CHOC Health Alliance

CHA Provider Training

January 2024

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Medi-Cal

Website: www.medi-cal.ca.gov

Medi-Cal is California's Medicaid program for low-income families, children, seniors, and persons with disabilities. The Department of Health Care Services (DHCS) administers the Medi-Cal program and has responsibility to formulate policy that conforms to federal and state requirements. The DHCS contracts with a managed care health plan to administer services through established networks of organized systems of care. The objective of the Medi-Cal program is to provide essential medical care and services to preserve health, alleviate sickness and mitigate handicapping conditions for eligible beneficiaries.

CalOptima Health

Website: www.caloptima.org

CalOptima Health 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. CalOptima Health manages programs funded by the state and federal governments but operates independently.

CHOC Health Alliance (CHA)

Website: www.chochealthalliance.com

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. Members must use the providers in their network when care is needed.

Medi-Cal Programs

Covered Services

Overview

"Covered Services" refers to those medically necessary items and services available to a member. These services include Medi-Cal covered services and optional Medi-Cal services administered by CalOptima Health, as well as Medi-Cal covered services not administered by CalOptima Health.

For more information about Medi-Cal covered services, please follow the link: Medi-Cal Providers

Early and Periodic Screening, Diagnosis and Treatment Referrals

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are initial, periodic or additional health assessments of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the CHDP program.

EPSDT services include medically necessary behavioral health treatment (BHT) for Medi-Cal eligible individuals less than 21 years of age. BHT includes, but is not limited to, applied behavioral analysis (ABA).

EPSDT supplemental services include, but are not limited to:

- Acupuncture
- Audiology
- Chiropractic
- Cochlear implants
- Case management services
- Hearing aid batteries
- In-Home private duty nursing
- Medical nutrition services
- Occupational therapy
- Pediatric day health care
- Speech Therapy

Child Health and Disability Prevention (CHDP) Program

What is the CHDP?

The CHDP program oversees the screening and follow-up components of the federally mandated EPSDT program for Medi-Cal eligible children and youth.

- 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

CalOptima Health refers to this program as the Pediatric Preventive Services (PPS) Program. CalOptima Health's PPS program follows the American Academy of Pediatrics (AAP) guidelines, which cover 14 additional regular preventive health assessments over and above those covered by the CHDP program.

Pediatric Preventive Services Guidelines

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	8 d-1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	→	★	★	★		★	★	★	★	★	★	●	●	●	★	●	★	●	←	●	→	←	●	→	←		●	→		
DEVELOPMENTAL/BEHAVIORAL HEALTH																																
Developmental Screening[11]							●			●			●																				
Autism Spectrum Disorder Screening[12]										●		●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																									
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[10]	●[10]	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	▲	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	●	→	★	★	★	★	★	←			●	→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←	●	→	★	★	★	★
Hepatitis C Virus Infection[31]																													●	→		
Cervical Dyslasia[32]																																●
ORAL HEALTH[33]							●[34]	●[34]	★		★	★	★	★	★	★	★															
Fluoride Varnish[35]							←		●		→																					
Fluoride Supplementation[36]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on this schedule, or if any items are not accomplished at the suggested age, this schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://pediatrics.aappublications.org/content/142/1/e20181218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://pediatrics.aappublications.org/content/145/1/e20193449).
12. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://pediatrics.aappublications.org/content/145/1/e20193447).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://crafft.org.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://pediatrics.aappublications.org/content/143/1/e20183259).
17. At each visit, age-appropriate physical examination is essential, with infant totally undressed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/newborn-screening/states) establish the criteria for and coverage of newborn screening procedures and programs.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

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Initial Health Assessment (IHA)

What is the IHA?

The Department of Health Care Services (DHCS) requires all new Medi-Cal members complete their comprehensive Initial Health Assessments with their primary care provider within 120 days from plan enrollment. The Initial Health Assessment (IHA) can be completed by a primary care physician (PCP), nurse practitioner, certified nurse midwife, or physician assistant. At a minimum, it must include:

- Comprehensive health history
- Preventive services
- Comprehensive physical and mental status exam
- Diagnoses and plan of care
- Individual Health Education Behavioral Assessment (IHEBA) also know as the Staying Healthy Assessment (SHA) for each appropriate age group

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

Individual Health Education Behavioral Assessment (IHEBA)

Requirement:

CalOptima Health 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 Health and the Department of Health Care Services

What is the Staying Healthy Assessment?

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

SHA Coding

96156 – Health Behavior Assessment or Reassessment

Pharmacy Services

The Medi-Cal outpatient pharmacy benefit transitioned from CalOptima Health 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.

Be aware there may be some exceptions in which medications are managed by another entity. For example, physician administered medications are the responsibility of CalOptima Health.

Electronic Visit Verification (EVV)

In California, for Medi-Cal Electronic Visit Verification (CalEVV) is a telephone and computer-based solution that electronically verifies when **in-home** service visits occurred for Personal Care Services (PCS) and Home Health Care Services (HHCS).

All EVV systems must electronically verify the following six visit data elements:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the services
- Time the service begins and ends

For additional information, please visit the DHCS website: EVV (ca.gov)

Electronic Visit Verification (EVV)

CalEVV is required for the following provider types:

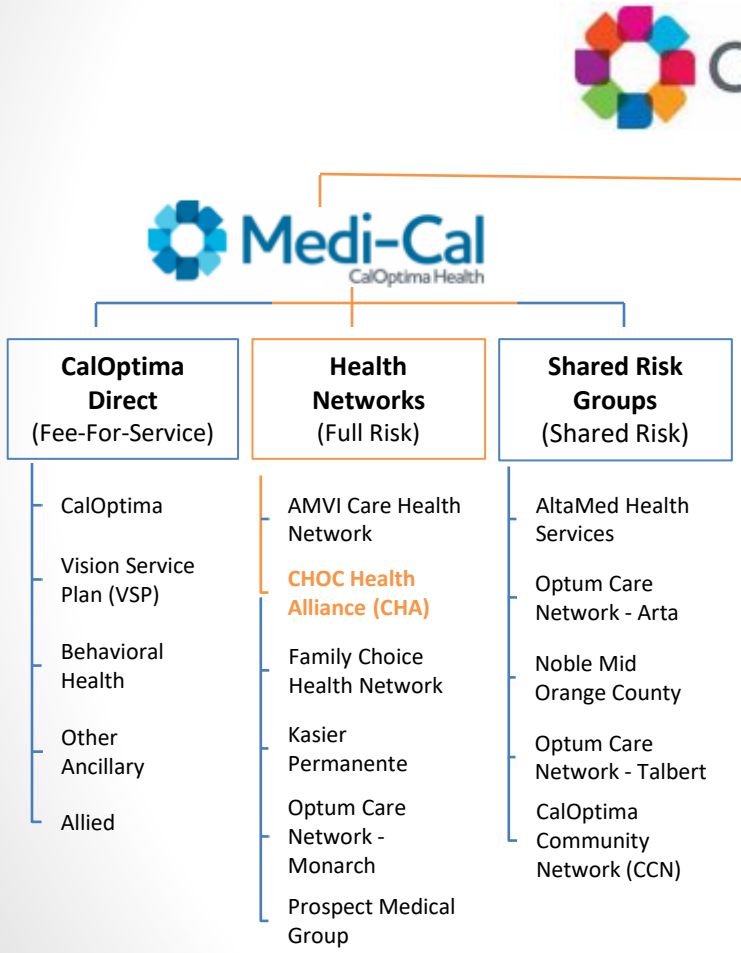
- AIDS Waiver Services
- Employment Agency
- Home and Community Based Services (HCBS) Benefit Provider
- Home Health Agency
- Licensed Clinical Social Worker
- Licensed Vocational Nurse, Registered Nurse
- Multipurpose Senior Services Program (MSSP)
- Non-Profit Proprietary Agency
- Occupational Therapist
- Personal Care Agency
- Physical Therapist
- Professional Corporation
- Speech Therapist

Providers who provide in-home services are required to register with CalEVV in the Provider Self-Registration portal: https://vendorregistration.calevv.com/

CalOptima Health Operations

CalOptima Health Programs

CalOptima Health Programs



Please Note: Each Health Network may have its own unique authorization, billing and service procedures.

While CHA is responsible for professional, facility, and ancillary services, some services may be authorized by CHA but the financial responsibility of CalOptima Health (such as Private Duty Nursing and Physician Administered Medications).

Whole Child Model (WCM)

What is the WCM?

The WCM is a program that aims to help children up to age 21 eligible for CCS and their families get better care coordination, access to care, and health results.

CalOptima Health members who are CCS-eligible will receive their CCS and non-CCS services under CalOptima Health's WCM program. In Orange County, both CCS and Medi-Cal services will be managed by CalOptima Health and its health networks, like CHA.

California Children's Services (CCS) Program

What is CCS?

CCS is a state program that treats children under 21 years of age with certain health conditions, diseases or chronic health problems.

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 https://www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx

California Advancing and Innovating Medi-Cal (CalAIM)

Enhanced Care Management

Community Supports

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multiyear initiative by the DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms across the Medi-Cal program.

The initiative leverages Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, including individuals experiencing homelessness, children with complex medical conditions, justice-involved populations who have significant clinical needs, and the growing aging population.

Goals:

- Improve member and provider experience through whole person care approaches and addressing Social Determinants of Health
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility
- Improve quality outcomes, reduce health disparities and drive innovation

For additional information: California Advancing and Innovating Medi-Cal (CalAIM) (caloptima.org)

Enhanced Care Management (ECM)

DHCS will establish a new, statewide ECM benefit under the CalAIM initiative. ECM would provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal members. ECM builds on the current Health Homes Program (HHP) and Whole Person Care (WCP) Program.

In counties with a WPC and/or HHP will automatically transition all members currently served by them or those in the process of enrolling in WPC or HHP, into ECM.

ECM Includes:

- Comprehensive assessment and care management plan
- Care coordination and integrating services of cost-effective, quality direct health care services
- Connection to community resources for indirect care needs
- Improving health outcomes by addressing social determinants of health, such as environment, education and access to quality health care

Community Supports

Community Supports are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay.

Community Supports can only be covered if:

- The state determines the service is a medically appropriate and cost-effective substitute or setting for the State Plan service
- The services are optional for the managed care plan to provide
- The services are optional for members, and they aren't required to use
- Services are authorized and identified in the state's Medi-Cal MCP contracts

For a list of community support services available, please go to the website: Community Supports (caloptima.org)

Long-Term Services and Supports

Long-Term Services and Supports

CalOptima Health 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) 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 to LTSS?

- 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

Community-Based Adult Services

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.

CalOptima Health is responsible for determining CBAS eligibility and medical necessity criteria.

- CalOptima Health may receive an inquiry for CBAS from a variety of sources, including: CBAS center, a member or member's authorized representative, a member's PCP or Specialist, a member's case manager or personal care coordinator.
- CalOptima Health may also initiate an evaluation based on the results of the member's initial risk stratification or health risk assessment results.

CalOptima Health's Long-Term Support Services staff shall process all CBAS benefit inquiries and CBAS authorizations requests.

Reporting Requirements

Critical Incident Reporting

Fraud, Waste, and Abuse

Critical Incident Reporting

Community-Based Adult Services centers shall report critical incidents to CalOptima Health using the Critical Incident Reporting Form. Forms must be sent to CalOptima Health's QI Department within 24 hours of the findings, along with supporting documentation of the reportable incident, to qualityofcare@caloptima.org or fax to (657) 900-1615.

Critical Incidents:

- Mental anguish caused by willful use of offensive, abusive or demeaning language by caretaker
- Knowing, reckless or intentional acts of failures to act which cause injury or death to an individual, or which places that individual at risk of injury or death
- Rape or assault
- Corporal punishment or striking of an individual
- Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual
- Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations

Fraud, Waste, and Abuse

Federal and state regulations require CalOptima Health and CHA to work with its providers to identify and report potential cases of health care fraud, waste or abuse to law enforcement agencies.

How to Report Suspected Health Care Fraud

Please notify potential cases to CHA Compliance at chacompliance@choc.org.

Suspected fraud or abuse should be reported to CalOptima Health 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 Health website.
- Email the form and supporting documents to fraud@caloptima.org or fax the form and all supporting documents to CalOptima Health's Office of Compliance at 714-481-6457.

FWA Training: Fraud, Waste and Abuse (caloptima.org)

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 a provider becomes aware that a breach of PHI has occurred affecting any CHA member, whether caused by CalOptima Health, CHA, a delegated entity or an FDR, the provider should notify CHA and CalOptima Health immediately upon discovery.

To report a breach to CHOC Health Alliance Compliance please email chacompliance@choc.org, and CHOC Corporate Compliance by calling 877-388-8588 or email compliancehotline@choc.org.

To report a breach to CalOptima Health, call 888-587-8088 and ask for the Privacy Officer, or email privacy@caloptima.org.

Quality of Care Issues

CalOptima Health performs case reviews, investigate potential quality of care issues and determines the severity of issues. Based upon these investigations, CalOptima Health determines the appropriate follow-up action required for individual cases.

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 mental or physical health
  - Unnecessary prolonged treatment, complications or readmission
  - Failure to provide appropriate treatment that results in significantly diminished health status, impairment, disability or death
  - An unexpected occurrence involving death or serious physical or psychological injury

Quality of Care Issues

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

To report a potential quality of care issue, the issue should be directed to CalOptima Health at:

CalOptima Health

Attention: Quality Improvement

505 City Parkway West

Orange, CA 92868

Or qualityofcare@caloptima.org

Or fax at 657-900-1615

Please include the member's name, CIN, provider's full name, and a description of the issue or concern including the date(s) the incident occurred.

Behavioral Health Services

Behavioral Health Services

CalOptima Health is responsible for the outpatient behavioral health services for Medi-Cal. CalOptima Health directly manages the Medi-Cal behavioral health benefits.

Available services include:

- Outpatient psychotherapy (individual and group therapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include lab work, drugs, and supplies
- Outpatient services for the purposes of monitoring drug therapy
- Psychiatric consultation
- Screening, Assessment, Briefing Intervention and Referral to Treatment (SABIRT)

Behavioral Health Services

CalOptima Health manages behavioral health treatment for members who have mild to moderate impairments. Members with severe impairments will receive services from the Orange County Health Care Agency.

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): (855) 625-4657	• Treatment of severe health mental conditions • Services directly through the Orange County Mental Health Plan (MHP) • Recommendation from a licensed provider is required

Behavioral Health Services

Behavioral Health Services at Long-Term Care Facilities

Medi-Cal beneficiaries receiving services under the LTC are eligible for behavioral health services covered by CalOptima Health. To assist a CalOptima Health member residing in a LTC facility access behavioral health services for mild to moderate conditions, the nursing facility can call CalOptima Health Behavioral Health.

Behavioral Health Treatment

CalOptima Health covers behavioral health treatment (BHT) services under EPSDT. BHT services include applied behavioral analysis (ABA) and other evidence-based services. A CalOptima Health Medi-Cal member may qualify if the member:

- Is under 21 years of age
- Meets medical necessity criteria
- Has a recommendation from a licensed physician, surgeon, or a licensed psychologist that evidence-based BHT services are medically necessary
- Is medically stable and without need for 24-hour medical/nursing monitoring provided in a hospital or intermediate care facility for persons with intellectual disabilities

Dementia Care Aware Provider Training

The Dementia Care Aware program offers ways for providers and primary care teams to receive training on the cognitive health assessment and other relevant dementia care topics.

Dementia Care Aware has developed a compressive cognitive screening approach that providers can use quickly, confidently, and regularly with their older adult patients. This screening approach, is known as the cognitive health assessment and was developed with California's dementia and primary care experts. The assessment is a 5–10-minute annual screen that includes a cognitive screen, functional screen, and care partner assessment. The California DHCS recommends the assessment as standard of care for dementia screening for older adults.

Resources and training are available live, virtual, on-line, and via webinars.

Education & Training – DCA (dementiacareaware.org)

CalOptima Health Member Services

Member Handbook

Member Grievances and Appeals

Member Handbook

CalOptima Health Member Handbook - Member Documents (caloptima.org)

Member Benefits

Covered services are listed in the CalOptima Health Member Handbook. For more details, members can call CalOptima Health'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)

Member Rights and Responsibilities

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

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

Member Handbook

Member Rights and Responsibilities

Member rights includes, but are not limited to members taking the following actions:

- Voice complaints or appeals, either verbally or in writing, about CalOptima Health, CHA, provider or the care any provides. There is no time limit to file a compliant. CalOptima Health can assist with filing a complaint or grievance.
- Get oral interpretation services in the language that they understand at no-cost.
- Ask for a State Fair Hearing, including information on the conditions under which a State Fair Hearing can be expedited. CalOptima Health can assist with filing for a State Fair Hearing.
- Receive written member information in alternative formats, including Braille, large-size print no smaller than 20 point font, accessible electronic format, and audio format upon request and in accordance with 45 CFR sections 84.52(d), 92.202, and 438.10.
- Be free from any form of control, restraint, seclusion or limitation used as a means of coercion, discipline, pressure, punishment, convenience or retaliation

Please refer to the Member Handbook for a full list of Member's Rights and Responsibilities

Member Grievances and Appeals

Member Grievances and Appeals

A **grievance** is any complaint or dispute expressing dissatisfaction with the manner in which CalOptima Health or a delegated entity provides health care services, regardless of whether any remedial action can be taken.

An **appeal** is a request to review a plan's decision. Refers to the procedures that deal with the review of an adverse coverage decision on the health care services a member believes they are entitles to receive, including the delay in providing, arranging for, or approving the health care services or on the amount the member must pay for a service.

Member Grievances and Appeals

Member Grievances and Appeals

A member or a Provider or authorized representative acting on behalf of the member and with the member's written consent, can submit a grievance or appeal. Any of the below methods can be used to file a grievance towards a Network Provider and Out-of-Network Provider.

Members can submit a grievance or appeal by:

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

  CalOptima Health
  Grievance and Appeals Resolution Services
  505 City Parkway West
  Orange, CA 92868

CalOptima Health Provider Resources

Provider Resources on CalOptima Health's Website

Provider Communications

This includes the monthly provider newsletter, as well as Provider Updates based on recent Operating Instruction Letters received by the Department of Health Care Services

News and Events (caloptima.org)

CalOptima Health Policies & Procedures

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

Resource Guides (caloptima.org)

In the event of a conflict or inconsistency between the Provider Manual and other documents or laws, the following shall apply in the order of descending precedence: federal and state statutes; regulations and regulatory guidance; the provider contract; CalOptima Health policies and procedures; and the Provider Manual.

CHOC Health Alliance Operations

Provider Manual

The provider manual is a CHA administrative guide containing information to assist health care professionals with general information, policies and procedures to assist when providing healthcare to our members.

CHOC Health Alliance Website - CHOC Health Alliance

Network Certification Requirements

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 Health's compliance with the Annual Network Certification (ANC) requirements to the Centers for Medicare & Medicaid Services before the calendar year begins.

CalOptima Health 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.

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.

Provider Access Standard Requirements

Appointment standards
Telephone standards
Cultural and Linguistic standards

Access Standards

Appointment Access Standards

Emergency and Urgent Care Services

Type of Care	Standard
Emergency Services	Immediately: 24 hours a day, 7 days a week
Urgent Care Services	Available within 24 hours of request

Primary Care Services

Type of Care	Standard
Urgent Appointments	Available within 48 hours of request
Non-Urgent Primary Care	Available within 10 business days of request
Routine Physical Exams & Health Assessments	Available within 30 calendar days of request
Initial Health Assessment (IHA) or IHEBA/SHA	Available within 120 calendar days of CalOptima Health enrollment

Access Standards

Appointment Access Standards

Specialty and Ancillary Care

Type of Care	Standard
Urgent Appointments that DO NOT require prior auth	Available within 48 hours of request
Urgent Appointments that DO require prior auth	Available within 96 hours of request
Non-Urgent Specialty Care	Available within 15 business days of request
Non-Urgent Ancillary Services	Available within 15 business days of request
Appointment for follow-up routine care with a physician behavioral health care provider	Members have a follow-up visit with a physician behavioral health care provider within 30 calendar days of initial visit for a specific condition

Access Standards

Appointment Access Standards

Other Access Standards

Type of Care	Standard
In-office wait time for appts	Shall not exceed 45 minutes before a member is seen by a provider
Rescheduling Appointments	Appointments will be rescheduled in a manner appropriate to the member's health care needs and that ensures continuity of care is consistent with good professional practice

Access Standards

Telephone Access Standards

Type of Care	Standard
Telephone Triage	Telephone triage shall be available 24 hours a day, 7 days a week. Telephone triage or screening waiting time shall not exceed 30 minutes
Telephone wait time during business hours	A non-recorded voice within 30 seconds
Non-urgent and non-emergency messages during business hours	Practitioner shall return the call within 24 hours after the time of message
Urgent message during business hours	Practitioner shall return the call within 30 minutes after the time of message
Telephone access after/during business hours for emergencies	The phone message and/or live person must instruct members to dial 911 or go to the nearest emergency room.

Access Standards

Telephone Access Standards continued

Type of Care	Standard
After-hours access	A PCP or designee shall be available 24 hours a day, 7 days a week to respond to after-hours member calls or to a hospital emergency room practitioner
Triage or screening service informs the member regarding the length of wait time for a return call from the provider	The provider informs the member regarding the length of wait time for a return call from the provider.

Access Standards

Cultural and Linguistic Standards

Type of Care	Standard
Oral Interpretation	Oral interpretation shall be made available to a member in person, upon a member's request, or by telephone at key points of contact, 24 hours a day, 7 days a week
Written Translation	All written materials shall be made available in threshold languages in accordance with CalOptima Health Policy
Alternative Forms of Communication	Informational or educational materials shall be made available at no cost in Threshold Languages in large print (no less than 20 point, Arial font), audio format, or Braille upon request or as needed within 21 days upon receipt of request or within a timely manner that is appropriate for the format requested
Telecommunications Device for the Deaf (TDD)	TDD shall be made available to a Member, upon request, at no cost to the Member

Cultural Competency Requirement

Cultural Competency

Cultural Competency is the state of being capable of functioning effectively in the context of cultural differences.

Culturally competent care is providing health care in a manner that is sensitive to the differing values and needs of cultural subgroups within our society.

Providers shall use culturally competent practices and provide access to services in a culturally competent manner for all Members regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56

Cultural Competency Training (including Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex and Asexual (LGBTQIA+) cultural competency training) : Cultural Competency Training (caloptima.org)

Cultural Competency

Cultural and Linguistic Services

CHA offers free interpreter services to all limited English proficient members. CHA's services cover two areas:

- Interpreter services (telephonic and face-to-face interpretation)
- Translation services (materials available in threshold languages)

Using a family member or friend to interpret should be discouraged.

To schedule a service, please contact CHA's Provider Services at (800) 387-1103 and a team member will assist the office and member with creating an appointment.

Members may contact CHA's Member Services at (800) 424-2462 to schedule a service.

Member Information

Member Eligibility

Member Disenrollment

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.

CalOptima Health member ID cards are used to help identify members and are NOT proof of member 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 Health	Provider Portal: https://providers.caloptima.org Phone (IVR): (800) 463-0935
CHOC Health Alliance (CHA)	Provider Portal (EZ-NET): https://eznet.rchsd.org Phone: (800) 387-1103

Member Disenrollment Request

A disenrollment request may be due to one of the following:

1. A member fails to maintain a satisfactory Member-Provider relationship and continually fails to follow the Provider's recommended treatment or procedure, resulting in deterioration of the member's medical condition and/or jeopardizing their health status; or
2. A member exhibits physically threatening or excessively disruptive behavior towards Providers, ancillary or administrative staff, or other Health Network members. The member's behavior must be of sufficient severity that a police report is filed for that behavior.

Provider shall continue to be available for any urgent/emergency services for up to thirty (30) days, while the request is reviewed.

Member Disenrollment Request

Disenrollment due to member non-compliance

Prior to submitting a request to CHA to disenroll a member, the provider MUST notify the member in writing regarding the non-compliance.

Disenrollment due to disruptive or violent behavior

Prior to submitting a request to CHA to disenroll a member, the provider must contact the appropriate law enforcement agency to file a report. If possible, attempt to rule out any medical or behavioral health conditions that may contribute to the disruptive or threatening behavior.

In either case, the Provider should submit the member's complete medical history with the request to disenroll to CHA, including interventions carried out to diagnose and treat medical and behavioral health problems. Also include a summary of the discussions and correspondence documenting efforts to reconcile issues with the Member.

Authorizations

Authorization Process

CHA Provider Portal

Authorization Process

What information is required to submit a referral/prior authorization?

- Member Identification Number & Member's Date of Birth
- Referring Provider Information
- Referring To Provider Information (Rendering Service)
- Requestor's Contact Information
- Requested Procedures and Codes
- Diagnosis Codes
- Clinical Documentation supporting request
- Date of Service and Number of Units

Expected Turn Around Times

- Urgent=72 hours
- Routine=5 business days
- Retro=30 calendar days

Prior Authorizations /Referrals Dept.

- Phone: (800) 387-1103, Press 2
- Fax:(855) 867-0868
- Site: https://eznet.rchsd.org

A list of services approved for Direct Referrals and services that require Prior Authorization can be found at www.chochealthalliance.com

Authorization Process

Prior Authorization Tips

- Check eligibility prior to providing services using one of the eligibility verification systems
- Check Authorization Quick Reference Guide
  - If the service/code is listed as not requiring a prior authorization, do NOT submit an authorization request
- Verify Current Procedural Terminology (CPT) code on the Medi-Cal fee schedule before rendering services
- Attach supporting notes/documentation, if applicable
- Authorization status can be viewed in the EZ-Net portal

Authorization Process

Utilization Management Appeals and Provider Dispute Resolution Process

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

Peer-to-Peer Review

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 Provider Services at (800) 387-1103.

Second Opinions

A member or the member's authorized representative may request a second medical opinion by contacting CHA. CHA will review the request for medical necessity.

Referrals for second opinions should be directed to a provider who is contracted with the member's health network. Referrals to non-contracting medical providers or facilities will be approved only when the requested services are not available within the contracting network.

EZ-Net Provider Portal

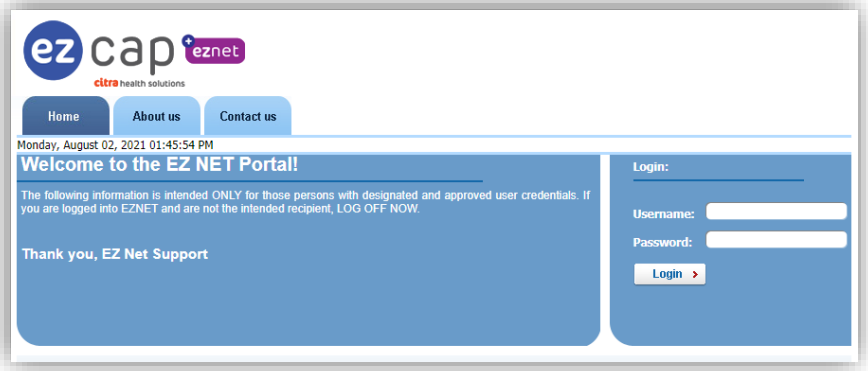
EZ-Net Services

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

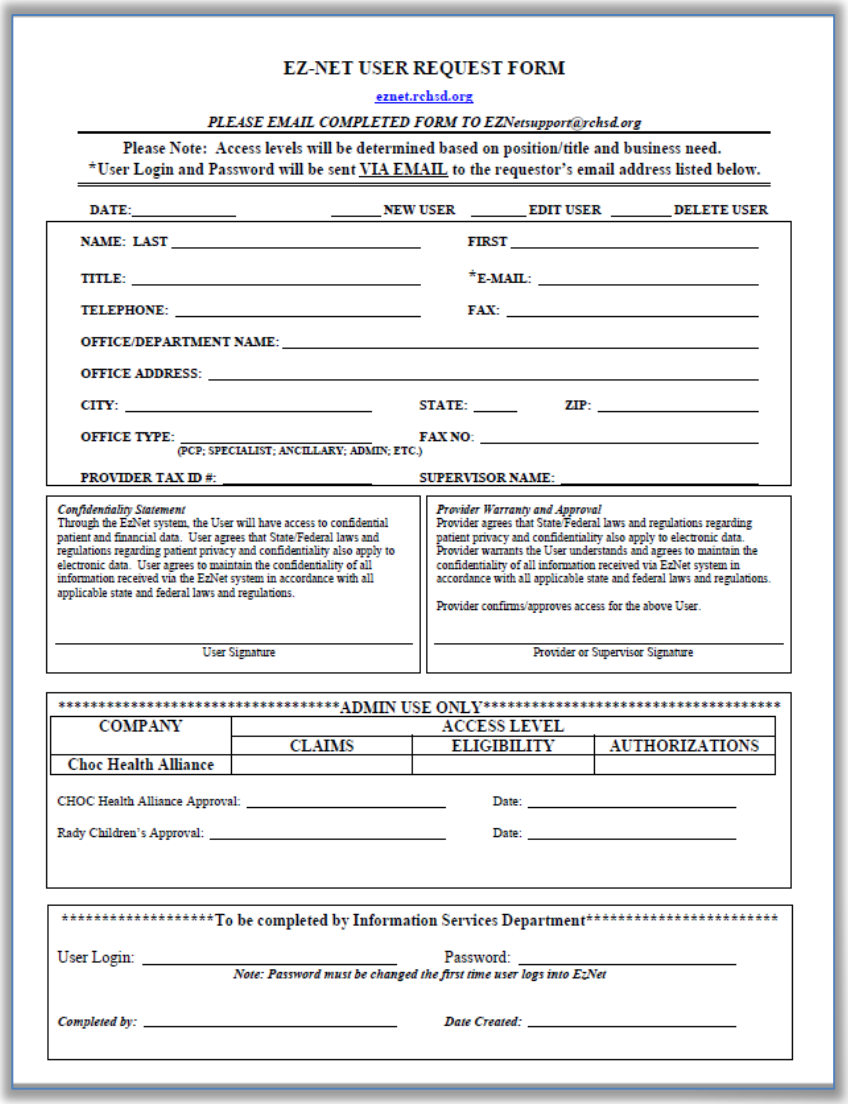


For access and training contact Provider Relations at providerrelations@choc.org.

EZ-Net Provider Portal

How to Access EZ-Net?

- Fill out all information required on the user request form
- Email to EZNetsupport@rchsd.org
- You will receive your username and temporary password to the email you provide on this form
- Please check your spam email
- Each user must have their own login and password



EZ-NET USER REQUEST FORM

eznet.rchsd.org

PLEASE EMAIL COMPLETED FORM TO EZNetsupport@rchsd.org

Please Note: Access levels will be determined based on position/title and business need.
*User Login and Password will be sent VIA EMAIL to the requestor's email address listed below.

DATE:_____ _____NEW USER _____EDIT USER _____DELETE USER

NAME: LAST _____ FIRST _____

TITLE: _____ *E-MAIL: _____

TELEPHONE: _____ FAX: _____

OFFICE/DEPARTMENT NAME: _____

OFFICE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OFFICE TYPE: _____ FAX NO: _____
(PCP; SPECIALIST; ANCILLARY; ADMIN; ETC.)

PROVIDER TAX ID #: _____ SUPERVISOR NAME: _____

Confidentiality Statement
Through the EzNet system, the User will have access to confidential patient and financial data. User agrees that State/Federal laws and regulations regarding patient privacy and confidentiality also apply to electronic data. User agrees to maintain the confidentiality of all information received via the EzNet system in accordance with all applicable state and federal laws and regulations.

User Signature

Provider Warranty and Approval
Provider agrees that State/Federal laws and regulations regarding patient privacy and confidentiality also apply to electronic data. Provider warrants the User understands and agrees to maintain the confidentiality of all information received via EzNet system in accordance with all applicable state and federal laws and regulations.

Provider confirms/approves access for the above User.

Provider or Supervisor Signature

**********ADMIN USE ONLY**********

COMPANY	ACCESS LEVEL		
	CLAIMS	ELIGIBILITY	AUTHORIZATIONS
Choc Health Alliance			

CHOC Health Alliance Approval: _____ Date: _____

Rady Children's Approval: _____ Date: _____

**********To be completed by Information Services Department**********

User Login: _____ Password: _____
Note: Password must be changed the first time user logs into EzNet

Completed by: _____ *Date Created:* _____

Clinical Programs

Model of Care
Case Management
UM Workplan

Model of Care Programs

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 Medi-Cal.

Includes: Senior and Persons with Disabilities (SPD), Whole Child Model (WCM), CalAIM Enhanced Care Management (ECM), and CalAIM Community Supports

Program Services

- CalOptima Health completes initial outreach to the member and sends the case to CHA for assignment to a (PCC).
- Patient Care Coordinator (PCC)
  - PCCs provide ongoing assistance to the member and member's family (i.e. "concierge" services).
  - PCCs are non-clinical associates.
  - PCCs are the main point of contract for members enrolled in the program. They are the liaison between the member, provider, CHA, and CalOptima Health.

Model of Care Programs

Program Services continued

- Individual Care Plan (ICP)
  - When deemed applicable by CalOptima Health, an ICP, driven by parent concerns and medical recommendations, is facilitated by a CHA Team.
  - An ICP includes personalized goals and objectives, specific services and benefits, and measurable outcomes.
  - NOTE: Not every eligible member will have an ICP created
- Interdisciplinary Care Team (ICT)
  - When deemed applicable by CalOptima Health, CHA holds ICT meetings based on the ICP.
  - Parents/Guardians and PCPs are encouraged to attend ICT meetings via phone.
  - PCPs can have a representative attend on their behalf (i.e. NP, PA, LVN).
  - Invitations to the ICT will be sent to the PCP via fax.

ICPs are sent to each member's PCP for review, input, and acknowledgement of member's care plan

Model of Care Programs

Based on the Model of Care assessment, CalOptima Health assigns a level of complexity

Case Management	Services
Basic Case Management	Lower risk members receive basic case management, which includes: • Initial Health Assessment (IHA) & Staying Healthy Assessment (SHA) • Identification and coordination of providers and facilities • Education on healthy living, coordination of special services, and referrals to community resources
Care Coordination	Moderate risk members receive care coordination which includes: • Comprehensive assessment of the member's condition • Determination of available benefits and resources • Implementation of care plan goals with monitoring and follow up
Complex Case Management	Higher risk members receive complex case management which includes: • Dedicated Case Manager • Comprehensive assessment of the member's condition • Determination of available benefits and resources • Implementation of care plan goals with monitoring and follow up • Coordination of care and service coordination for medical services

Seniors and Persons with Disabilities (SPD)

What is the SPD Program?

The SPD program is intended to help the below members access health care services

- Seniors
- Members with disabilities or chronic conditions
- Members without housing

Our Case Management team works closely with health care providers and agencies throughout Orange County to help guide members through the health care system.

Disability Awareness Training: Disability Awareness (caloptima.org)

SPD Resources: Seniors and Persons with Disabilities (caloptima.org)

Care Management

Additional members who do not fall under WCM, SPD or ECM can also be referred to our Care Management team. Any member or family struggling to cope with medical, social, or emotional challenges related to an acute or chronic illness can be referred.

Referral Submissions

Fill out the Care Coordination/Care Management Request form and fax it 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 medical records along with the form

Connecting with a Case Manager

Once a case is open, the referring provider will be notified by the assigned case manager. CHA staff will assign the member to a level of case management services based on their specific needs and case complexity.

When is a Case Closed?

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

Utilization Management Workplan

The Utilization Management (UM) workplan is evaluated by:

- Measurable goals and health outcome measurements
- Evaluate quality of health care delivered to members
- Utilization management measures
- Disease management measures
- Ongoing performance improvement evaluation

CHA uses clinical protocols, evidence-based practices, and specific levels of quality outcomes in their review during the annual UM workplan and annual UM evaluation

Doula Services

Doulas are birth workers who provide health education, advocacy and physical, emotional, and non-medical support for pregnant and postpartum persons before, during and after childbirth, including support during miscarriages, stillbirths, and abortions.

Doula services do not include diagnosis of medical conditions, provision of medical advice or any type of clinical assessment exam, or procedure. The following services are not covered under Medi-Cal or as doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e. sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Claims

Billing Procedures
Complaint/Dispute Process
Member Billing Restrictions

Claim Billing Procedures

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

Electronic Claim Submission

Submit claims/encounters electronically via one of our contracted clearinghouses

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

Paper Claim Submission

If you must send a paper claim, send 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

All claims that have attachments must be submitted via paper submissions

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

Claim Billing Procedures

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.)

Processing Time

The standard processing time for a claim is 30 calendar 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

Claim Billing Procedures

Corrected Claims

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

Send 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

Claim Billing Procedures

Coordination of Benefits (COB)

Coordination of Benefits 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:

1. File claim with the primary insurer
2. If the primary insurer issues a partial payment or denial, submit a claim with a copy of the EOB, including payment details, to CHA
3. If appropriate, CHA will pay the remaining balance up to the Medi-Cal allowable amount

Provider Complaint Process

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 PDR Request Form at www.chochealthalliance.com
- Fill out the form and attach supporting documentation
- Send the completed form and documents to:

Via Mail:
Rady Children's Hospital – San Diego
Attn: CHOC /CPN Claims
3020 Children's Way, MC 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

Second-Level Appeal

Providers who disagree with CHA's decision may file a second-level appeal with the CalOptima Health Grievance and Appeals Resolution Services. Providers must submit a request for review in writing within 180 calendar days of receiving a complaint resolution letter.

Member Billing Restrictions

Billing Members for Covered Services is Prohibited

The Department of Health Care Services (DHCS) prohibits providers from charging members for Medi-Cal covered services or having any recourse against the member or the DHCS for Medi-Cal covered services rendered to the member.

Includes, but is not limited to:

- Covered services
- Covered services provided during a period of retroactive eligibility
- Covered services once the member meets his or her share of cost requirement
- Co-payments, coinsurance, deductible or other cost sharing required under a member's other health coverage
- Pending, contested or disputed claims
- Fees for missed, broken, cancelled or same-day appointments
- Fees for completing paperwork related to the delivery of care (e.g. immunization cards, disability forms, sports physical forms, forms related to Medi-Cal eligibility etc.)

Member Billing Restrictions

Limited Circumstances in which the Member may be billed

A provider may bill a member only for services not covered by Medi-Cal, if:

- The member agrees to the fees in writing prior to the actual delivery of the non-covered services
- A copy of the written agreement is provided to the member and placed in his or her medical record
- The rendering provider is not registered with Medi-Cal

Provider Payments Portal

ECHO Health

ECHO Health is a leading provider of electronic solutions for payments to healthcare providers. ECHO consolidates individual provider and vendor payments into a single ERISA- and HIPAA-compliant format, remits electronic payments, and provides explanation of provider payment details to Providers.

- Receive payment electronically
- Pull EOB/EOP reports
- Pull capitation reports

ECHO Health

ECHO Provider Payments Portal: ECHO Provider Direct - Login (providerpayments.com)

Claims and Capitation Payments are completed by ECHO and can be reimbursed as:

- Paper check
- Virtual Card (Vcard) – virtual visa debit transaction
  - Default option for new providers
  - To manage Virtual Card payments or change payment method, providers can update via ECHO VCARD (echovcards.com)
  - For Vcard specific inquiries, you may call (877) 705-4230
- EFT/ACH – automatic direct deposit to a bank account
  - To enroll in EFT, providers can enroll online ECHO Health (echohealthinc.com)
  - Providers can also email EDI@echohealthinc.com

You may contact the ECHO Customer Service for General Payment Inquiries at (888) 834-3511.

Payment Models

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)

Fee-For-Service (FFS)

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, minor surgical procedures)
- All services rendered to members with a SPD aid code
- Services rendered by Specialists, Ancillary Providers, and Hospitals

CHA pays providers according to the current Medi-Cal fee schedule and Medi-Cal guidelines. For more information visit, Medi-Cal: Medi-Cal Rates

Quality Improvement (HEDIS)

Quality Improvement (HEDIS)

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

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

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. HEDIS Tools - CHOC Health Alliance

Applied Research Works

COZEVA®

Managing your HEDIS® Data in Real-Time

What is COZEVA®?

- NCQA (National Committee for Quality Assurance) HEDIS® certified platform for Pay for Performance
- Cozeva is the operating system that aggregates and transforms multiple data steams into a registry driven dashboard.
- Cozeva portal https://corp.cozeva.com/

How can COZEVA® help me?

- View your member information
- View HEDIS care gaps
- View and print opportunity lists

For Cozeva training and access please contact providerrelations@choc.org

Quality Improvement Workplan

The Quality Improvement (QI) workplan is evaluated by:

- Measurable goals and health outcome measurements
- Measuring member experience of care
- Ongoing performance improvement evaluation
- Dissemination of quality performance

CHA uses standardized QI measures performance and health outcomes such as:

- Healthcare effectiveness Data and Information Set (HEDIS)
- Disease management measures
- Utilization management measures
- Member satisfaction surveys
- Provider satisfaction surveys
- Ongoing monitoring of complaints and grievance summaries

CHOC Health Alliance Contacts

CHOC Health Alliance Contact List

Resources	Contact Information
Provider Services (M-F 8am-5pm)	(800) 387-1103
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
Interpreter Services	(800) 424-2462 (Member line) (800) 387-1103 (Provider line)
Member Services (Available 24/7)	(800) 424-2462
Member Services Hearing Impaired TTY / TDD	(800) 735-2922 English (800) 855-3000 Spanish
CHOC Health Alliance Admin Office	(714) 565-5100
Provider Portal (EZ-NET)	https://eznet.rchsd.org
Website	www.chochealthalliance.com

Provider Relations Contact List

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Thank you!