certification Monitoring Activities

CHA is responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance.

SECTION W: CALOPTIMA POLICIES & PROCEDURES

W1: Overview

A complete library of CalOptima policies and procedures can be found on their Compliance 360 site

Resource Guides (caloptima.org)

SECTION X: INDIVIDUAL HEALTH EDUCATION BEHAVIORAL ASSESSMENT (IHEBA)

X1: Requirement

CalOptima requires providers to administer an IHEBA as part of an IHA. Providers should administer the IHEBA utilizing the Staying Healthy Assessment (SHA), or other tool approved by CalOptima and the Department of Health Care Services

X2: Overview

The SHA consists of seven (7) age-specific questionnaires available on our website www.chochealthalliance.com and the DHCS website www.dhcs.ca.gov.

The SHA assists PCPs in:

- Identifying and tracking individual health risks and behaviors
- Targeting health education
- Counseling interventions
- Providing referrals and follow-up

SECTION Y: MEMBER RESOURCES

Y1: Member Rights and Responsibilities

CHA is required to inform its members of their rights and responsibilities, which are listed in the Member Handbook. Member Documents (caloptima.org)

Providers are required to post the members' rights and responsibilities in the waiting room of the facility in which services are rendered.

Y2: Member Benefits

Covered services are listed in the CalOptima Member Handbook. For more details, members can call CalOptima's Customer Service department at (714) 246-8500 or toll-free at (888) 587-8088 (TTY 711) or go to their website: Benefits (caloptima.org)

Y3: Member Grievances and Appeals

A **complaint** (or **grievance**) is when a member has a problem with their Health Network, CalOptima, or a provider.

An **appeal** is when a member does not agree with their Health Network or CalOptima's decision not to cover or change their services.

Members can submit a grievance or appeal by:

- Contact CalOptima's Customer Service department (714) 246-8500
- Fill out a member grievance or appeal on CalOptima's website
- Visit CalOptima's office at 505 City Parkway West, Orange, CA 92868
- Fill out a member complaint form and mail it to CalOptima

CalOptima

Grievance and Appeals Resolution Services

505 City Parkway West

Orange, CA 92868