CCHP Provider Manual

CCHP Health Plan

Revised 06/20

CCHP PROVIDER MANUAL

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SECTION 1 INTRODUCTION AND BACKGROUND

Section 1.1 Purpose of the Manual

This manual is intended to provide CCHP participating physicians, allied health care providers and facilities with information necessary for serving and coordinating the care of CCHP members.

Section 1.2 Welcome to Chinese Community Health Plan (CCHP)

Established in 1986, Chinese Community Health Plan (CCHP) is the health plan subsidiary of Chinese Hospital. CCHP Health Plan offers coverage to individuals, families, and employer groups, and to seniors through Medicare Advantage plans. Our service area includes the City and County of San Francisco and northern San Mateo County.

Section 1.3 Mission

The mission of CCHP is to improve the health of our community by delivering high-quality, affordable healthcare through culturally competent and linguistically appropriate services.

CCHP is committed to serving our community and is devoted to delivering the highest quality health plan to the people and organizations we serve. We consider our health care providers as our customers and vital partners in serving our members.

Section 1.4 History

As a San Francisco original, CCHP has a history of service in the San Francisco Bay Area and continues evolving to meet its healthcare needs. CCHP was founded over 30 years ago by the Chinese Hospital Association to deliver culturally sensitive and linguistically appropriate care. Along the way, we have come to extend our unique model of healthcare to all our neighbors.

Today, we continue to innovate and develop health plans in partnership with our network of over 1700 physicians (as of 2017). They are conveniently located throughout our service area that consists of San Francisco and northern San Mateo County with access to most hospitals.

At CCHP, we provide personalized and patient-focused healthcare services to all of our members.

Section 1.5 Regulatory Oversight

CCHP is a California licensed Knox-Keene health plan and offering a variety of commercial products for small and large group employers as well as products for individuals. CCHP is also one of few plans in San Francisco and San Mateo Counties to provide coverage through Covered California.

In addition, CCHP is contracted with the Centers for Medicare and Medicaid Services (CMS) to offer a Medicare Advantage HMO plan (Part C), a Medicare Advantage Special Needs Program (HMO SNP) and an integrated Medicare Advantage Prescription Drug Plan (Part D). CCHP's Senior Program (HMO) is for people with Medicare Parts A and B. CCHP's Senior Select

Program (HMO SNP, Special Needs Plan) is for people with Medi-Cal and Medicare Parts A and B. Please refer to Section 2, Products and Benefits, for more information.

Section 1.6 Governance - Board & Committee Structure

CCHP is a wholly-owned subsidiary of the Chinese Hospital Association. As such, the Board of Trustees is composed of representatives from 15 community organizations. The board is a true reflection of the community it has been serving for over 100 years.

- Chinese Democratic Constitutionalist Party
- Chinatown Y.M.C.A
- Chinese Consolidated Benevolent Association
- Hop Wo Benevolent Association
- Chow Benevolent Association
- Sue Hing Benevolent Association
- Ning Yung Benevolent Association
- Chinese-American Citizens Alliance
- Yeong Wo Association
- Sam Yup Benevolent Association
- Yan Wo Association
- Chinese Chamber of Commerce
- Kuomingtang of China
- Chee Kung Tong Chinese Christian Union of San Francisco

CCHP has many functioning committees reporting to the CEO and Board of Trustees. For the purposes of this provider manual, the following committees highlighted below are referenced in other sections and are responsible for setting polices for all providers who may care for CCHP members either directly associated with CCHP or through and affiliated entity such as through an Independent Physician Association (IPA).

- Quality Improvement and Utilization Management
- Credentialing
- Pharmacy & Therapeutics
- Medical Technology
- Compliance

Section 1.7 How to Contact Us - Helpful Resources

Main Information	Additional Info	Phone
Main Office	445 Grant Avenue, Suite 700 San Francisco, CA 94108	1-415-955-8800
Website	www.cchphealthplan.com	
Hours of Operation:	Monday – Friday 8:30 a.m. - 5:00 p.m.	
Eligibility and Benefits	**Additional Info**	**Phone**
Member Eligibility and Benefits Verification	Create an account on CCHP's Provider Portal: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx If you have issues logging in please contact Provider Network Management Department at 628-228-3281.	Or call Member Services seven days a week from 8:00 am to 8:00 pm. 1-888-775-7888 (toll free) 1-415-834-2118 (local)
Provider Network	**Additional Info**	**Phone**
Provider Network Information	Use the new web-based provider search function for CCHP at www.cchphealthplan.com/doctors/search Please report any inaccuracies or changes to **Provider Network Management** via Provider Relations email: pr@cchphealthplan.com.	1-628-228-3281
General Inquiries	Provider Network Management	1-628-228-3281
Request Username & Password for Online Portal	Provider Network Management	1-628-228-3281
Request Service Authorization Forms Request Consultation Referral Forms	Provider Relations	1-628-228-3214
Provider Contracting	Contact Provider Contract Management: CCHP.Contracting@cchphealthplan.com	1-628-228-3277

Claims	Additional Info	Phone
Check Claims Status	Create an account on CCHP's Provider Portal: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx If you have issues logging in please contact Provider Network Management Department at 628-228-3281.	1-628-228-3322
Claims General Inquiries	Member Services	1-415-834-2118
Submit Electronic Claims	For electronic submissions, the please direct them to CCHP's **Payer ID 94302**	
Submit Paper Claims	Paper claims can be mailed to**:** CCHP Claims Department 445 Grant Avenue, Suite 700 San Francisco, CA 94108	
Provider Disputes	**Additional Info**	**Phone**
Provider Dispute Forms & Instructions	www.cchphealthplan.com/cchp-providers-dispute-process	1-628-228-3214
Submit a Provider Dispute Dispute must be submitted on Dispute Form	Disputes can be mailed to**:** CCHP Provider Dispute Resolution 445 Grant Avenue, Suite 700 San Francisco, CA 94108	Fax: 1-415-955-8815
Clinical Services	**Additional Info**	**Phone**
Request Prior Authorization	Call to request prior authorization Or Fax Service Authorization Form to:	1-877-208-4959 Fax: 1-415-398-3669
View Authorizations Online	Create an account on CCHP's Provider Portal: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx If you have issues logging in please contact Provider Network Management Department at 628-228-3281.	

Pharmacy	Additional Info:	Phone
Request Prior Authorization for RX	Senior & Senior Select: CCHP Member Services Commercial Program: MedImpact Healthcare Systems	1-888-775-7888 1-800-788-2949
Formulary Questions	Pharmacy Manager	1-628-228-3334
CCHP Formularies Pharmacy Directory	www.cchphealthplan.com/cchp-providers-formulary-pharmacy	
Sales	**Additional Info**	**Phone**
Sales Department	Sales@cchphealthplan.com Senior & Senior Select Programs: Commercial Programs:	 1-888-681-3888 1-888-371-3060
Compliance	**Additional Info**	**Phone**
Report Suspected Fraud, Waste or Abuse Report Privacy or Security Issue	Compliance Hotline – Confidential **or** CCHP Compliance Officer	1-415-955-8810 1-628-228-3340

SECTON 2 PRODUCTS AND BENEFITS

Section 2.1 Programs and Products

CCHP offers a variety of commercial products for small and large group employers as well as products for individuals and families. In addition, CCHP offers Medicare Advantage Plans including Part D drug coverage. The following programs are offered by CCHP:

- **CCHP Commercial Products** for employer groups and individuals and families. CCHP offers several plans with different choices of copayments and optional dental and vision riders. CCHP's group and individual plans, including those offered in the Covered California™ marketplace, can be purchased from one of CCHP's authorized brokers or directly from CCHP sales associates.
- **CCHP Senior Program HMO** is a Medicare Advantage plan for people with Medicare Parts A and B. This plan includes a Medicare Part D drug benefit and offers an optional dental rider.
- **CCHP Senior Select Program HMO Special Needs Plan (SNP)** is a Medicare Advantage plan for people with both Medicare Parts A and B *and* Medi-Cal. This plan includes a Medicare Part D drug benefit and a dental benefit.

Section 2.2 Service Area

CCHP's Service Area is the City and County of San Francisco and northern San Mateo County for all programs and products, except for the CCHP Senior Select Program. The Service Area for CCHP Senior Select Program members is the City and County of San Francisco only. For details go to: www.cchphealthplan.com/already-member-overview.

Section 2.3 Benefits Summary/Matrix and Evidence of Coverage

A summary of benefits and comparisons for each product and plan type can be found on CCHP's website at www.cchphealthplan.com/coverage-overview. Benefits are subject to change from time to time. Providers must verify a member's benefits and eligibility prior to rendering services as well has having prior authorization when required by CCHP. Refer to "Section 4.3 Website Instructions for Verifying Eligibility" for information on Web access to verify eligibility and benefits and "Section 8.15 Services Requiring Prior Authorization" for services requiring prior authorization.

Section 2.4 Primary Care Physicians

CCHP members must select a primary care physician to coordinate their care. The primary physician coordinates all care including referrals to specialists. The member must use plan physicians, providers and facilities except for emergencies. For services not available from the CCHP physician panel, prior authorization must be sought from the Utilization Management Department. (See Section 8.18 How to Request Prior Authorization)

Section 2.5 Member Cost-Sharing

CCHP members may be responsible for certain member cost-sharing. The amount of the copayment varies by the plan to which they enroll. For enroll member cost sharing information

specific to each Jade/CCHP patient, you can look it up on our Website at our secure log in for contracted providers at: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx

You can also call our Member Services department:

Member Services
1-888-775-7888 (toll free)
1-415-834-2118 (local)
Seven days a week from 8:00 a.m. to 8:00 p.m.

Co-payments and co-insurance/deductibles may be collected from the patient at the time of service, and are deducted from the allowable amount. CCHP members have a yearly maximum limit on the amount of member cost sharing before they reach what is called the Out-Of-Pocket-Maximum (OOP Max). During each calendar year, once the member individually, (or if part of a couple or family) has met the respective OOP Max, then for the remainder of the calendar year any copayment amount would not be due from the member, or as applicable, from other family members (if the couple, or family maximum has been reached).

Members will receive periodic updates of their copayments, deductibles, coinsurance and out of pocket maximums throughout the year. If your patient has a question, direct them to member services at the number listed above.

Section 2.6 Preventive Services Covered Without Copayments

CCHP's goal is to partner with providers to ensure that members receive preventive care services. CCHP provides preventive services to members without any copayments or cost sharing. Over time this is expected to significantly improve health and reduce incidence of preventable conditions. Providers are expected to review a patient's chart to determine if and when they need these important services and encourage patients to participate in their health by getting preventive services.

Section 2.8 Summary of Preventive Services Covered Without Copayments

The following preventive services are covered without member co-payments or cost sharing. A member's plan may include other preventive services not listed here that are at no cost to the member. Please consult the member's benefit plan description or contact CCHP Member Services with questions.

Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
Abdominal Aortic Aneurysm, Screening[1]	B	x			
Alcohol Misuse Screening and Mental Counseling Interventions by PCP	B	x	x	x	

Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
Anemia, Prevention – Counseling by PCP[2]	B				x
Anemia, Screening[3]	B			x	
Anemia, Screening– Hemoglobin/Hematocrit in Chidhood[4]	B				x
Annual Well Visits for childrens[5]	-				x
Annual Women's Well Visits[6]	-		x		
Aspirin for the Prevention of Cardiovascular Disease, Counseling by PCP(Aspirin is Over the Counter and Not Covered)[7]	A	x	x		
Asymptomatic Bacteriuria in Adults, Screening[8]	A			x	
Breast Cancer, Screening[9]	B		x		
Chemoprevention for Breast Cancer for High Risk Women Discussion with PCP[35]	B		x		
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA MutationTesting[10]	B		x		
Breastfeeding, Counseling by PCP Regarding Mental Interventions[11]	B		x	x	
Cervical Cancer Screenig[12]	B		x		
Chlamydial Infection, Screening[13]	A		x	x	
Colorectal Cancer, Screeniogn[14]	A	x	x		
Congenital Hypothyroidism, Screenign[15]	A				x
Dental Caries in Preschool Children, Prevention and fluoride Prescription[16]	B				x
Depression (Adults), Screening[17]	B	x	x		
Diet, Mental Counseling By PCP to Promote a Healthy Diet[18]	B	x	x		

Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
Folic Acid Supplementation, Generic Prescription Folic Acid (Brand Name and Over the counter are Not Covered) [19]	A			x	
Gonorrhea, Screening[20]	B		x	x	
Gonorrhea, Prophylactic Medication[21]	A				x
Hearing Loss in Newborns, Screening[15]	B				x
Hepatitis B Virus Infection, Screening[22]	A			x	
High Blood Pressure, Screening[34]	A	x	x		
HIV, Screening[23]	A	x	x	x	x
Inmunizations[37]	-	x	x	x	x
Lead Screening up to Age 7[36]	I				x
Lipid Disorders in Adults, Screening[24]	A&B	x	x		
Major Depressive Disorder in Children and Adults, Screening[24]	B				x
Obesity in Adults, Screening[26]	B	x	x		
Osteoporosis in Postmenopausal Women, Screening[27]	B		x		
Phenylketonuria, Screening[15]	A				x
Rh (D) Incompatibility, Screening[28]	A			x	
Sexually Transmitted Infections, counseling By PCP or OB/GYN[29]	B	x	x		x
Sickle Cell Disease, Screening[15]	A				x
Syphilis Infection, Screening[30]	A	x	x	x	
TB Skin Test[38]	-				x
Tobacco Use and Caused Disease, Counseling by PCP and Generic Prescription Medications (Brand Name and Over the Counter Medications Not Covered)[31]	A	x	x	x	

Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
Type 2 Diabetes Mellitus in Adults, Screening[32]	B	x	x		
Visual Impairment in Children Younger than Age 5 Years, Screening[33]	I				x

This document includes the evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved and, with respect to infants, children, and adolescents, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources Services Administration. In order for an office visit to be considered "preventive", the service must have been provided or ordered by a CCHP Participating PCP, or an OB/GYN. Participating.

Footnotes:

1. One-time screening by ultrasonography in men aged 65 to 75 who have ever smoked.
2. Counseling regarding routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Iron supplements are available over the counter and are not covered.
3. Routine screening in asymptomatic pregnant women.
4. Screening for anemia in children under age 18.
5. Children under age 18.
6. Women of all ages.
7. When the potential harm of an increase in gastrointestinal hemorrhage is outweighed by a potential benefit of a reduction in myocardial infarctions (men aged 45-79 years) or in ischemic strokes (women aged 55-79 years).
8. Pregnant women at 12-16 weeks gestation or at first prenatal visit, if later.
9. Mammography every 1-2 years for women 40 and older.
10. Referral for women whose family history is associated with an increased risk for deleterious mutations in BRCAI or BRCA2 genes for genetic counseling and evaluation for BRCA testing.
11. Interventions during pregnancy and after birth to promote and support breastfeeding.
12. Women aged 21-65 who have been sexually active and have a cervix.
13. Sexually active women 24 and younger and other asymptomatic women at increased risk for infection. Asymptomatic pregnant women 24 and younger and others at increased risk.
14. Adults aged 50-75 using fecal occult bold testing, sigmoidoscopy, or colonoscopy. Procedures to treat any abnormalities will require a co-payment, even if performed at the same time as the screening.
15. Newborns.
16. Prescription of oral fluoride supplementation at currently recommended doses to preschool children older than 6 months whose primary water source is deficient in fluoride.

17. In clinical practices with systems to assure accurate diagnoses, effective treatment, and follow-up.
18. Adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.
19. Recommendation that women pregnant or planning on pregnancy have folic acid supplement.
20. Sexually active women, including pregnant women 25 and younger, or at increased risk for infection.
21. Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
22. Pregnant women at first prenatal visit.
23. All adolescents and adults at increased risk for HIV infection and all pregnant women.
24. Men aged 20-35 and women over age 20 that are at increased risk for coronary heart disease; all men aged 35 and older.
25. Adolescents (age 12-18) when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.
26. Discussion/counseling about intensive counseling and mental interventions to promote sustained weight loss for obese adults.
27. Women 65 and older and women 60 and older at increased risk for osteoporotic fractures.
28. Blood typing and antibody testing at first pregnancy-related visit. Repeated antibody testing for unsensitized Rh (D) –negative women at 24-28 weeks gestation unless biological father is known to be Rh (D) negative.
29. All sexually active adolescents and adults at increased risk for sexually transmitted infections.
30. Persons at increased risk and all pregnant women.
31. Discussion/counseling about tobacco cessation interventions for those who use tobacco. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered.
32. Asymptomatic adults with sustained blood pressure greater that 135/80 mg Hg.
33. To detect amblyopia, strabismus, and defects in visual acuity; part of well-child.
34. Screening for high bold pressure in adults ages 18 and older without known hypertension.
35. Discussion/counseling about chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
36. Children ages 1-5 at increased risk for lead poisoning.
37. Refer to recommendations made by the CDC and ACIP for immunization of children and adults,
38. Refer to CDC guidelines.

Section 2.9 Member Entitlement to Copayment Parity for Services Not Available at Chinese Hospital

CCHP has some benefit plans where the copayment for services rendered at Chinese Hospital is lower than the copayment rendered at other hospitals. It is the policy of CCHP that in the event a member's benefit plan has a lower copayment for services rendered at Chinese Hospital, and the member requires and is authorized for healthcare services at a facility other than Chinese Hospital, or its outpatient facilities for reasons beyond the member's control and care must be obtained at an outside facility, the member's copayment for the services rendered

at a facility other than Chinese Hospital will not exceed that which would have been applicable, if the services could have been have obtained at Chinese Hospital. In addition, this policy is also applicable if Chinese Hospital is not within the required mandated standards of being within 15 miles from the member's residence, as long as the member obtains prior authorization for services from a contracted CCHP facility.

In regard to specialty services not provided by Chinese Hospital (such as Inpatient Mental Health, Substance Abuse, or OB-Labor & Delivery), members will be responsible for copayments that are no more than would be required for similar treatment or stays at Chinese Hospital for commensurate care for inpatient or outpatient services.

1. It is the policy of CCHP that in the event a commercial member requires and is authorized for health care services, other than at CH for reasons beyond the member's control and must be obtained at an outside facility, and/or if CH is not within the required California mandated standard of being 15 miles or less from the member's official residence, and so long as member obtains services from preauthorized and contracted CCHP facility that is within the 15 mile standard, the member's copayment amount due and payable for the services will not exceed that which would have been applicable, if the services could have been or might have been obtainable at CH.

2. In specific regard to Mental Health Services and or Substance Abuse benefits, since CH does not offer specialized inpatient, partial hospitalization or day treatment programs for substance abuse, that the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtained at CH. Due to legal requirements for parity between categories of service and reimbursement between 'medical physical health' and 'mental health' and 'substance abuse', the member shall not be charged the lower of the near 'equivalent' for the 'medical' benefits and copayments whether at CH or a non-CH facility.

3. In regard to Obstetrical, Pediatric, or other inpatient services not provided by CH, or the intensity or specialty of which has been determined by CCHP's Medical Director to be medically necessary to be obtained from a facility other than CH; or in the event that CH does not have available capacity or cannot accommodate member in a timely manner; the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtainable at CH.

4. Other reasons the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtainable at CH, if as preauthorized by the CCHP Medical Management as being medically necessary, prudent, and or required by law or regulation in order to assist the member to obtain crucial and specialized treatment.

5. This policy and procedure does not apply to emergency or emergent services for which no authorization is required and before medical stabilization has been achieved.

PROCEDURE:

1. CCHP's Utilization Management department shall provide the member receiving any authorization to a non CH facility that appears to fit within the guidelines of this Policy and Procedure, with a letter confirming that the authorized services apply to the benefit, and that the member's copayment shall be at parity to CH level, and they shall update the file to indicate the Member's reduced copayment.

2. Until and unless CH inaugurates a newly licensed and operating Psychiatric, Substance Abuse-Detoxification or Rehabilitation, Pediatric Unit, and or an Obstetrical-Labor & Delivery Units, then UM shall notify all members of the applicability of the CCHP Parity Benefit and shall inform them in writing as to the applicable CH copayments that will apply to their required non-CH services and/or stay. They shall then update the members billing file to indicate the applicable copayment that shall apply and be collected from the member.

3. In the event that the Utilization Management department has made a determination, that the request and authorized services to a non-CH facility have been voluntary; or do not apply to a service related to Mental Health, Substance Abuse, or Obstetrical Labor & Delivery Services; or do not result from the closure, full census, or inability to accommodate a specific member due to a unique disability or individually unique treatment requirement, then it may determine this policy does not apply. In this case, they shall inform the member by mail and include the reason it does not apply, as well as provide CCHP appeal, grievance and DMHC rights and notification letters to the member.

Section 2.10 Mental Health Parity

Mental Health, Mental, Psychological or Psychiatric, Developmental Disorders, and/or Substance Abuse Specialists or Detoxification or Mental Health Specialty Facilities

CCHP is committed towards full compliance with mental health parity which means equal treatment and access to all covered mental health, substance abuse, development, emotional, and/or mental healthcare services, as it provides for 'medical' or 'physical health' (i.e. other than mental, mental, substance abuse, or emotional disorders, diseases, or conditions as defined within the most current version of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Not only does this parity provide needed access by members and their covered family members, but it ensures that CCHP and its providers comply with applicable California and Federal laws and regulations, (California Department of Managed Health Care Regulation 1300.74.72). These laws are consistent with the federal rules on and Addiction Equity Act (MHPAEA), together with mental health coverage mandates which took effect under the Affordable Care Act (ACA) on January 1, 2014.

Further, requires plans to:

A. Monitor what people receive across the health care network;
B. Identify people who could benefit from case management; and
C. Help people get support outside of the plan's benefits.

Proper, timely, and consistent referral of patients exhibiting any possible or obvert signs of mental health issues, including but not limited to depression, anxiety attacks, mood disorders, or

childhood affective, developmental, psycho-emotional issues will not only affect the quality of life of these referred patients, but will benefit our providers, the health plan by reducing unnecessary medical services and potentially prevent physical disorders that could develop from untreated psychological or emotional conditions.

Recent studies of Asian American populations (including the Chinese American communities that comprise a significant portion of CCHP's membership) have documented under-utilization and a reluctance of patients to seek care (self-report) for all manner of mental health, psychological, mental, and or substance abuse treatment[1]. It is important for all CCHP providers to be cognizant of the need to look for, identify, and refer to CCHP's mental providers, including Psychiatrists, Psychologists, and other specialty providers and facilities. If the provider suspects any possible psychological, emotional, substance abuse, or any other mental or developmental disorders or conditions, they should diligently refer patients to CCHP mental health specialists via the same process and procedures used for physical or medical conditions or illnesses. PCP's are expected to follow the patient's referral to these specialists and should consult and coordinate care with the referring mental health specialist, similar to that necessary for non-mental health care.

To comply with 'parity'/'equality' standards described above, CCHP oversees the care, management, coverage, and delivery of mental health services and conditions (including psychological, psychiatric, mental health, developmental disorders of childhood, and substance abuse & treatment), in a manner equivalent to that required for medical or physiological conditions, and or disorders. Therefore, CCHP requires referrals, utilization management, and coordination of care that are equal to what is required or needed for non-mental health or substance abuse issues.

[1] American Psychiatric Association-Office of Minority and National Affairs, APA Fact Sheet , **Let's Talk Facts about Mental Health in Asian American and Pacific Islanders,** 2007.

SECTION 3 PROVIDER PORTAL ACCESS

Section 3.1 Create Provider Portal User ID

Providers are required to create a CCHP Provider Portal Account with User ID so that you can easily check eligibility and claim status. This will also make communication between CCHP and providers more streamlined.

Main Account Set-Up

1. Go to website: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Create new user account by "**Click here to create a new user**…"
3. Select "**Provider**" for providers or "**Office**" for offices. You will receive an email with your appropriate entity instructions.
4. The first account created will be the primary user and will be able to create other accounts. Create main account with the information in your email.
5. You will receive an activation email.
6. Click on the activation link to activate account.

Creating New User

1. After the "PrimaryWebAccount" is created, this user can go to "Manage Users" on the left sidebar and add new users.
2. Click "Add a User" and make sure to assign the "WebProvider" role to new users.
3. Complete user information.
4. An activation email will be sent to the user email.
5. Click the activation link to activate account.

***There are some functions on the new portal that require pop-ups. Go to your Privacy Settings and allow pop-ups from site: **portal.cchphealthplan.com**

SECTION 4 MEMBER ENROLLMENT AND ELIGIBILITY

Section 4.1 Member Enrollment and Assignment

CCHP Members can enroll in in a variety of ways based upon the program for which they are eligible.

- **CCHP Commercial Group -** For the employer group plans, including the Covered California for Small Businesses, the employee can enroll themselves and their dependents through a combination of their Human Resources Department, appointed broker, agent or consultant or with the help of CCHP's sales representatives. Employees are eligible to enroll in CCHP's commercial group plans if they live or work in CCHP's service area. The enrollment can occur annually during the group's open enrollment period, during the middle of the year if the employee has just satisfied the group's waiting period or if the individual had a qualifying event the enabled them to have a special enrollment period.

- **CCHP Individual & Family -** For individuals and family members who purchase coverage for themselves on Covered California or directly either through an appointed broker or agent, or CCHP sales representatives, the family must reside in CCHP's service area. The enrollment can occur annually during the open enrollment period, during the middle of the year if individual had a qualifying event the enabled them to have a special enrollment period.

- **CCHP Senior Program HMO** is a Medicare Advantage plan for people who live in CCHP's service area with Medicare Parts A and B.

- **CCHP Senior Select Program HMO** is a Special Needs Plan (SNP) that is for people who live in San Francisco County, have Medicare Parts A and B **and** is eligible for Medi-Cal benefits.

Members select a Primary Care Physician (PCP) upon enrollment from available provider lists, rosters or directories for their respective product. The selection of the PCP determines the Affiliated Medical Group or applicable network they will use for covered services. Sales Representatives or other CCHP staff will assist enrollees with their PCP selection without bias for one or particular physician or clinic.

If the enrollee attempts to elect a PCP or clinic that is no longer accepting new patients, the CCHP representative will make known to enrollee. If enrollee request for the CCHP representatives assistance in selecting a PCP, the CCHP staff uses the following criteria's tactfully to help enrollee pinpoint their next PCP choice.

A. Location, i.e., geographically convenient for the member
B. Language
C. Gender

CCHP representatives discusses PCP selection with the enrollee, whenever the enrollment application's required PCP selection box is incomplete or the PCP or clinic selected is no longer accepting new patients.

These criteria will help enrollees narrow down their range of PCP selection without the CCHP representative's comments, suggestions, or encouragement.

In the event that the members do not select a PCP, CCHP will assign a member to a PCP that is open an available to see new patients based on the above criteria.

Should a PCP become unavailable during the coverage period, the members will be notified and allowed to select a new PCP from the remaining available PCPs in the network. If the member does not select a PCP, CCHP will assign a member to a PCP that is open an available to see new patients based on the above criteria.

Section 4.2 Verifying Member Eligibility

Providers are responsible for verifying member eligibility before rendering services. Eligibility must be verified every time services are received. To verify eligibility for Jade/CCHP members, go to our Website at https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx

It contains real time information and can be accessed 24 hours a day. After checking member eligibility on the Website, if you have questions, please contact CCHP Member Services at 415-834-2118.

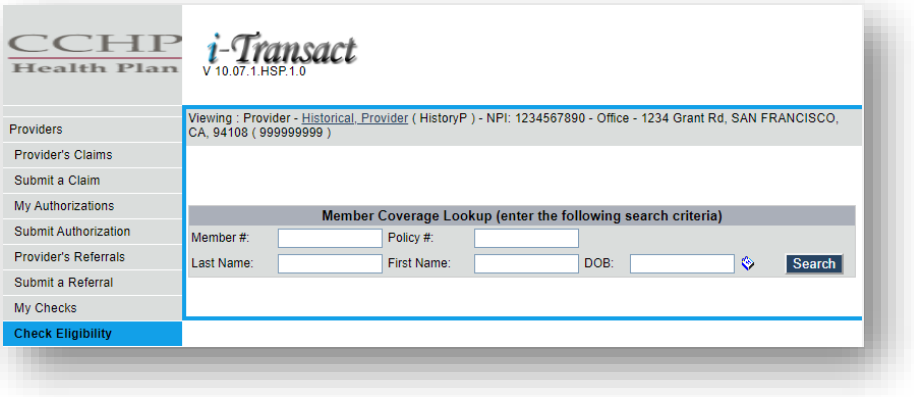
If members are affiliated with other CCHP contracted medical groups, please use the appropriate eligibility verification process.

Section 4.3 Website Instructions for Verifying Eligibility

To use CCHP's Website to check CCHP member eligibility and benefits:

1. Go to https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Enter your username and password and click on "Logon".
3. For CCHP Member Eligibility Search, select the "**Check Eligibility**" option on the left side bar.
4. Enter the CCHP Member ID under "**Member #**" (Example: 0001234).
5. To search with the old CCHP Member ID, please enter the old CCHP Member ID without the asterisk under "**Policy #**" (Example: 00011122201).
6. You can also search by Last Name, First Name, and Date of Birth (DOB).
7. After you entered the member information, the coverage dates will be under the effective and expiration date.
8. For a summary of the member's benefits and copayments, please click on "**view**" under Benefits.
9. For member's PCP and Medical Group information, please click on "**view**" under Member Face Sheet.

See **"Eligibility search"** screenshot below.



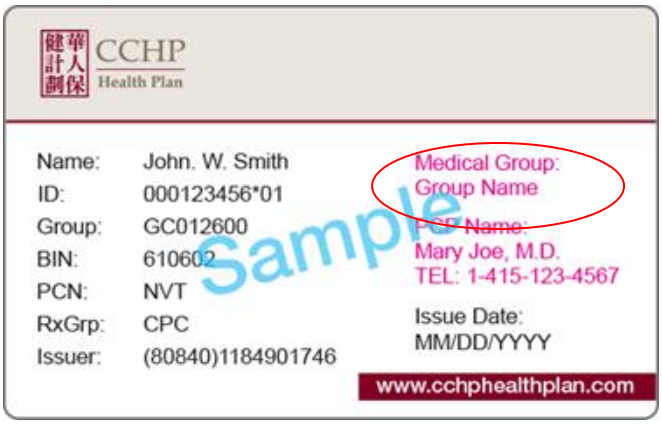
Note:
To verify eligibility and benefits for Medical Group's other health plan and program members, please use the applicable health plan website

Section 4.4 Member ID Cards

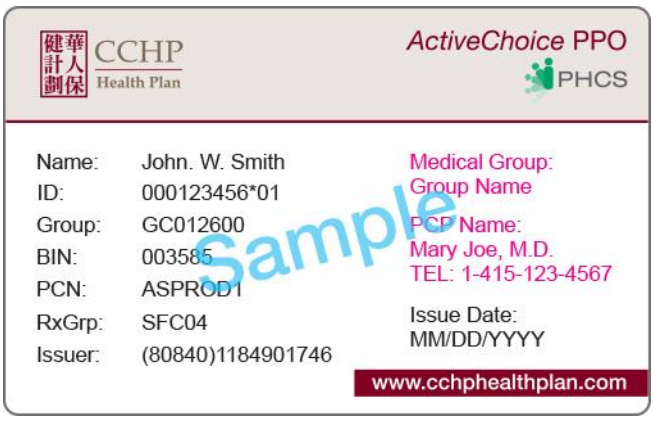
Please ask patients to present their CCHP ID Card each time they present for services. The ID Card is not proof of eligibility. It is for identification purposes only, however it contains information to assist you in verifying eligibility on our website. If a member does not have an ID Card, you can still use the website to verify eligibility. Because member eligibility and benefits are subject to change, **providers are responsible for verifying eligibility each time services are received.**

The following are samples of CCHP Member ID Cards:

CCHP Commercial (HMO) Program ID Card (Employer Group and Individual/Family Plan)



CCHP Commercial (PPO) Program ID Card (Employer Group and Individual/Family Plan)



CCHP Covered California (HMO) Program ID Card (Covered California)

CCHP Senior Program (HMO) ID Card (Medicare Advantage Members with Medicare Parts A + B)

CCHP Senior Select Program (HMO SNP) ID Card (Medicare Advantage Members with Medi-Cal and Medicare Parts A + B)

Please note that the service area for CCHP's Senior Select Program (HMO SNP) is the City and County of San Francisco. It does not include northern San Mateo County. Senior Select Program Members must obtain care within CCHP's San Francisco Provider Network.

SECTION 5 CCHP PROVIDER NETWORK

Section 5.1 Medical Group Affiliations

CCHP has a network of over 6,000 physicians available to provide care to CCHP members directly or via affiliated medical groups in a variety of products. CCHP network PCPs have offices throughout San Francisco and San Mateo County. CCHP has several options for members to access providers. This includes network relationships with the Jade Health Care Medical Group, Hill Physicians Medical Group in addition to providers who are contracted with CCHP. At the time if this writing, the summary below are the medical group options available to the respective CCHP members.

CCHP Membership Program	Commercial (Including Covered California) – Individual, Small Group and Large Group			Medicare – Senior and Senior Select Programs	
Medical Group Affiliation (or CCHP Direct)	Jade Health Care Medical Group	Hill Physicians Medical Group	CCHP Direct	Jade Health Care Medical Group	CCHP Direct
Member ID Card Abbreviation Designates Medical Group Affiliation	Jade	HPMG	CCHP	Jade	CCHP

Many practices may participate in one or several of these options. Please ask your CCHP Patients for their most current member ID card to look for the medical group information above.

Section 5.2 Providers Associated with Medical Group Affiliations

In addition to physicians, the CCHP network includes many allied health providers, facilities and hospitals. The following describes how members are to use the network.

A. CCHP contracts with the following medical groups to provide Primary Care and Specialist services, including but not limited to:
    - Hill Physicians Medical Group (HPMG)
    - One Medical Group (OMG)
    - Jade Health Care Medical Group (Jade)

Depending on the members' plan and choice of PCP, they may have access to doctors in the above medical groups.

B. Members must select a primary care provider (PCP) to coordinate his or her care.
C. Providers will assist CCHP in updating CCHP's Provider Directory and making sure we comply with State regulations
D. Providers will use the Provider Directory and the Preferred Outpatient Facilities List and refer to in-network providers

PROCEDURES:

A. Each CCHP member selects a primary care physician (PCP) from the available panel. The primary care provider coordinates all care provided to the CCHP member, including referrals to specialists and arrangements for medically necessary hospitalizations.
B. State regulations and CCHP ensure that its contracted network satisfies the following maximum practitioner to member ratios:
    - Primary Care Physician (MD and DO) to member ratio must be 1:2,000
    - Physician Extender (NP and PA) may increase the supervising PCP's ratio to an additional 1:1,000.
C. You will find provider directories for CCHP's various products – Commercial Group and Individual/Family members, Senior Program HMO members and Senior Select Program HMO SNP members. The printed provider directory is updated on at least a quarterly basis and the searchable online provider directory is updated weekly or as notified by a provider regarding changes.
D. For an online directory of CCHP providers, go to www.cchphealthplan.com/doctors/search
E. CCHP's directories list some of the following provider information:
    - Name
    - Primary Office Address
    - Secondary Office Address (if applicable)
    - Telephone Number
    - Type of practitioner
    - Area of specialty,
    - Name of each affiliated provider group currently under contract with the plan through which the provider sees enrollees
    - Language(s) spoken by the provider or other medical professional, as well as languages(s) spoken by a qualified medical interpreter on the provider's staff, if any
    - Education
    - Panel status (If provider is not accepting new patients)
F. Provider obligation regarding panel status (If provider is not accepting new patients):
        i. You are required to notify us within five (5) business days when not accepting new patients.

ii. You are also required to notify us within five (5) business days if you were previously not accepting new patients, but are currently accepting new patients.
iii. If you are not accepting new patients please direct enrollees or potential enrollees seeking to become a new patient to CCHP for additional assistance in finding a provider.
iv. CCHP will update provider's panel status on a weekly basis upon notification.

G. Plan oversight and provider obligation regarding updating provider information:
v. CCHP will notify you at least once annually you to update your information
vi. You are required to affirm receipt of this notification and verify the information for accuracy.
vii. If we do not receive an affirmative response and confirmation from you that the information is current and accurate within 30 business days, we shall take no more than 15 business days to verify whether your information is correct or requires updates.
viii. If we are unable to verify whether the provider's information is correct or requires updates, we shall notify you 10 business days in advance of removal that you will be removed from the provider directory.
ix. You shall be removed from the provider directory at the next required update of the provider directory after the 10-business day notice period. You shall not be removed from the provider directory if you respond before the end of the 10-business day notice period.

H. CCHP provides a telephone number, a dedicated email address, and an electronic form to receive reports of a potential directory inaccuracy.

I. Physicians who employ mid-level practitioners such as nurse practitioners, physician assistants, or those who have licensed providers like physical therapists, optometrists, etc., must adhere to the following requirements:
   a. All mid-level practitioners and/or licensed providers rendering care to CCHP patients must be credentialed.
   b. Services provided by mid-level practitioners or licensed providers must be billed using their individual National Provider Identifier (NPI) number.
   c. Only services provided by a contracted physician can be billed under the physician's name and NPI.

J. The credentialing process includes a request for the names and license numbers of health professionals employed by participating physicians. Once the credentialing department has completed and approved the provider, they will be added to the provider directory for marketing purposes.

K. We contract with the following hospitals, including:
   - Chinese Hospital
   - Dignity (St. Mary's & St. Francis)
   - Sutter: CPMC (California, Pacific, Davies Campus & St. Luke's Campuses)
   - Mills Peninsula
   - Verity: Seton Medical Center (Daly City, Coastside)
   - UCSF and Stanford are available subject to prior authorization requirements

L. Chinese Hospital is our primary hospital in San Francisco for CCHP members residing in San Francisco or affiliated with San Francisco primary care physicians (PCPs).

M. Seton Medical Center is CCHP's primary hospital in San Mateo County.

N. **Chinese Hospital (www.chinesehospital-sf.org)** offers a wide range of medical, surgical and diagnostic services. Please utilize the services of Chinese Hospital by referring patients as appropriate for both outpatient and inpatient care. Referral for services at Chinese Hospital does not require prior authorization.

Inpatient Care (except for Neurology, extensive Cardiac or Psychiatric)

- Intensive Care, Medical-Surgical, Telemetry, Surgical Suite and PACU Outpatient Care
- Same Day Surgery Unit, Endoscopy Suite (except Endoscopy Ultrasound)
- Outpatient Medical Therapy Center (Infusion)
- 24-hour Treatment Center with Board Certified ER Physicians
- Diagnostic and Interventional Radiology Services
- Ultrasound, CAT Scan, Mammography, Dual Energy X-ray Absorptiometry (DEXA) Scan
- Cardiac Diagnostic Testing (Non-interventional)
- Laboratory / Pathology Services (Outpatient and Inpatient)
- Inpatient Dialysis
- Nuclear Medicine
- Nutritional Counseling and Health Education
- Ophthalmologic Laser Services
- Pharmacy

O. For services not available at Chinese Hospital, the Utilization Management Department will make a determination as to where necessary services can be provided. Hospital services for obstetric patients will be authorized at California Pacific Medical Center (CPMC) or Seton Medical Center. Hospital services for pediatric patients will be authorized at CPMC.

P. CCHP contracts with several outpatient facilities. Please refer members to the facilities indicated on the “Outpatient Services Providers” list in this section.

Q. Laboratory services must be performed at a CCHP preferred facility. Complete a laboratory requisition and direct the member to a CCHP preferred laboratory-drawing site. (See “Outpatient Services Providers” list in this section.)

R. Routine radiology films do not require prior authorization at CCHP preferred facilities. Prior authorization is required for many radiology and imaging procedures, except for services at Chinese Hospital. Outpatient services at Chinese Hospital do not require prior authorization, except elective epidural injections for pain management. (See Outpatient Services Providers” list in this section.) It is the responsibility of the imaging service provider to:
    1) Verify member eligibility prior to rendering services
    2) Confirm authorization has been approved for services that prior authorization.

S. In San Francisco County, CCHP’s preferred providers for mammography services and bone density scans in San Francisco are Chinese Hospital on Jackson Street and RadNet on California Street. Please refer CCHP members to these facilities.
    a. In San Mateo County, CCHP doctors may refer CCHP Commercial and Senior Program (HMO) Members for mammograms and bone density screenings to Seton Medical Center in Daly City, RadNet in Redwood City or to one of our preferred facilities in San Francisco. CCHP Senior Select (HMO SNP) members may only be referred to preferred facilities in San Francisco.

b. Prior authorization is NOT required at these San Francisco and San Mateo County facilities for mammograms (1 per year in accordance with USPSTF Recommendations) and bone density scans. Mammograms beyond 1 per year require prior authorization. All other facilities require prior authorization. Prior authorization for services at other facilities will only be approved when medically necessary. Patient preference or the fact that a patient previously received mammography or bone density services from a non-preferred facility does not constitute medical necessity and will not be authorized by the Utilization Management Department.

T. In addition to the participating providers previously listed in this section, the CCHP provider network includes providers of DME, Home Health, Skilled Nursing, Medical Supplies, Transportation, etc. All of these services require prior authorization. When you submit a Service Authorization Request, the Utilization Management Department will direct you to a contracted provider.

Section 5.3 Notification of Provider Information Changes

Any change in your provider information must be reported to CCHP in writing within 90 days of the change. Some examples of these changes include practice location, phone number, Tax Identification Number (TIN), claims payment address, hours of operation, status as open to newly assigned members (for Primary Care Physicians), affiliated or covering physicians, physician assistants and nurse practitioners.

If you are a participating provider through one of the medical groups, such as Jade, Hill Physicians please notify their respective credentialing or network contracting department.

If terminating your participation directly with CCHP or through an affiliated IPA, you must submit a termination notice in writing to CCHP in the time frames stated in your respective Participating Provider Agreement.

Providers with CCHP or Jade Contracts should notify the CCHP Provider Contract Manager.

CCHP Provider Contract Manager
Chinese Community Health Plan
445 Grant Avenue, Suite 700
San Francisco, CA 94108
pic@cchphealthplan.com

SECTION 6 CREDENTIALING AND RE-CREDENTIALING

This policy section applies to all CCHP directly contracted providers or participating providers affiliated via other medical groups.

1. CCHP promulgates credentialing and re-credentialing decision guidelines for contracted providers.
2. CCHP follows these same guidelines for practitioners directly credentialed by CCHP.
3. CCHP adheres to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing and re-credentialing process, including the confidentiality of practitioner information obtained during the credentialing process.

Section 6.1 Practitioner Guidelines

CCHP will use the following guidelines when credentialing or re-credentialing practitioners for participation in CCHP's network.

1. Education and Training Guidelines
    a. PCPs – physicians being reviewed for credentialing as a PCP must meet the following criteria as indicated:
        i. Pediatrics - either board certified, three (3) years pediatrics residency training, or rotating internship plus two (2) years residency [Post Graduate Years (PGY-2, 3)] in pediatrics.
        ii. Family Practice - either board certified, three (3) years family practice residency training, or rotating internship plus two (2) years residency (PGY-2, 3) in family practice.
        iii. Family Practice 1 (Family Practice including outpatient OB services) – either board certified, three (3) years family practice residency training or rotating internship plus two (2) years residency (PGY-2, 3) in family practice. Must include signed agreement with delivering OB which states that Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members.
        iv. Family Practice 2 (Family Practice including full OB services and delivery) - board certified with three (3) years family practice residency training. Must have full delivery privileges at an CCHP network hospital, a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e.: low- risk, cesarean section, etc.). A written agreement for an available OB back up Provider is required. Providers that fulfill these requirements may be referred to and see OB/GYN Members within the health plan.
        v. Internal Medicine - either board certified, three (3) years internal medicine residency training, or rotating internship plus two (2) years residency (PGY-2, 3) in internal medicine.
        vi. OB/GYN - board certification, or completion of a four (4) year OB/GYN residency, documentation of primary care practice in the United States and fifty (50) Continuing Medical Education (CME) units for prior three (3)

year period, half of which must be in primary care related areas. Must have full delivery privileges at a CCHP network hospital.

vii. General Practice - at a minimum, completion of a one (1) year rotating internship or PGY-1 Family Practice, documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients, and evidence of fifty (50) CME units in primary care related areas for prior three year period.

viii. Practitioners outside of scope - occasionally Practitioners may practice outside of scope with approval from the Peer Review Committee. Practitioners must have evidence of half of all CME in the specialty outside of their normal scope of practice (i.e. Internal Medicine with expanded age range to all ages or General Practice board certified in Pediatrics only).

ix. Practitioners who do not meet the internship or residency requirements can be considered for General Practice if they demonstrate significant recent (past five (5) years) primary care practice experience and evidence of significant recent CME in primary care related areas.

x. PCP's must pass all requirements for the Facility Site Review and the Medical Records Review (FSR/MRR). Providers at a site without an active participating PCP must still have an FSR/MRR completed and passed to be considered a Non-Par provider in the network. No PCPs or Non-Par providers will be able to provide services at sites without completing an FSR/MRR.

xi. Physicians being reviewed for credentialing as a specialist practitioner must meet one of the following criteria:

1. Board Certification in the specialty and subspecialty, if applicable, or
2. Proof of residency training and/or fellowships as appropriate for the particular specialty and additional training required for subspecialties as applicable.
3. All OB/GYN Providers must provide obstetric as well as gynecological care to Members. All OB/GYN Providers must have full delivery privileges at a CCHP network hospital.
4. All certified nurse midwives (CNMs) may provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services only after they are fully credentialed and approved by CCHP. Agreement must include back-up physician's full delivery privileges at an CCHP network hospital, a protocol for identifying and transferring high risk Members, stated types of deliveries.

2. Patient Age Ranges
   a. Patient age ranges for PCPs and non-physician practitioners must be specifically delineated as part of the credentialing process.
   b. Guidelines for age ranges for PCPs are:
      i. Pediatrics - ages 0-18 or 0-21
      ii. Family Practice - all ages
      iii. Internal Medicine - age 14 and above, 18 and above, or 21 and above
      iv. OB/GYN - age 14 and above, restricted to females
      v. General Practice – age 14 and above or all age ranges if evidence of pediatric training, experience and/or CME is present.

c. Each physician extender can only increase one PCPs panel at a specific location.
d. A physician extender can only increase the total of two (2) PCPs panels at two (2) separate locations.
e. Guidelines for age ranges for non-physician practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Dieticians and Nutritionists are as applicable to the training and certification of the non-physician practitioner.
f. Patient age ranges for specialty physicians are specific to the specialty involved, training, and education of the physician.

3. Provider Privilege Adjustments
   a. Providers are required to submit a detailed explanation when requesting a change in practice parameters such as an expansion or education in Member age range or specialty care privileges.
   b. CCHP will consider all relevant information including practice site demographics, Provider training, experience and practice capacity issues before granting any such change.
   c. At a minimum, Provider submissions must include:
      i. A written explanation specifically outlining the material basis for the requested change;
      ii. Documentation of any relevant training (e.g., Continuing Medical Education, post graduate/residency training, etc.);
      iii. Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.); and
      iv. All limitations or expansions of age ranges will be reviewed and approved by CCHP Medical Director. Further review may be completed by the Credentialing Committee who will either approve or deny.
4. Adverse History Guidelines
   a. CCHP must carefully review all practitioners with evidence of adverse history, including malpractice history, adverse licensing, privileges, sanctions or other negative actions.
   b. For practitioners with a history of malpractice suits or decisions, the following criteria warrants full CCHP Medical Director review of the history and should be applied in making credentialing and re-credentialing decisions:
      i. Number of claims - any claims within the prior seven (7) years.
      ii. Results of cases - any settlements within the prior seven (7) years.
      iii. Trends in cases - practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).
      iv. Higher than average grievance rate or trend in grievances.
   c. Practitioners with any history of negative license actions, sanctions by Medicare or Medi-Cal, negative privilege actions or other negative actions against them (felony convictions, etc.) must be fully discussed and reviewed by CCHP's Credentialing Committee prior to a committee recommendation.
   d. Practitioners who are currently on probation with the Medical Board of California (MBOC) or Osteopathic Medical Board of California (OMBC), or any appropriate licensing board must be fully discussed and reviewed by or CCHP's Credentialing Committee. The reason for the probation, conditions of the probation and compliance with probation conditions by the practitioner must be considered during the credentialing decision making process.

e. Providers that have been deemed suspended and ineligible from Medi-Cal, sanctioned by the Office of Inspector General, or are identified on the Medicare Opt-Out will not be credentialed with CCHP or will be terminated for all lines of business if they are a currently credentialed Provider.

5. CCHP reserves the right to approve, deny, terminate or otherwise limit practitioner participation in the CCHP network for quality issues. If a Provider is denied participation, he/she may reapply after one (1) year.
6. Practitioners can appeal adverse decisions by the CCHP Credentialing Committee or Board of Trustees as delineated in CCHP's Peer Review Process and Level I Review and Level II Appeal (See Attachments, "CCHP Peer Review Process and Level I Review" and "CCHP Peer Review Process and Level II Appeal" in Section 5).

Section 6.2 Practitioner Credentialing Requirements

1. CCHP are required to contract with and credential all practitioners defined as PCPs, specialists, non-physician practitioners, and physician admitters, including employed physicians participating on the provider panel and published in external directories, who provide care to Members. At a minimum, this includes all Physicians (MDs), Osteopaths (DOs), Podiatrists (DPMs), Chiropractors (DCs), Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Audiologists (AUD), Dieticians and Nutritionists who are contracted to treat Members and who fall within CCHP's scope of authority and action. CCHP is required to credential all psychiatrists, psychologists, master level clinical nurses, Licensed Clinical Social Workers (LCSW), and Marriage, Family Therapist (MFTs), and other mental health professionals licensed to provide mental health services in the state of California. CCHP contracts and credentials Oral Surgeons (DDS or DMDs) who provide medical services only. CCHP does **not** contract with Oral Surgeons where services rendered by these practitioners are not covered by CCHP. CCHP does not require covering practitioners and locum tenens that do not have an independent relationship with CCHP to be credentialed. CCHP does not credential practitioners that are hospital based and do not see Members on a referral basis.

2. CCHP are required to verify the accreditation status, license, certification and standing with regulatory bodies of all subcontracted organizational providers (as applicable), in compliance with the most current URAC standards. Subcontracted organizational providers include but are not limited to hospitals, home health agencies, laboratories, skilled nursing facilities, and freestanding surgical centers, including family planning facilities and alternative birth centers. CCHP must also contract with hospice, outpatient rehab, outpatient physical and speech therapy and provide end-stage renal disease services, outpatient diabetes self-management training and portable x-ray. Subcontracted providers include inpatient, residential, and ambulatory settings for mental health and substance abuse.

3. CCHP must obtain approval of practitioners seeking participation with CCHP from CCHP's Credentialing Committee and CCHP's Medical Director before assignment of Members. CCHP credentialed and approved practitioners must meet CCHP practitioner guidelines for education, age limits and other criteria as specified in the CCHP Provider Manual.

4. CCHP must maintain a full credentialing file and perform all necessary credentialing activities per the most current URAC guidelines requirements.

5. CCHP may designate to their Medical Director the authority to determine and sign off on a credentialing and re-credentialing file that meets the CCHP's standards as complete, clean, and approved. CCHP may assign an associate medical director or other qualified medical staff member as the designated medical director if the individual has equal qualifications as the medical director and is responsible for credentialing, as applicable. CCHP's Credentialing Committee has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet the established criteria, and to offer advice as necessary.

PROCEDURES:

1. Completed application signed by the practitioner that includes:
   a. Education and training; and
   b. Work history.
2. Current attestation completed, dated and signed by the practitioner regarding:
   a. Reasons for any inability to perform essential functions of the position with or without accommodation;
   b. Physical and mental status;
   c. Lack of present illegal drug use;
   d. Lack of impairment due to chemical dependency/substance abuse;
   e. History of loss of license;
   f. Felony convictions;
   g. History of loss or limitation of privileges or disciplinary action or other negative license or privilege actions;
   h. Judgments entered against or settlements pending, filed and served regarding liability lawsuits or arbitration;
   i. Correctness and completeness of above attestations and information on application;
   j. Certification that the practitioners will keep the information up-to-date; and
   k. The health status attestations conform to the legal requirements of the Americans with Disabilities Act (ADA).
3. Primary Source verification of (all verifications are kept in Provider credentialing file):
   a. Current valid license - All practitioners must be licensed by the state of California for the specialty in which they practice. Current California state medical license must be obtained by direct confirmation from the Medical Board of California (MBOC), via the Internet, mail or phone. Verification of license must be within the one hundred eighty (180) days immediately preceding the credentialing decision by the committee. The license must be current at the time of credentialing and must remain current throughout the practitioner's participation with CCHP;
   b. Clinical privileges - All practitioners must have admitting privileges or appropriate admitter arrangements at a contracted CCHP Hospital, as necessary. Verification that all clinical privileges are in good standing to perform functions for which the practitioner is contracted must be confirmed with the Hospital, in writing, via approved website or verbally, and must include the date of appointment, scope of

privileges, restrictions (if any) and recommendations. If a published hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the practitioner is in "good standing." If an admitter arrangement is used, a written agreement that meets CCHP admitter requirements (see Policy 5D, "Hospital Privileges") confirming coverage for all inpatient work covering the entire age range of the practitioner must be included in the practitioner's credentialing file. Verification of clinical privileges must be within the one hundred eighty (180) day immediately preceding the credentialing decision by the committee;

c. Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate, as applicable - All practitioners, except non- prescribing practitioners, must have a valid DEA certificate. Verification may be in the form of a photocopy of the current DEA certificate or a query of the National Technical Information Service (NTIS) database. The copy of the practitioner's certificate or query must be initialed and date stamped to show receipt prior to the credentialing decision, be effective at the time of the credentialing decision and remain effective throughout the practitioner's participation with CCHP;
d. Education and training - All practitioners must have completed appropriate education and training for practice in the designated specialty or subspecialty. Because Medical boards verify education and training, verification of board certification fully meets this requirement. Only the highest level of credentials must be verified:
    i. Residency Training - Confirmation is required for non-board certified practitioners. Verification of completion of residency must be obtained from the institution or clearinghouse where the postgraduate medical training was completed, the American Medical Association (AMA) Physician Master File, or the American Osteopathic Association (AOA) Physician Master File; and
    ii. Medical School - If no residency has been completed, verification of medical school completion must be confirmed from the medical school or clearinghouse, AMA Physician Master File, AOA Physician Master File, or confirmation from the Education Commission for Foreign Medical Graduate (ECFMG), or unbroken, sealed transcripts from the institute in which the practitioner completed the appropriate training program. Evidence that CCHP inspected the contents of the envelope and confirmation that transcript shows that the practitioner completed the appropriate training program must be include in file if verified via sealed transcripts.
e. Board certification, as applicable - Verification of board status must be performed through the American Board of Medical Specialties (ABMS), AOA Physician Master File, American Board of Physician Specialties (AMPS), AMA Physician Master File and Behavior Analyst Certification Board (BACB). Oral Surgeon, Mental Health Therapy (BHT) and Podiatric board certification may be verified through the specialty board as long as that board performs primary-source verification. Verification must be performed through a letter directly from the board or an internet query of the appropriate board as long as the board states that they verify education and training with primary sources and indicate that this information is correct. Verification is valid for up to one hundred eighty (180) calendar days.

f. Malpractice insurance - All practitioners must have appropriate malpractice insurance coverage that is current and meets CCHP's standard of $1 million individual claims and $3 million for aggregate claims. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the practitioner via a copy of the policy and the signed attestation completed by the practitioner. The copy of the practitioner's certificate must be initialed and date stamped to show receipt prior to the credentialing decision, be effective at the time of the credentialing decision and remain effective throughout the practitioner's participation with CCHP;
g. Malpractice history - Verification of claims history must be obtained from the current and/or previous carriers and public record as necessary. A minimum of five years of claims history must be reviewed for initial credentialing and three (3) years for re-credentialing. The National Practitioner Data Bank (NPDB) may be queried in lieu of verification of history from carriers. Verification must be within the one hundred eighty (180) days immediately preceding the credentialing decision by the committee; and
    i. Failure to keep current and active license, DEA and malpractice insurance can result in administrative termination of the practitioner.
    ii. No exclusions, suspensions, ineligibility or opt-out of any state or federal health care program at the time of the Credentialing Committee's decision or during their participation in the CCHP network.
    iii. Eligible for payment under Medicare. Provider must not appear on Medicare Opt-Out Report.
    iv. No exclusion from participation at any time in federal or state health care programs based on conduct within the last five (5) years that supports a mandatory exclusion under the Medicare program as set forth in Title 42, United States Code, Sections 1320.7(a) as follows:
        1. A conviction of a criminal offense related to the delivery of an item or service under federal or state health care programs;
        2. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;
        3. A felony conviction related to health care fraud; or
        4. A felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.
h. Work history - All practitioners must supply a minimum of five years of work history for initial credentialing and three years for re-credentialing. This may be in the form of a curriculum vitae (CV), practitioner's application, or work history summary, providing it has adequate information. CCHP is required to review gaps in work history for a time period of six (6) months or more. Any work history gap that exceeds one (1) year must be clarified in writing. Verification of work history must be within the one hundred eighty (180) days immediately preceding the credentialing decision by the committee.
i. NPI – Practitioners are required to maintain an individual NPI number which must be verified through CMS. Providers that have group NPI numbers may submit that information in addition to the mandatory individual NPI number. Verification of NPI must be completed within the one hundred eighty (180) day time limit.
j. Information with regard to disciplinary actions, restrictions, limitations and Medicare/Medi-Cal sanctions must be obtained from the following and be no more than one hundred eighty (180) days old at the time of the credentialing decision:

i. NPDB query;
ii. MBOC query; and
iii. Medicare/Medi-Cal sanctions reports including:
    1. Medi-Cal Suspension and Ineligible List
    2. Medicare Exclusion Database

4. Practitioner Rights
    a. Right of practitioners to review information submitted to support their credentialing application:
        i. Practitioners are notified of their right to review information obtained by the organization to evaluate their credentialing application.
        ii. The evaluation includes information obtained from any outside source (e.g. malpractice insurance carrier, state licensing boards) with the exception of references, recommendations or other peer-review protected information.
    b. Right of practitioner to correct erroneous information:
        i. Practitioners are notified in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner and must clearly identify time frame, methods, documentation and responsibility for notification.
        ii. CCHP is not required to reveal the source of information if the information is not obtained to meet credentialing verification requirements or if discloser is prohibited by law.
        iii. Practitioners have the right to correct erroneous information submitted by another source and must clearly state:
            1. Time frame for changes.
            2. Format for submitting corrections.
            3. Person to whom corrections must be submitted.
            4. Documentation of the receipt of the corrections.
            5. How practitioners are notified of their right to correct erroneous information.
        iv. The right of practitioner to be informed of the status of their credentialing or re-credentialing application upon request.

5. Credentialing Committee
    a. CCHP must have a Credentialing Committee that reviews practitioner's information and either approves or denies practitioner participation.
    b. CCHP does not make credentialing and re-credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Medi-Cal) in which the practitioner specializes. This does not preclude CCHP from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.
    c. Committee minutes must reflect thoughtful discussion and consideration of all practitioners being credentialed or recredentialed before a credentialing decision is determined.
    d. Practitioners are notified of the credentialing and re-credentialing decision within ten (10) business days of the Committee's decision.
    e. CCHP adopts a "clean file" process for credentialing and re-credentialing and the policies and procedures must describe the process used to determine clean files (i.e. files that meet CCHP's criteria) and must include the following:

i. The Medical Director is the individual with the authority to determine that the file is "clean" and to sign off on it as complete, clean, and approved.
ii. CCHP may assign an associate medical director or other qualified medical staff member as the designated medical director if this individual has equal qualifications as the Medical Director and is responsible for credentialing.
iii. At a minimum, the designated medical director must review and sign off on all files of practitioners who meet the established criteria. CCHP uses this sign off date as the "committee review date."
iv. The designated medical director may use a handwritten signature, handwritten initials, or unique electronic identifier as documentation of sign off. Stamped signatures are not acceptable.
v. The Medical Director's sign off date is used as the "credentialing decision date." CCHP may choose to continue submitting all practitioner names to the Credentialing Committee.

6. Facility Site Reviews
   a. Prior to credentialing, or when a practitioner relocates, CCHP must perform an on-site facility review for all contracted PCPs. Policy and procedure must meet CCHP's facility site review requirements for the Medicare Programs, as stated in Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring." Documentation of site review must include:
      i. Standards and thresholds for acceptable performance;
      ii. Evaluation of initial site, new site or relocation against standards;
      iii. Evidence of corrective actions for improvement of sites that do not meet established thresholds; and
      iv. Follow-up for sites with significant deficiencies to ensure compliance.

7. Re-credentialing
   a. CCHP must formally recredential its practitioners at least every three (3) years. This three year (3) period must be within thirty-six (36) months of the last Committee approval date.
      i. Failure to meet the thirty-six (36) month time frame will result practitioner going through the initial credentialing procedures as listed above.
   b. Re-credentialing must include primary source verification of the following (as defined for credentialing primary source verification):
      i. Current state license;
      ii. Current and valid DEA;
      iii. Clinical privileges;
      iv. Board certification;
      v. Current malpractice insurance;
      vi. Malpractice history - a minimum of three (3) years;
      vii. Individual Practitioner NPI number; and
      viii. Current, signed attestation statement by the practitioner which conforms to the legal requirements of the Americans with Disabilities Act (ADA) regarding:
         1. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
         2. Physical and mental status;

3. Lack of present use of illegal drugs;
4. Lack of impairment due to chemical dependency/substance abuse;
5. History of loss or limitation of privileges or disciplinary action or negative license or privilege actions;
6. History of loss of license;
7. Felony convictions;
8. Malpractice insurance coverage, as applicable;
9. Judgments entered against or settlements pending, filed and served regarding liability lawsuits or arbitration;
10. Certification that the practitioner will keep the information up-to-date; and
11. The correctness and completeness of information.

c. A re-query must be made during the re-credentialing process regarding disciplinary actions, restrictions, limitations, and Medicare/Medi-Cal sanctions as defined above and include.
   i. Medi-Cal Suspension and Ineligible List
   ii. Medicare Exclusion Database

d. Medicare Opt-out Providers
   i. Credentialing staff shall verify Providers who are excluded from participation in Medicare and Providers who have opted out of Medicare utilizing the OIG/Medicare website during primary source verification, initial credentialing, re-credentialing and during monthly monitoring.

8. Performance Monitoring
   a. When re-credentialing a practitioner, CCHP must include review of data from Member grievances, results of quality reviews, and any information obtained from CCHP specific to the practitioner in any of the above areas. Documentation of the review must be sufficient to determine that the information was received and reviewed prior to the re-credentialing decision.
9. Notification to Authorities and Practitioner Appeal Rights
   a. CCHP must have policies and procedures for, and evidence of implementation of the conditions that alter a practitioner's participation with CCHP based on issues of quality of care and service defining:
      i. Methods used to identify deficiencies both during the credentialing and re-credentialing process and on an ongoing basis.
      ii. Process for follow-up of any identified deficiencies.
      iii. Range of actions that CCHP takes prior to termination.
      iv. Appeals process for the practitioner and mechanism for notification of the right to appeal by practitioner.
      v. Procedures for reporting to authorities of any adverse action.
      vi. Description of how, when, and what serious quality deficiencies are reported to appropriate authorities.
10. Assessment of Subcontracted Organizational Providers
   a. CCHP must have policies and procedures for the initial and ongoing assessment of subcontracted organizational Providers. Policies and procedures must include how they perform the following:
      i. Confirms that the subcontracted organizational provider is accredited by an approved accrediting body
      ii. Conducts an onsite Quality Improvement facility review, if there is no accreditation status.

iii. Verifies the subcontracted organization Provider's license is current and that the facility has met all state and federal licensing and regulatory requirements.
iv. Confirms that the subcontracted organizational provider is in good standing with federal and regulatory bodies, including Medicare/Medi-Cal sanctions.
v. Reassesses the subcontracted organizational provider at least every contract period, but no less than every three (3) years.

11. All PCPs must also pass a CCHP facility review at the time of initial credentialing and every three (3) years thereafter
12. CCHP and any regulatory oversight agency, has the right, within two (2) working days advance notice, to examine credentialing/re-credentialing files or sites as needed to perform oversight of all practitioners or to respond to a complaint or grievance.
13. All information obtained by CCHP during the credentialing/re-credentialing process is confidential to the extent required by law.

Section 6.3 Hospital Privileges

1. CCHP contracted and subcontracted practitioners have privileges at a designated CCHP contracted Hospital. The contracted Hospital must be within a fifteen (15) mile radius or thirty (30) minute drive via private or public transportation, of the Member's residence, when applicable.
2. If the Primary Care Physician (PCP) does not or cannot obtain hospital privileges directly, the PCP must arrange for an admitter or hospitalist (when required) to be responsible for admissions and providing inpatient care on behalf of the contracted practitioner.
3. Admitting practitioners must be contracted and credentialed (unless practitioners are hospital based only) in accordance with regulatory standards and CCHP requirements.
4. Utilizing on-call hospital practitioners without a contract is not an acceptable arrangement.
5. All specialty practitioners must obtain hospital privileges directly with a CCHP contracted Hospital.

PROCEDURES:

1. During the credentialing process, CCHP identify PCPs who do not have privileges at the designated CCHP contracted Hospital. Provider must arrange for an admitter or hospitalist (when required) to be responsible for admissions and providing inpatient care on behalf of the non-admitting practitioner.
2. A written verification in the form of a signed agreement or letter from the admitting practitioner that such arrangements are in place is required. This agreement must include the following information:
   a. Non-admitting practitioner name
   b. Non-admitting practitioner specialties
   c. Non-admitting practitioner address and phone number
   d. Admitting practitioner name(s)
   e. Admitting practitioner specialties
   f. Admitting practitioner phone number and fax number

g. Admitting practitioner's age range
h. CCHP contracted Hospital(s)
i. Terms of arrangement
    i. The agreement must stipulate a minimum of thirty (30) days advance notice of intent to terminate by either party. Notice of termination must be submitted to CCHP within five (5) days of knowledge of pending termination.

3. The Agreement must be signed and dated by the non-admitting practitioner, admitting practitioner, and the CCHP.
4. The Agreement must also specify that bills for services rendered are submitted to and paid by the CCHP.
5. Upon receipt of written admitting arrangements, CCHP verifies:
    a. The non-admitting practitioner's specialty is completely covered by the admitting practitioner's specialty. (For example, a Family or General Practitioner may admit all patients for another Family or General Practitioner, an Internist and a Pediatrician may collectively cover admissions for a Family or General Practitioner.)
    b. Hospital privileges of the admitting practitioner(s) are in place and in good standing.
6. No enrollment is given to any PCP until appropriate and complete arrangements for Hospital admissions are in place and verified by CCHP.
7. In the event it is discovered that a PCP with assigned enrollment does not have privileges at the designated CCHP contracted Hospital, and has not made arrangements with other practitioners to provide admitting and inpatient care services for that practitioner, CCHP may freeze the membership of the PCP and/or transfer these Members immediately.

Section 6.4 Subcontracted Organizational Providers

1. CCHP directly contracts with ancillary and organizational Providers to provide medical services to Members.
2. CCHP directly contracts with Hospitals (Providers). In turn, Providers subcontract with ancillary and organizational Providers (subcontracted Providers) to provide services to Members. Ancillary and organizational providers include, but are not limited to, Home Health Agencies (HHA), Acute Rehab Facilities, Long Term Care (LTC) Facilities, Skilled Nursing Facilities (SNF), Dialysis Centers, Hospice Services, Free-standing Ambulatory Surgical Centers (ASC), Outpatient Hospital services and Laboratories.
3. All delegated Providers that subcontract with ancillary and organizational Providers, and Providers contracted directly with CCHP must use only those facilities that:
   a. Are appropriately licensed;
   b. Are in good standing with either a CCHP recognized accrediting body (e.g., The Joint Commission, AAAHC) or approved directly by CCHP;
   c. Are in good standing with state and federal regulatory bodies: and
   d. Do not have sanctions (CMS/DHCS) that would prevent them from participating in the CCHP network.
   e. CMS participating agreement letter, if applicable
   f. Hospitals contracted with CCHP
4. CCHP must review the accreditation status, license, and standing with regulatory agencies (i.e., sanctions/negative license activities) for each contracted or subcontracted Provider during initial contracting and at least once every three (3) years, thereafter. CCHP must have a tracking mechanism for ensuring that expiring documents and licensures and tri-annual reviews are compliant. CCHP audits delegated compliance annually.
5. All Providers must adhere to all procedural and reporting requirements under state and federal laws and comply with the most recent URAC, DMHC and CMS guidelines for ancillary and organizational Providers, as well as CCHP requirements.
6. CCHP recognized accrediting bodies are as follows:
   a. Hospitals and other acute care facilities
      i. The Joint Commission (JCAHO)
      ii. American Osteopathic Association (AOA)
      iii. Commission on Accreditation of Rehabilitation Facilities (CARF)
      iv. Center for Improvement in Healthcare Quality's (CIHQ)
   b. Acute Rehab Facilities:
      i. The Joint Commission (JCAHO)
      ii. American Osteopathic Association (AOA)
   c. Home Health Agencies:
      i. The Joint Commission (JCAHO)
      ii. Accreditation Association for Ambulatory Health Care (AAAHC)
      iii. Community Health Accreditation Program (CHAP)
      iv. Accreditation Commission for Health Care, Inc. (ACHC)
   d. Skilled Nursing Facilities:
      i. The Joint Commission (JCAHO)
      ii. Accreditation Association for Ambulatory Health Care (AAAHC)
      iii. Continuing Care Accreditation Commission (CCAC)
      iv. Commission on Accreditation of Rehabilitation Facilities (CARF)

e. Dialysis Centers:
    i. The Joint Commission (JCAHO)
    ii. The National Dialysis Accreditation Commission (NDAC)
f. Hospice Services:
    i. The Joint Commission (JCAHO)
    ii. Accreditation Commission for Health Care, INC. (ACHC)
    iii. Community Health Accreditation Program (CHAP)
g. Free-Standing Surgical Centers:
    i. The Joint Commission (JCAHO)
    ii. Accreditation Association for Ambulatory Health Care (AAAHC)
    iii. American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
    iv. The Medical Quality Commission (TMQC)
    v. Institute for Medial Quality (IMQ) Ambulatory Program
h. Laboratories:
    i. Clinical Laboratory Improvement Amendment (CLIA)

7. Delegated Providers that subcontract with ancillary and organizational Providers are responsible for ensuring that their subcontracted Providers meet CCHP's requirements. CCHP audits delegate's compliance with CCHP requirements on an annual basis, using the CCHP Delegation Oversight Audit Tool beginning with a pre-contractual assessment. Delegated Providers are subject to corrective action.
8. Directly contracted ancillary and organizational Providers that are not accredited are assessed by QM and reviewed and approved by the Credentialing Committee.
9. CCHP reserves the right to perform facility site audits when quality of care issues arise and to deny contracted or subcontracted Providers participation in the CCHP network if CCHP requirements for participation are not met.
10. Contracted and/or subcontracted Provider's failure to meet CCHP's requirements may result in adverse action up to and including non-renewal or termination of the delegated entity contract or CCHP contract.

Section 6.5 Credentialing Appeals Process

1. A practitioner's status or participation in the CCHP network may be denied, reduced, suspended, or terminated for any lawful reason, including but not limited to: a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at a CCHP contracted Hospital; or a determination by CCHP based on information obtained during the credentialing process that the practitioner cannot be relied upon to deliver the quality or efficiency of Member care required by CCHP.
2. Practitioners have the right to appeal any adverse credentialing decision that impacts their participation status with CCHP, in accordance with the appeals procedures provided herein.
3. CCHP complies with the reporting requirements of the Medical Board of California (MBOC), the Osteopathic Medical Board of California (OMBC), the California Board of Optometry (CBO), and the National Practitioners Data Bank (NPDB) as required by law. CCHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement

Act regarding adverse credentialing actions. Practitioners are notified of the report and its contents in accordance with law.

4. Practitioners must appeal directly to CCHP for adverse credentialing decisions rendered by the CCHP.

PROCEDURES:

1. The CCHP Quality Improvement Committee performs oversight of credentialing activities, including retrospective practitioner quality reviews referred by a CCHP Medical Director.
2. The CCHP Quality Improvement Committee reviews Provider appeals for adverse credentialing decisions.
3. All credentialing decisions for practitioners credentialed by CCHP are made by the CCHP Credentialing Committee, based on information obtained during the credentialing process.
4. If the CCHP Credentialing Committee denies a practitioner's participation in the CCHP network for reasons related to credentialing requirements, the practitioner is entitled to an appeal.
5. CCHP does not discriminate in terms of participation, reimbursement or indemnification, against any health care professional who is acting within the scope of their license, who serves high-risk populations, or who specializes in the treatment of costly conditions.
6. CCHP sends written notification, by certified mail, return receipt requested, to any practitioner denied participation within ten (10) working days of the decision reached by the Credentialing Committee. The written notice includes the following:
    a. The action of denied participation status has been proposed or taken against the practitioner.
    b. A brief description of the factual basis for the proposed action that includes but is not limited to:
        i. A lapse in basic qualifications such as licensure, insurance, or required medical staff privileges;
        ii. A determination that the practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by CCHP;
        iii. A determination that the practitioner cannot be relied upon to follow CCHP's clinical or business guidelines or directives;
        iv. Falsification of information provided to CCHP;
        v. Medicare/Medi-Cal sanctions;
        vi. Adverse malpractice history;
        vii. Adverse events that have potential for or have caused injury or negative impact to Members; and/or
        viii. Felony convictions.
    c. A statement that the practitioner may request an appeal conducted by the CCHP Credentialing Committee in accordance with this policy.
    d. Provider is notified that a request for an appeal must be requested by the practitioner in writing, addressed to the CCHP Chief Executive Officer or Medical Director, and received within thirty (30) days of the date of receipt of the notice by the practitioner. The practitioner's written request must include:
        i. A clearly written explanation of the reason for the request; and
        ii. A request to exercise the right to present the appeal orally, if so desired per below.

e. A summary of the practitioner's rights at the appeal and that the meeting takes place before the CCHP Credentialing Committee. The summary states:
    i. The practitioner has the right to present additional written material for review by the CCHP Credentialing Committee;
    ii. The practitioner has the right to present any information orally to the CCHP Credentialing Committee, in person, at the time of the meeting;
    iii. That the appeal meeting is not a hearing, and procedural rights associated with formal peer review hearings do not apply for adverse credentialing decisions. At the appeal meeting, practitioners may not be represented by a licensed attorney; however, they have a right to be represented by a non- attorney representative of their choice.
f. A notice that the action, if implemented, must be reported to the MBOC, OMBC, or CBO and NPDB, as applicable under California Business and Professions Code, Section 805, as applicable, and/or under any other applicable federal or state law.

7. If an appeal is submitted in a timely manner, CCHP arranges for a review of the appeal to be conducted at the next scheduled meeting of the CCHP Credentialing Committee. Prior to the meeting, CCHP sends a written notice to the practitioner via certified mail informing the practitioner of the date, time and place of the meeting.
8. When the CCHP Credentialing Committee completes its evaluation and renders a decision to uphold or overturn the denial made by the CCHP Credentialing Committee, the practitioner is notified, in writing, within ten (10) business days of the decision.
9. If the appeal decision by the Credentialing Committee upholds the original denial of the practitioner's participation in the CCHP network by the CCHP Credentialing Committee, the written notice includes the following:
    a. The decision, including a brief description of the decision and the reasons for it;
    b. The decision will be adopted as the final action;
    c. The action, if implemented, must be reported to the MBOC, OMBC, CBO or NPDB, under Business and Professions Code, Section 805, as applicable, or under any other applicable federal or state law; and
    d. The practitioner may re-apply after one (1) year.
10. Practitioners that have been denied (initial or recredential) by Credentialing Committee and upheld by Peer Review may not request Level II Appeal.
11. Practitioners not requesting an appeal within the required timeframe and as specified above, waives his or her right to further appeals, and the decision of the CCHP Credentialing Committee is final.
12. A practitioner may not reapply to be in the CCHP network until one (1) year after termination, or denial.
13. CCHP complies with all reporting requirements of the MBOC, OMBC, CBO or NPDB, as applicable as required by law. CCHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing decisions. CCHP notifies the practitioner of such reporting and its contents in writing.
14. Actions that are reported to the MBOC, OMBC, CBO, or NPDB, as applicable, include a decision to deny or reject a practitioner's application for staff privileges or membership for a medical disciplinary cause or reason; a decision to terminate or revoke a practitioner's membership, staff privileges or employment for a medical disciplinary cause or reason; restrictions imposed or voluntarily accepted, on staff

privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reasons; and or a practitioner's resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

15. All credentialing records and proceeds are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.

Section 6.6 Level I Peer Review and Credentialing Appeal

Denial, Reduction, Suspension or Termination of Practitioner Status

Purpose:

To provide:

1. a mechanism for peer review of CCHP providers of service (practitioners),
2. a process for practitioner to request review of negative peer review recommendations, decisions, and actions, for any reason related to quality of care issues, non-quality of care issues, and/or credentialing requirements, including, but not limited to, denial, reduction, suspension or termination of practitioner status, as requested by the CCHP Peer Review Committee, the CCHP Quality Management (QM) Committee, the CCHP Credentialing Committee, or the CCHP Medical Director, and
3. a mechanism for appropriate action.

Scope:

The following policies and procedures apply to all practitioners participating or requesting participation as a provider for CCHP, including, but not limited to, the following licentiates: Physicians (MD), Osteopathic Physicians (DO), Podiatrists (DPM), Pharmacists (Pharm D or RPh), Oral Surgeons (DDS or DMD), Optometrists (OD), Chiropractors (DC), Audiologists, Clinical Psychologists, (PhD), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Physical Therapists (PT), Occupational Therapists (OT), and Speech/Language Therapists (S/LT), Psychiatrists, Psychologists, Master Level Clinical Nurses, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC/MFT) and other mental health professionals licensed to provide mental health services in the state of California.

Policy:

1. A provider's status or participation may be denied, reduced, suspended or terminated for any lawful reason, including, but not limited to: a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at a CCHP contracted hospital; a determination by CCHP that the practitioner cannot be relied upon to deliver the quality or efficiency of patient care required by CCHP; a determination by CCHP that the practitioner cannot be relied upon to follow CCHP's clinical or business guidelines or directives; or a change in CCHP's business needs.
2. A practitioner may request review of any initial adverse recommendation, decision or action by CCHP that is based on quality of care issues, non-quality of care issues,

and/or credentialing requirements, and impacts his or her participation status with CCHP, including denial, reduction, suspension, or termination of his or her participation status with CCHP, in accordance with the Level I Review procedures, as provided herein.

Procedure:

1. Issues raised about either an applicant or a participating practitioner's credentialing packet or performance as a practitioner shall be considered initially by the CCHP Medical Director, who shall have the discretion to investigate and to determine the necessary and appropriate response and intervention as delegated to the CCHP Medical Director as a member of the CCHP Peer Review Committee or CCHP Credentialing Committee. His/her options shall include, but not be limited to: maintaining a record of the matter without further investigation or action; investigating the matter personally and making a report and recommendation to the CCHP Peer Review Committee or CCHP Credentialing Committee, as warranted; or referring the matter to the CCHP Peer Review Committee or CCHP Credentialing Committee for investigation and the preparation of a report and recommendation to the CCHP Medical Director.
2. In instances where there may be an imminent danger to the health of any individual, the CCHP Medical Director and/or the CCHP Peer Review Committee may summarily restrict or suspend the participating practitioner's privilege to provide patient care services, effective immediately upon written notice to the practitioner. The notice shall be in the same format as described in Section 3 herein, pending consideration and action by the CCHP Peer Review Committee. The CCHP Peer Review Committee may continue to enforce the reduction or suspension pending further action.
3. If an unfavorable recommendation, decision or action is made or taken by the CCHP Peer Review Committee or CCHP Credentialing Committee for a reason relating to quality of care issues, non-quality of care issues, and/or credentialing requirements, the practitioner shall be entitled to a Level I Review. The practitioner shall be sent a written notice, by certified mail, of the recommendation or decision and shall be afforded thirty (30) days in which to respond in writing to request a Level I Review. A copy of the "CCHP Peer Review Level I and Credentialing Appeal" document shall be provided with the notice. The notice will state:
    a. The action which has been proposed against the practitioner;
    b. A brief description of the factual basis for the proposed action;
    c. That the practitioner has the right to request that a Level I Review be conducted by the CCHP Peer Review Committee;
    d. That a Level I Review must be requested by the practitioner in writing, addressed to the CCHP Medical Director within thirty (30) days of the date of receipt of the notice by the practitioner. The practitioner's written request for a Level I Review must state the reasons for the request clearly, and if the practitioner wishes to exercise the right to present information orally at the Level I Review meeting as provided in Section 4b below, the practitioner shall so indicate in the written request for Level I Review;
    e. A brief summary of the practitioner's rights at the Level I Review, as set forth below;
    f. That the Level I Review shall take place before the CCHP Peer Review Committee; and

g. That the action, if implemented, must be reported to the Medical Board of California under California Business and Professions Code Section 805 or 809 as applicable, National Practitioner Data Bank (NPDB), and/or under any other applicable federal or state law.

4. A practitioner's rights at the Level I Review include:

   a. Right to present any additional written material for review by the CCHP Peer Review Committee.
   b. Right to present any information orally to the CCHP Peer Review Committee in person at the time of the meeting for the Level I Review.
   c. If the Level I Review is not requested by the practitioner within the time and in the manner specified, all administrative Level I Review rights of the practitioner shall be deemed waived, and the decision made by the CCHP Peer Review Committee or CCHP Credentialing Committee shall be final.

5. If Level I Review is requested within the time and in the manner specified, the CCHP Medical Director shall arrange for the review to be conducted at the next scheduled meeting of the CCHP Peer Review Committee, and the practitioner shall be sent a written notice via certified mail stating the date, time, and place of the Level I Review meeting. The practitioner's written response to the notice of action or proposed action shall be summarized in or attached to a report to the CCHP Peer Review Committee which shall be written by the CCHP Medical Director, as a member of the CCHP Peer Review Committee or CCHP Credentialing Committee.
6. As provided in this "CCHP Peer Review Level I and Credentialing Appeal", the Level I Review shall include an opportunity for the practitioner to present information and arguments in writing and/or orally. However, the Level I Review meeting is not a hearing, and the procedural rights associated with formal peer review hearings do not apply in Level I Review. At a Level I Review meeting, practitioners may not be represented by a licensed attorney; however, they have a right to be represented by a non-attorney representative of their choice. The CCHP Peer Review Committee shall have the discretion to prescribe such additional procedural elements as it deems appropriate to the circumstances. When the CCHP Peer Review Committee is satisfied that sufficient information and arguments have been presented in this review process, it shall recommend or take such action as it deems appropriate and send written notice via certified mail to the practitioner.
7. In cases where the decision by the CCHP Peer Review Committee or Credentialing Committee for the Level I Review will result in the denial, suspension, reduction or termination of the practitioner's participation status with CCHP, the written notice will include the following:
   a. The Level I Review decision, including a brief description of the proposed recommendation, decision or action and the reasons for it;
   b. That the action, if implemented, must be reported to the Medical Board of California under Business and Professions Code Section 805 or 809 as applicable, National Practitioner Data Bank (NPDB), or under any other applicable federal or state law;

c. That the practitioner may request a Level II Appeal hearing for adverse peer review decisions (this does not apply to initial adverse and denied credentialing decisions upheld by the CCHP Peer Review Committee);
d. That a Level II Appeal hearing must be requested in writing, within thirty (30) days of receipt of the notice by the practitioner and the request must include a statement of the grounds for requesting a Level II Appeal;
e. A brief summary of the practitioner's rights with respect to the Level II Appeal hearing;
f. A statement that the practitioner is required to exhaust the administrative remedies of the Level II Appeal hearing prior to seeking judicial review of the recommendations, decisions or actions of the CCHP Peer Review Committee; and
g. The Level II Appeal proceeding shall take place before a Hearing Officer, selected by the CCHP Medical Director in accordance with the procedures set forth in the Level II Appeal document, and the final action shall be taken by the Peer Review Committee.

8. Request for a Level II Appeal
   The practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse recommendation, decision or action resulting from a Level I Review to request a formal Level II Appeal. The request must be submitted in writing, directed to the CCHP Medical Director, and must be received at CCHP within the prescribed period. If the practitioner does not request a formal Level II Appeal within the time and in the manner prescribed, they shall be deemed to have accepted the recommendation, decision, or action involved, and shall be deemed to have waived all administrative appellate review rights, and the recommendation, decision, or action may be adopted by the Peer Review Committee or CCHP Credentialing Committee as CCHP's final action.
9. Reporting
   CCHP shall comply with the reporting requirements of the Medical Board of California (MBOC) as required by law. CCHP shall comply with the reporting requirements of the California Business and Professions Code, the Federal Health Care Quality Improvement Act, and the National Practitioner Data Bank (NPDB) regarding adverse credentialing and peer review actions. The practitioner will be notified of the reports and its contents.
   MBOC requires reports whenever*:* a licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason; a licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; restrictions are imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any 12-month period, for a medical disciplinary cause or reason; and/or a licentiate's resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.
10. Confidentiality
    All credentialing and peer review records and proceedings shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law

Section 6.7 Level II Peer Review Process and Credentialing Appeal

PEER REVIEW PROCESS AND LEVEL II APPEAL

Reduction, Suspension or Termination of Practitioner Status

Purpose:

To provide:

1. a mechanism for peer review of CCHP providers of service (Providers);
2. a process for practitioners (as defined below under section B, “Scope”) to appeal negative peer review recommendations, decisions and actions for any reason related to quality of care, non-quality of care, and/or other professional conduct issues including, but not limited to, denial, reduction, suspension or termination of practitioner status, as requested by the Chinese Community Health Plan (CCHP) Peer Review Committee, the CCHP Quality Management (QM) Committee, or the CCHP Chief Medical Officer ; and
3. a mechanism for appropriate final action.

Scope:

The following policies and procedures apply to all health care professionals participating or requesting participation as a practitioner for CCHP (Practitioners), including, but not limited to, the following licentiates: Physicians (MD), Osteopathic Physicians (DO), Podiatrists (DPM), Pharmacists (Pharm D or RPh), Oral Surgeons (DDS or DMD), Optometrists (OD), Chiropractors (DC), Audiologists, Clinical Psychologists, (PhD), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Physical Therapists (PT), Occupational Therapists (OT), and Speech/Language Therapists (S/LT), Psychiatrists, Psychologists, Master Level Clinical Nurses, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC/MFT) and other mental health professionals licensed to provide mental health services in the state of California.

Policy:

1. A Practitioner’s status or participation may be denied, reduced, suspended or terminated for any lawful reason, including, but not limited to: a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an CCHP contracted hospital; a determination by CCHP that the practitioner cannot be relied upon to deliver the quality or efficiency of patient care required by CCHP; a determination by CCHP that the practitioner cannot be relied upon to follow CCHP’s clinical or business guidelines or directives; or a change in CCHP’s business needs.
2. A Practitioner may appeal any adverse peer review Level I Review recommendation, decision or action by CCHP that is based on quality of care, non-quality of care, and/or other professional conduct issues and impacts his or her participation status with CCHP, including denial, reduction, suspension, or termination of participation status with CCHP, in accordance with the Level II Appeal procedures, as provided herein. A Practitioner may not appeal a recommendation, decision or action based on reasons unrelated to quality of

care, non- quality of care, and/or other professional conduct issues. For example, there is no right to appeal if any application is denied or not processed because the applicant fails to provide requested information. Additionally, Level II Appeal procedures are not available for initial adverse credentialing decisions upheld by the CCHP Peer Review Committee or CCHP Credentialing Committee.

Procedure:

1. Final Authority -
   CCHP, as a health care service plan, is defined as a peer review body under applicable law. Certain peer review functions are the responsibility of the CCHP Peer Review Committee and the CCHP Credentialing Committee. The CCHP Peer Review Committee serves as the final level of review and is the final authority in credentialing and peer review decisions. The CCHP Peer Review Subcommittee has delegated the hearing of any Level II Appeal to the Board of Trustees.
2. Hearing Officer -
   a. Selection
      The Peer Review Committee or its designee shall appoint a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law who has been admitted to practice before the courts of this State for at least five (5) years prior to appointment, and who is qualified by knowledge and experience to preside over a quasi- judicial peer review hearing. The hearing officer shall gain no direct financial benefit from the outcome of the hearing. The hearing officer must not act as a prosecuting officer, or as an advocate for CCHP, Peer Review Committee, the body whose action prompted the hearing, or the Practitioner. If requested by the Board, the hearing officer may participate in the deliberations of the Board of Trustees and be legal advisor to it, but he/she shall not be entitled to vote. The hearing officer will be sent a letter of appointment by the Peer Review Committee.
   b. Duties
      The duties of the hearing officer shall be to preside over the hearing, including any pre- hearing and/or post-hearing procedural matters; to rule on the challenges to the impartiality of Board of Trustees members and/or the hearing officer; to rule on requests for access to information and/or relevancy; rule on requests for continuances; to rule on evidentiary and burden of proof issues; to prepare the written report and recommendation of the Board of Trustees; and to perform such other functions as may be necessary or appropriate to facilitate completion of a fair hearing process as expeditiously as possible.
3. Scheduling of Appeal/Notice of Hearing -
   Upon the selection of the Board of Trustees, the Level II Appeal shall be scheduled at a time and place mutually agreeable to the Practitioner and to CCHP. The Practitioner shall be given notice of the time, place and date of the hearing. CCHP shall make its best efforts to ensure that the date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date that CCHP receives the request for a Level II Appeal. The time frames set forth herein may be shortened or extended for a reasonable time by mutual written agreement of the parties (or by the Chairperson of the Board of Trustees if the hearing officer has not been appointed yet) upon a showing of good cause in

accordance with Section 11 below. The peer review process shall be completed within a reasonable time after the Practitioner receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges, unless the Board of Trustees issues a written decision that the Practitioner failed to comply with the discovery provision herein, or consented to the delay in the proceedings

4. Notice of Charges -
   A Notice of Charges shall be sent to the Practitioner along with the Notice of Hearing, further specifying, as appropriate, the acts or omissions with which the Practitioner is charged. This Notice of Hearing also shall provide a list of the patient records, if any, which are to be discussed at the hearing, if that information has not been provided previously.
   Witness lists shall be amended as soon as possible when additional witnesses are reasonably known or anticipated. A failure by either party to comply with this requirement, shall be good cause to postpone the hearing.
5. Discovery -
   a. Rights of Discovery and Copying
      The Practitioner may inspect and copy (at his/her own expense) any documentary information relevant to the charges that the CCHP Peer Review Committee has in its possession or under its control, as soon as practicable after the receipt of the Practitioner's request for a Level II Appeal. The CCHP Peer Review Committee shall have the right to inspect and copy (at its own expense) any documentary information relevant to the charges that the Practitioner has in his/her possession or control, as soon as practicable after the Practitioner's receipt of the CCHP Peer Review Committee's request for such documents.
      This right of discovery and copying does not create or imply an obligation to modify or create documents in order to satisfy a request for information. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners, other than the practitioner under review. Failure to comply with reasonable discovery requests at least ten (10) days prior to the Level II Appeal hearing shall be good cause for a continuance of the Level II Appeal hearing.
   b. Limits on Discovery
      The Hearing Officer, upon the request of either side, may impose safeguards including, but not necessarily limited to, the denial of a discovery request. The Hearing Officer when ruling upon requests for access to information and determining the relevancy thereof shall, among other factors, consider the following:
      i. Whether the information sought may be introduced to support or defend the charges;
      ii. Whether the information is "exculpatory" in that it would dispute or cast doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendation;
      iii. The burden on the party of producing the requested information; and
      iv. Other discovery requests the party has previously made or has previously resisted.
6. Pre-Hearing Witness List and Document Exchange -
   At least (10) working days prior to Level II appeal hearing, the parties shall exchange lists of the names of witnesses expected to be called at the hearing and

copies of all documentation expected to be introduced in the evidence at the hearing. A failure to comply with this rule shall be good cause for the hearing officer to grant a continuance. Repeated failures to comply shall be good cause for the hearing officer to limit introduction of any documents or witnesses not provided or disclosed to the other side in a timely manner.

7. Representation -
   Level II Appeals are provided for the purpose of addressing issues of professional conduct or competence in health care. Practitioner is required to notify CCHP if they intend to be represented by legal counsel. Accordingly, neither the Practitioner nor the peer review body whose decision prompted the hearing may be represented by an attorney at the hearing unless a majority of the Board of Trustees members, in their discretion, permit both sides to be so represented. In no case may the CCHP Peer Review Committee be represented by an attorney if the Practitioner is not so represented. The foregoing shall not be deemed to deprive any party of its right to the assistance of an attorney for the purpose of preparing for the hearing. When attorneys are not allowed in the hearing, the Practitioner and the CCHP Peer Review Committee each may be represented at the hearing by a licensed Practitioner who is not an attorney.
8. Failure to Appear -
   Failure, without good cause, of the Practitioner to appear and proceed at the Level II Appeal shall be deemed to constitute voluntary acceptance of the recommendation or action involved and it shall thereupon become the final action of the CCHP Peer Review Committee.
9. Postponements and Extensions -
   After a timely request for a hearing has been received as described above, postponements and extensions of time beyond the times expressly permitted in this Level II Appeal Process may be effected upon written agreement of the parties or granted by the hearing officer (or the Chairperson of the Board of Trustees if the hearing officer has not been appointed yet) on a showing of good cause and subject to the hearing officer's discretion to assure that the hearing proceeds and is completed in a reasonably expeditious manner under the circumstances.
10. Record of the Hearing -
    A record of the Level II Appeal shall be produced by using a certified court reporter to record the hearing (an audio tape recording of the proceedings may be made in addition). The Practitioner shall be entitled to receive a copy of the transcript upon paying his or her share of the court reporter's fees, and the reasonable cost for preparing the transcript. Oral evidence shall be taken under oath administered by the court reporter.
11. Rights of the Parties -
    Both parties shall have the following rights, which shall be exercised in an efficient and expeditious manner and within reasonable limitations imposed by the hearing officer:
    a. To be provided with all of the information made available to the Board of Trustees;
    b. To have a record made of the proceedings as provided herein;
    c. To call, examine and cross-examine witnesses;
    d. To present and rebut evidence determined by the hearing officer to be relevant; and
    e. To submit a written statement at the close of the hearing.
    f. The Practitioner may be called by the CCHP Peer Review Committee's representative and examined as if under cross-examination. The Board of Trustees

may interrogate the witnesses, or call additional witnesses, as the Board of Trustees deems appropriate. Each party has the right to submit a written statement at the close of the Level II Appeal. The Board of Trustees may request such a statement to be filed following the conclusion of the presentation of oral testimony.

12. Rules of Evidence -
    Rules relating to the examination of witnesses and the presentation of evidence in courts of law shall not apply in any hearing conducted herein. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs. A Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the underlying peer review, application, or other credentialing process, unless the Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.
13. Basis of Recommended Decision -
    The recommended decision of the Board of Trustees shall be based on, but may not be limited to, the evidence produced at the hearing and any written statements submitted to the Board of Trustees.
14. Burden of Going Forward and Burden of Proof -
    In all Level II Appeals, the CCHP Peer Review Committee shall have the burden of initially presenting evidence to support its recommendation, decision or action.
    a. If the CCHP Peer Review Committee's recommendation is to deny initial CCHP affiliation, the Practitioner shall bear the burden of persuading the Board of Trustees, by a preponderance of the evidence, that he/she is sufficiently qualified to be awarded such affiliation in accordance with the professional standards of CCHP. This burden requires the production of information that allows for an adequate evaluation and resolution of reasonable doubts concerning the practitioner's qualifications, subject to the CCHP Peer Review Committee's right to object to the production of certain evidence as provided herein. A Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
    b. If the CCHP Peer Review Committee's action involves the termination of existing CCHP participation; or the suspension, reduction or limitation of privileges to perform patient care services, the CCHP Peer Review Committee shall have the burden of persuading the Board of Trustees, by a preponderance of the evidence that its action is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives available, and not necessarily that the action is the only measure or the best measure that could be taken in the opinion of the Board of Trustees.
15. Preparation of Recommended Findings of Fact, Recommended Conclusions of Law and Recommended Decision -
    Within a reasonable time after the final adjournment of the Level II Appeal hearing, the Board of Trustees shall issue a decision that shall include finding of fact and conclusions of law articulating the connection between the evidence produced at the hearing and the result. A copy shall be sent to the CCHP Chief Medical Officer, the Practitioner involved, and the CCHP Chief Executive Officer. Final action shall be taken by the Peer Review Committee, as provided below.

There shall be no right of further appeal to the Peer Review Committee following a formal Level II Appeal. The Practitioner shall receive a written decision of the Peer Review Committee, including a statement of the basis for the decision, which shall be sent via certified mail. The notice shall contain a statement that there is no right of appeal the final decision of the Peer Review Committee.

16. Reports -
    CCHP shall comply with the reporting requirements of the California Business and Professions Code, the Federal Health Care Quality Improvement Act, the National Practitioner Data Bank (NPDB), and any other applicable law regarding adverse peer review actions.
17. Confidentiality -
    All peer review records and proceedings held pursuant to this procedure shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable State and/or Federal law.
18. Privileges and Immunities -
    All activities conducted pursuant to this Level II Appeal Process are in reliance on the privileges and immunities afforded by the Federal Health Care Quality Improvement Act (42 USC Section 11101, et seq.) California Business and Professions Code Section 805, et seq. and the California Civil Code Sections 43.7, 43.8 and 47(b)(4) and (c).
19. Severability -
    This document and the various parts, sections and clauses thereof are hereby declared to be severable. If any part, sentence, paragraph, section or clause is adjudged unconstitutional or invalid, such unconstitutionality or invalidity shall affect only that part, sentence, paragraph, section or clause of this document, or person or entity; and shall not affect or impair any of the remaining provisions, parts, sentences, paragraphs, sections or clauses of this document, or its application to other persons or entities.
20. Applicability -
    This document shall be applicable to all peer review Level II Appeals, and shall be controlling.
21. Costs of Hearing -
    a. The costs associated only with the conduct of the Level II Appeal hearing, excluding the costs listed in subsection 21.b below, shall be divided equally between the Practitioner and CCHP. Such costs shall include, but not be limited to, the costs of the certified shorthand reporter and rental of a hearing room, if applicable.
    b. The costs to be divided between the practitioner and the CCHP shall not include the costs, fees, and any other charges associated with legal representation of either party; the cost of the Board of Trustees, if any; the costs of discovery; the costs of preparation for the hearing; mileage costs for either party or witnesses; witness fees; or the costs of obtaining copies of the hearing transcripts or tapes. Except for the costs of the hearing officer and Board of Trustees, which shall be borne by CCHP, each party shall bear its own costs for these items individually.
22. Exhaustion of Administrative Remedies -
    A Practitioner shall be required to exhaust the administrative remedies herein prior to seeking judicial review of the actions of the CCHP Peer Review Committee.

SECTION 7 ACCESS, APPOINTMENT STANDARDS AND LANGUAGE ASSISTANCE SERVICES

Section 7.1 Timely Access Regulations

State regulations require plans to assure timely access for its commercial member plans regulated under the Department of Managed Health Care (DMHC) effective January 17, 2011.

Timely access involves physician offices being able to offer appointments within certain time frames. If your office is unable to provide an appointment within the time frame, you could refer the patient to the Chinese Hospital clinics for a one-time appointment. Please note that the waiting time in an office for scheduled appointments should not exceed 15 minutes. Please review "CCHP Appointment and Availability Standards" on the following page for a description of standards for different types of medical appointments. CCHP conducts appointment access surveys, provider satisfaction surveys, and member satisfaction surveys to identify trends or problems.

Section 7.2 Nurse Advice Line

Timely access also requires that 24-hour a day seven day a week triage and screening services be available. The primary care physician office should be the primary responder. After hours, physicians also should indicate on their answering lines what time frame a patient may expect a response. For CCHP, if the physician is not available, a nurse advice line staffed by Chinese Hospital is available to respond to the member and offer advice. **The service is not a backup after hours service for physicians. In addition, it is not intended to replace or substitute for the services of the Primary Care Physician** but respond to calls from members needing to talk with a qualified medical professional on general health education information or seeking medical care advice in a medical situation.

CCHP's nurse advice line (1-888-243-8310) provides for a licensed health care professional to be available to assist members by phone 24 hours a day, seven days a week. Although the timely access standards are technically not applicable to the senior plans, the nurse advice line will respond to any member who calls. The function of the nurse advice line is to determine the severity of the caller's complaint using a series of algorithms nationally vetted, then offer recommendations or health information based on assessment and established protocols. The nurse advice line will send a record of the call to the PCP.

Section 7.3 After Hours Instructions

Chinese Community Health Plan requires that each physician office's automated message or answering service will provide appropriate after hours emergency instructions and will have a healthcare professional available to return patient calls within 30 minutes. Every after-hours caller is expected to receive emergency instructions, whether a line is answered live or by recording. Callers with an emergency are expected to be told to hang up and dial 911, or to go to the nearest emergency room.

After hours calls (defined as those hours which are not normal medical group business hours) may be managed by a telephone system which pages a provider or an on-call provider for patient triaging or authorization of care.

The answering service shall give the following information to the patient. “If you feel that your problem is a life-threatening call 911 immediately.”

If a physician uses an answering machine, the message must include:

- Have a number to connect to a message pager or physician directly.
- A phone number to connect to a covering physician or answering service.
- Instructions to call 911 if the problem is a life-threatening emergency or go to the nearest emergency/treatment center.
- Assurance that the member will receive a call back within 30 minutes.

If the physician uses an answering service, the physician must instruct the service to let their patients know that if they feel they have a serious acute medical condition that they should seek immediate care by calling 911 or going to the nearest emergency room. If a message is left for the physician, the answering service will assure that the member will receive a call back within 30 minutes.

Section 7.4 Appointment and Availability Standards

All applicable contracted physicians and providers are responsible for complying with the following standards:

Table 7.4.A Commercial Non-Emergent Medical Appointment Access Standards	
Appointment Type	Must Offer Appointment Within
Non-urgent Care appointments for Primary Care (PCP)	10 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	48 hours of request
Urgent Care appointments that require prior authorization	96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 15 minutes

Table 7.4.B Mental Health Emergent Standards and Non-Emergent Appointment Access Standards	
Appointment Type	Must Offer Appointment Within
Non-urgent appointments with a physician mental health care provider	10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider	10 business days of request

Urgent Care appointments	48 hours of request
Access to Care for Non-Life Threatening Emergency	6 hours
Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for Mental Illness	Must Provide Both: 1 follow-up encounter with a mental health provider within 7 calendar days after discharge Plus 1 follow-up encounter with a mental health provider within 30 calendar days after discharge.

Exceptions to Appointment and Availability Standards

Preventive Care Services and Periodic Follow Up Care: Preventive care services and periodic follow up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice
Advance Access: A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.
Appointment Rescheduling: When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.
Extending Appointment Waiting Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

Section 7.5 Language Assistance Services

California law requires health plans and insurers provide language assistance and free interpreter services to their limited English proficient (LEP) members and health care providers. This includes free interpreter services at all health plan points of contact which includes CCHP's physicians' offices and other contracted provider offices and facilities. Interpreters are required to be professionally trained and versed in medical terminology and health care benefits.

CCHP's multilingual staff supported by a team of professional interpreters are ready to provide personalized service and answer questions about your plan benefits, provider network information, and procedure for using your plan. The website also includes the ability to translate information into Chinese or Spanish. You can also change the font size to accommodate visually impaired individuals.

CCHP Member Services is available to take your calls from 8:00 a.m. to 8:00 p.m., seven days a week. You can reach Member Services Center by calling toll-free at 1-888-775-7888 or locally 1-415-834-2118. TTY users can call 1-877-681-8898.

Provider Responsibilities

CCHP physicians and providers are encouraged to facilitate a member's access to their health plan's LAP services.

CCHP physicians and contracted providers must:

1) Document the language preference of patients who are Limited English Proficient (LEP) in their medical records.
2) Inform LEP patients of the availability of free interpreter services. This includes Informing LEP patients who bring a family member or friend to act as an interpreter.

   Note: A copy of CCHP's member notice "Important Information on Language Assistance Services" is included in this section. Please provide it to all LEP CCHP Members.

3) If interpreter services are offered and refused, providers should document the refusal in the patient's chart.
4) Please contact the patient's health plan to assist them in arranging for interpretation services or to identify a patient's preferred language.

Interpreter Services

CCHP makes health plan language assistance services information available to all contracted providers and their office staff. Providers are encouraged to facilitate a member's access to their plan's language assistance services. When language assistance services are required by a CCHP member, you can get an interpreter at no cost to you or the member by following the below instructions:

- To get an interpreter during CCHP Member Services' hours, please call CCHP Member Services at 1-415-834-2118 or TTY 1-877-681-8898, seven days a week from 8:00am to 8:00pm.
- To get an interpreter during all other times, please follow these instructions:
    1. Call 1-800-264-1552
    2. Use access code: 841498

3. Identify the member's preferred spoken language to the operator.

Providers should document a member's preferred language in their chart and inform members of the availability of free languages services from their health plan. If a member refuses language assistance services, providers should document the refusal in the member's chart.

Tips for Working with Limited English Proficient (LEP) Members

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP). How to identify a LEP member over the phone:

- Member is quiet or does not respond to questions.
- Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions.
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.
- Member self identifies as LEP by requesting language assistance.

Tips for Working with LEP Members and How to Offer Interpreter Services

1) Member speaks no English and you are unable to discern the language.
   → Connect with health plan or plan's contracted telephonic interpretation vendor to identify language needed.
2) Member speaks some English:
   → Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.

   → How to offer interpreter services:

   "I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?"

   Or

   "*May I put you on hold? I am going to connect us with an interpreter.*" (If you are having a difficult time communicating with the member)

Best Practice to Capture Language Preference

For LEP members it is a best practice to capture the members preferred language and record it in the provider's record.
"In order for me to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?"

Tips for Documenting Interpretive Services for Limited English Proficient (LEP) Patients:
Notating the Provision or the Refusal of Interpretive Services

Documenting refusal of interpretive services in the medical record not only protects you and your practice, it also ensures consistency when your medical records are monitored through site reviews/audits by contracted health plans to ensure adequacy of the plan's Language Assistance Program.

- It is preferable to use professionally trained interpreters and to document the use of the interpreter in the patient's medical record.
- If the patient was offered an interpreter and refused the service, it is important to note that refusal in the medical record for that visit.
- Although using a family member or friend to interpret should be discouraged, if the patient insists on using a family member or friend, it is extremely important to document this in the medical record, especially if the chosen interpreter is a minor.
    - Smart Practice Tip: Consider offering a telephonic interpreter *in addition* to the family member/friend to ensure accuracy of interpretation.

- For all LEP patients, it is a best practice to document the patient's preferred language in paper and/or electronic medical records (EMR) in the manner that best fits your practice flow.*
    - For a paper record, one way to do this is to post color stickers on patient's chart to flag when an interpreter is needed. (For example: Orange = Spanish, Yellow = Vietnamese, Green = Russian)*
    - For EMRs, contact your IT department to determine the best method of advising all health care team members of a preferred spoken language. Be sure to document this information in the EHR Demographics Section.

*Source: Industry Collaboration Effort (ICE) Tips for Communicating across Language Barriers; *www.iceforhealth.org*

**This universal symbol for interpretive services is from Hablamos Juntos, a Robert Wood Johnson funded project found at:
http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

Important Information about Language Assistance Services

Interpreter Services

You can get an interpreter at no cost to you if you need an interpreter to communicate with your doctor or to arrange health care services. To get an interpreter, please call 1-888-775-7888 or 1-415-834-2118 or TTY 1-877-681-8898, 7 days a week, from 8:00am to 8:00pm.

Translation of Written Information to Plan Enrollees

The language most frequently spoken among the Plan's membership is Chinese. Upon your request, the Plan will translate written information that impacts your health care coverage. To request a free translation, please call 1-888-775-7888 or 1-415-834-2118 or TTY 1-877-681-8898, 7 days a week, from 8:00am to 8:00pm.

If unable to reach us, please contact the Department of Managed Health Care's Help Center at 1-888-HMO-2219 or TTY 1-877-681-8898. It provides telephone translation services in over 100 languages. The Help Center also provides a written translation of the Independent Medical Review and Complaint Forms in Spanish and Chinese. The Help Center is available Monday to Friday 8:00am to 6:00pm to answer questions.

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call right away at 1-415-834-2118.

重要事項：您是否能閱讀此文件？ 如果無法閱讀， 我們將為您提供專員協助服務。我們也能將此信翻譯成您所使用的語文件。 欲洽詢免費服務，請立即致電: 1-415- 834-2118。

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語言服務的重要信息

傳譯協助

如有需要與醫生及醫療服務機構聯絡，我們可為您提供免費傳譯協助。詳情請致電 1-888-775-7888 或 1-415-834-2118，聽力殘障人士請致電 1-877-681-8898，每週7天，上午 8 時至晚上 8 時。

提供會員翻譯服務

在計劃的會員當中最頻繁講的語言是中文。 在您的要求下，本計劃會翻譯您醫療保健的受保範圍資料。假如您需要這免費翻譯服務，請致電 1-888-775-7888 或 1-415-834-2118，聽力殘障人士請致電 1-877-681-8898，每週7天，上午 8 時至晚上 8 時。

如果您不能夠聯絡我們，可以致電 1-888-HMO-2219 或 TTY 1-877-681-8898（聽力障礙人士電話）與加州醫療護理管理部查詢。該部門提供超過一百種語言的電話翻譯服務。他們還提供西班牙文及中文的獨立覆查投訴表格。辦公時間由星期一至星期五上午 8 時至晚上 6 時，為您解答疑問。

Información importante sobre servicios de asistencia con el lenguaje

Servicios de interpretación

Usted puede conseguir un intérprete sin costo alguno si usted necesita un intérprete para comunicarse con su médico u obtener servicios de atención médica. Para conseguir un intérprete, por favor llame al 1-888-775-7888 o 1-415-834-2118 o TTY 1-877-681-8898, siete días a la semana de 8:00am a 8:00pm.

Traducción de información escrita para miembros del plan

El idioma que se habla con más frecuencia entre los miembros de CCHP es chino. Si usted así lo desea, podemos traducirle la información escrita que afecta su cobertura de atención médica. Para solicitar una traducción gratuita, por favor llame al 1-888-775-7888 o 1-415-834-2118 o TTY 1-877-681-8898, siete días a la semana de 8:00am a 8:00pm.

Si no puede comunicarse con nosotros, por favor póngase en contacto con el Departamento de Centro de Ayuda de Atención Médica Administrada llamando al 1-888-HMO-2219 o TTY 1-877-681-8898. Ellos proporcionan servicios de traducción telefónica en más de 100 idiomas. El Centro de Ayuda también proporciona una traducción escrita de la Revisión Médica Independiente y de los Formularios de Reclamaciones en español y en chino. El Centro de Ayuda está disponible de lunes a viernes de 8:00 am a 6:00 pm para responder preguntas.

SECTION 8 UTLIZATION MANAGEMENT PROGRAM

Section 8.1 Utilization Management Program

The Utilization Management (UM) Department is responsible for the concurrent review and prior authorization process, which includes monitoring inpatient hospitalizations and patients in skilled nursing facilities as well as working with physicians for those patients in need of case management services.

CCHP uses evidence-based clinical guidelines developed by InterQual criteria. InterQual criteria identify benchmark patient care and recovery stages to enhance health care services delivery, resource management and patient outcomes. This approach can reduce unnecessary variation in health care delivery and health care disparities in our community. InterQual criteria provide health care professionals with evidence-based clinical guidelines at the point of care. They also support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.

CCHP may have delegated this function to one of the affiliated medical groups in which you may be a Participating Provider. Please refer to the section on Verifying Member Eligibility on how to verify which provider arrangement is applicable.

For those members you serve as a Participating Provider under Jade/CCHP, the following UM program components will apply to you; for other affiliated Medical Groups, please refer to the respective Medical Group Utilization Management Programs.

Section 8.2 Notice of Utilization Management Decision-Making

Utilization Management (UM) decision-making is based on medical necessity and appropriateness of service in conjunction with eligibility and covered benefits. CCHP does not reward practitioners or other individuals for issuing denials of coverage or services. There are no financial incentives for UM decision makers to encourage decisions that result in denial of care.

Section 8.3 Determination of Medical Necessity

Objective criteria are used in making utilization decisions and are reviewed and updated as necessary, but no less than yearly. The sources of criteria are:

- State and Federal Mandates and Guidelines
- Member Benefits
- CCHP medical policy for CCHP member authorization requests
- Health Plan medical policies and benefits for which CCHP are Third Party Administrator (TPA)
- InterQual criteria
- Hayes Medical Technology Directory
- National standards reflecting best practice
- Guidelines established by partner health plans
- On-line searches for national and community best practices
- Other sources as appropriate and available

Sufficient member specific medical information is required to make a determination of medical necessity. Physicians from appropriate specialty areas of medicine and surgery, either board certified or equivalent, are available to review cases pertaining to their specialty. The UR/Case Managers and physician advisors perform interrater reliability studies at least annually to assure the consistent application of the criteria.

Section 8.4 Primary Care Physician Referral Process

Members of CCHP are required to select a primary physician (PCP) from the CCHP Provider Directory. The directory can be found at www.cchphealthplan.com/doctors/search . Family members may select different primary care physicians. The primary care physician is responsible for:

1. Assuring reasonable access and availability to primary care services,
2. Making referrals to specialists and other plan providers,
3. Providing 24 hour coverage for advice and access to care, and
4. Communicating authorization decisions to the health plan member.

CCHP members may require services that go beyond the scope of their PCP. When this occurs, the PCP refers the member to an appropriate participating specialist for Jade/CCHP Participating Providers using the Specialty Consultation Referral process.

In the event the CCHP does not have a needed provider or consultant, the member's primary physician or attending physician or CCHP specialist must request prior authorization from the Utilization Management Department to use a non-contracted, out-of-network specialist.

A. CCHP delegates the responsibility for providing general medical care for Members to Primary Care Physicians (PCPs).
B. PCPs are responsible for requesting specialty care, diagnostic tests, and other medically necessary services through their Delegated entity's referral process.

PROCEDURES:

1. Referrals to specialists, second opinions, elective hospital admissions, or any service which require prior authorization are initiated by PCPs or specialists through the CCHP UM Department. Prior authorization for proposed services, referrals, or hospitalizations involve the following:
    a. Verification of Member eligibility;
    b. Written documentation by the PCP or specialist of medical necessity for service, procedure, or referral;
    c. Verification of the place of service, referred to practitioner, or specialist is within the CCHP network; and
    d. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial for the proposed service or referral.
2. PCPs shall maintain a Referral Tracking Log for all referrals submitted for approval. The prior authorization/referral process shall meet all standards, including timeliness.

3. For expedited referrals, Member should receive notice of decision within seventy-two (72) hours of receipt of request. For routine referrals, Medicare and Commercial Members should receive notice of decision within fourteen (14) calendar days and five (5) business days, respectively.
4. The PCP informs Members that if the referral is denied or modified, they can file an appeal or grievance with CCHP. A written notice of denial shall be provided through CCHP that includes the appeal and grievance process.
5. Referrals to specialists or out-of-network practitioners require documentation of medical necessity, rationale for the requested referral and prior authorization. Once the prior authorization has been obtained, the PCP shall continue to monitor the Member's progress to ensure appropriate intervention and assess the anticipated return of the Member to the CCHP network.
6. Members requiring special tests/procedures or referral to a specialist may have to obtain prior authorization.
    a. Each specialist provides written documentation of findings and care provided or recommended to the PCP within two (2) weeks of the Member encounter.
    b. The PCP evaluates the report information, initials and dates the report once reviewed, and formulates a follow-up care plan for the Member. This follow-up plan shall be documented in the Member's medical record.
    c. The presence of specialist reports on the PCP's medical records is assessed during periodic chart audits by CCHP.
7. Denial logs and letters for in-network and out-of-network denials and modifications shall be maintained by CCHP shall on a monthly basis for monitoring purposes. Information on the denial logs shall include at a minimum: Member name, CCHP number, requesting physician name, date of referral or request, the specifics of referral or request, diagnosis, decision by CCHP (i.e. approval, denial, partial approval or modification specifics), alternatives offered and date of decision.
8. CCHP reserves the right to perform site audits or to verify accuracy of information on referral logs by examining source information.
9. Referrals for mental health and substance use disorder services for Members are initiated by the PCP through CCHP as outlined in CCHP Policy.

Section 8.5 Consultation Referral Forms and Procedure

The Consultation Referral Form is to be used for referring patients to participating CCHP physicians or participating mental health specialists only. It cannot be used for referring to non-CCHP physicians or providers, nor can it be used to request services that require prior authorization.

To refer a patient to a CCHP specialist physician or CCHP mental health specialist:

Complete a CCHP Consultation Referral Form.

1. The primary or referring physician should complete all pertinent information on the top half of the Consultation Referral Form, including the reason for consultation. If the referring physician is not the primary physician, the referring physician should obtain consent from the primary physician and check mark the box "If referring MD is not the PCP, has PCP consent". The referring physician shall keep the white copy for his/her records.

2. After completing the Consultation Referral Form, the referring physician should keep the white copy for his/her records and give the remaining copies to the patient who should be told to bring the Consultation Referral Form to the CCHP specialist physician or CCHP mental health specialist.
3. Following consultation, the specialist will fill out the bottom half of the Consultation Referral Form and send a copy of the form/report to the referring physician and primary physician. Consulting physicians and mental health specialists must send a written communication to the referring physician.
4. The specialist physician shall keep a copy of the form for his/her records.
5. For electronic claims, the CCHP specialist physician or mental health specialist (consultant) must indicate the name of the referring CCHP physician on the electronic claim. For paper claims, the specialist (consultant) physician or mental health specialist must submit a copy of the CCHP Consultation Referral Form with the claim.
6. If the specialist physician determines the patient needs a procedure that is an office procedure and the procedure does not require prior authorization, the treating specialist may perform the procedure after consultation with the primary physician.
7. If the procedure requires authorization based on the criteria in "Section 8.15 Services Requiring Prior Authorization" then the specialist must request prior authorization from the Utilization Management Department by completing and submitting a Service Authorization Form (SAF) by fax. If the request is urgent, mark "URGENT" at the top of the SAF.

Section 8.6 Primary Care Physician (PCP) Referrals - Referral Tracking Log

All Primary Care Physicians (PCPs) are required to maintain a system for tracking all referrals submitted to CCHP.

PROCEDURES:

1. All PCPs shall maintain a referral log that contains all of the information noted below:
    a. Date referral sent for review;
    b. Member Name;
    c. Member CCHP ID number;
    d. Acuity of referral (Emergent, Urgent, or Routine);
    e. Reason for Referral or Diagnosis;
    f. Service/Activity Requested;
    g. Date referral returned;
    h. Referral Decision (Approved, Partially Approved (Modified), Denied);
    i. Date Patient Notified;
    j. Date of Appointment or Service; and
    k. Date Consultation or other Report Received.
2. PCPs may either use a manual tracking log or another system that contains all of the above-required information.
3. PCPs shall utilize a referral log to coordinate care for the Member, to obtain assistance from CCHP if specialty appointments are delayed, or consultation notes are not received
4. Referral logs, or equivalent system, shall be available at all times at the PCP site.

5. Copies of referrals and any received consultation and/or service reports shall be filed timely in the Member's medical record.

Section 8.7 Referral from PCP to Participating Specialists

The Specialty Consultation Referral Process enables a Primary Care Physician (PCP) to coordinate the process by which their patients receive care from CCHP specialist physicians, mental health specialists and other CCHP participating health care providers. When a CCHP primary care physician identifies the need for a referral, the PCP may refer patients to a CCHP specialist physician, including mental health specialists as medically appropriate by completing a CCHP Consultation Referral Form.

- A referral is good for four (4) visits in a calendar year for the **same diagnosis** to the same specialist. Referrals submitted in December are also valid for the following year up to a maximum of four visits.
- CCHP specialist visits for a different diagnosis require a new and separate Consultation Referral Form from the PCP with the new specific diagnosis.
- Additional visits beyond four (4) for the same diagnosis range require prior authorization.
- Specialty Services exceeding $500 (of Medicare allowable) also require prior authorization. If a patient self-refers to a CCHP OB/GYN specialist for women's health services a referral is not required.
- The Consultation Referral Form cannot be used for non-CCHP physicians or non-CCHP mental health specialists. All services from non-CCHP physicians and non-CCHP mental health specialists require prior authorization by the CCHP Utilization Management Department.

Section 8.8 Additional Care by a Participating Specialist

(For more than 4 visits in a Calendar Year)
The specialist, in consultation with the primary physician, may need to see a patient beyond the primary physician's referral (**valid for 4 office visits per calendar year for the same diagnosis**; prior approval is required for further visits). The specialist is required to request for Service Authorization to the Utilization Management Department for additional office visits. The service authorization request must include the diagnosis, medical justification for additional visits, and treatment plan (i.e., frequency and duration of visits).

Section 8.9 Referral from PCP to Mental Health Specialists, Substance Abuse Specialists or Detoxification or Mental Health Facilities

CCHP requires a referral from the member's primary care physician (PCP) for all services rendered by CCHP specialists, including referrals to CCHP specialists and specialty facilities contracted to provide mental health care, psychological or psychiatric or mental or substance abuse assessments, interventions or treatments. Prior authorization is required for non-emergency admissions to detoxification or mental health facilities.

The PCP may refer a patient to a CCHP contracted mental health specialist for office visits. No prior authorization is required for in-network outpatient mental health services performed in Place of Service (POS) 11 (office visits).

Section 8.10 Mental Health Coordination of Care

Chinese Community Health Plan (CCHP) requires coordination of care between mental health specialist and the primary care physicians to achieve optimal health for each member. Effective coordination of care is dependent upon clear and timely communication among practitioners and facilities. In sharing members' mental health information, including the diagnosis, progress and current medications, the PCP and mental health specialist can effectively and confidentially coordinate care with appropriate treatment for individuals that have coexisting medical and mental diagnoses. The communication can also reduce complications or adverse outcomes from medication interactions, duplicate medications and tests resulting from the lack of communication.

Primary Care Physicians are expected to exchange any relevant information with the mental health specialist such as medical history, diagnosis, current medications, test results, and hospital admission/discharge information. All efforts to coordinate care on behalf of the member should be documented in the member's medical record. The PCP must document and initial in the patient's medical chart signifying review of information received from a mental health specialist who is treating the member.

Mental health providers are expected to consult with the PCP and communicate with the PCP in writing or verbally regarding the patient's progress including the diagnosis, treatment plan and current medications. The mental health specialist must document in the patient's chart communication with the patient's PCP.

Section 8.11 Documentation Requirements and Communication Methods

Documentation of communication between the primary care physician and the mental health specialist is required for all CCHP patients. The CCHP Consultation Report Form may be used for communicating with a patient's PCP, or other methods of written communication may include a letter, a reply documenting clinical findings and recommendations on the CCHP Consultation Referral Form as well as copies of test results and hospital reports. For urgent matters, verbal communication via telephone is often appropriate. For verbal communications, the following must be documented in the patient's progress notes: date, time, content of the phone call and treatment/outcome.

Section 8.12 Review Procedures - Standing Referral/Extended Access to Specialty Care

A. CCHP established procedures for Primary Care Physicians (PCPs) to request a standing referral to a specialist for a Member who, as a component of ongoing ambulatory care, requires continuing specialty care over a prolonged period of time, or extended access to a specialist for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a specialist.

B. Members with a life-threatening, degenerative or disabling condition or disease shall receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist or specialty care center coordinate the Member's care.

C. Practitioners that are Board Certified in appropriate specialties, e.g., Infectious Disease, are able to treat conditions or diseases that involve a complicated treatment regimen that requires ongoing monitoring. Board certification is verified during the Provider credentialing process. Members may obtain a list of practitioners who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring by contacting CCHP at (415) 955-8800 or for TTY (877) 681-8898 or searching CCHP's online provider directory at www.cchphealthplan.com/doctors/search.

D. PCPs are responsible for coordinating the care of the Member in consultation with the specialist, Delegated entity and Member.

PROCEDURES:

1. CCHP shall develop and implement a procedure for standing referrals or extended access to a specialist at the Member or PCP request. The PCP and/or Member determines, in consultation with the specialist and the Medical Director or designee, within three (3) business days if a Member needs continuing care from a specialist.
2. After consultation with the specialist as needed, and the Medical Director, the PCP shall submit his/her request for a standing specialty referral or extended access to CCHP using the designated form. Appropriate medical records shall be attached to the request.
3. Standing referrals are processed according to turnaround timeframes as outlined in section on UM section.
4. If CCHP determines that the standing referral should be limited in terms of number of visits or timeframe, CCHP, in consultation with the PCP and specialist, shall develop a treatment plan specifying the limits. The treatment plan shall be approved by CCHP.
5. Treatment plans shall be submitted to CCHP Medical Director by fax at (415)398-3669. CCHP shall make its determination regarding the treatment plan within three (3) business days.
6. Standing referrals or extended access to specialty care approved without limitations do not require a treatment plan.
7. After approval of the standing referral or extended access to specialty care with or without a treatment plan, the PCP, specialist, and Member shall be notified in writing of the specifics of the determination within two (2) business days of the determination.
8. Potential conditions necessitating a standing referral and/or treatment plan include but are not limited to the following:
    a. Significant cardiovascular disease;
    b. Asthma requiring specialty management;
    c. Diabetes requiring Endocrinologist management;
    d. Chronic obstructive pulmonary disease;
    e. Chronic wound care;
    f. Rehab for major trauma;

g. Neurological conditions such as multiple sclerosis, uncontrollable seizures among others;
h. GI conditions such as severe peptic ulcer and chronic pancreatitis among others.; And
i. Members with a combination of conditions that require complex including but not limited for example to diabetes mellitus, COPD and congestive heart failure.

9. Potential conditions necessitating extended access to a specialist or specialty care center and/or treatment plan include but are not limited to the following:
    a. Hepatitis C;
    b. Lupus;
    c. HIV;
    d. AIDS;
    e. Cancer;
    f. Potential transplant candidates;
    g. Severe and progressive neurological conditions;
    h. Renal failure; and
    i. Cystic fibrosis.
10. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine the Member shall be referred to an HIV/AIDS specialist. An HIV/AIDS specialist is a physician who holds a valid, un-revoked and unsuspended license to practice medicine in the state of California who meet any one of the following four criteria:
    a. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM); or
    b. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a certificate of Added Qualification in the field of HIV medicine; or
    c. Is board certified in the field of infectious diseases and meets the following qualifications:
        i. In the preceding twelve (12) months has clinically managed medical care to a minimum of twenty-five (25) patients who are infected with HIV; and
        ii. In the preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of Category 1 Continuing Medical Education (CME), (as directed by the Medical Board of California), in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-positive patients, including a minimum of five (5) hours related to antiretroviral therapy per year; or
    d. Meets the following qualifications:
        i. In the preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are HIV-positive; and
        ii. Has completed any of the following;
            1. In the preceding twelve (12) months has obtained board certification or recertification in the field of infectious diseases; or
            2. In the preceding twelve (12) months has successfully completed a minimum thirty (30) hours of Category 1 CME in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-positive patients; or

3. In the preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of Category 1 CME in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-positive patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the AAHIVM.

11. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:
    a. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
    b. The nurse practitioner or physician assistant meets the qualifications specified in this policy; and
    c. The nurse practitioner or physician assistant and the supervising HIV/AIDS specialist have the capacity to see an additional patient.
12. The Member may be referred to a non-network provider if there is no HIV/AIDS specialist, or appropriately qualified nurse practitioner or physician assistant under the supervision of an HIV/AIDS specialist within the network appropriate to provide care to the Member, as determined by the applicable medical group Medical Director and/or PCP in consultation with CCHP's Medical Director as appropriate.
13. Any medical condition requiring frequent or repeat visits to a specialist should be considered by the PCP for submission of a standing referral or extended access to a specialty care referral.
    a. Upon Member request for a standing referral, the PCP shall make a determination within three (3) business days regarding submission of a standing referral to CCHP. This determination should be made after consulting with the Member's Specialist.
    b. Once a decision is made that a standing referral is needed, the PCP shall submit a request for standing specialty referral to CCHP within four (4) business days, using the designated form (See Attachment, "Standing Referral/Extended Access to Specialty Care"). Appropriate medical records shall be attached to the request. A determination will be rendered by CCHP's Medical Director (or designee) after referral and medical documentation is received.
14. After approval of the standing specialty or extended access to specialty care with or without a treatment plan, CCHP are required to notify the PCP, specialist, and Member in writing of the specifics of the determination within two (2) business days of the determination.
15. All denials of standing specialty referral requests or extended access to specialty care shall be forwarded to CCHP within three (3) business days of the denial. Delegates shall also inform the PCP, specialist, and Member of the denial in writing according to prescribed formats for denials.
16. CCHP can require specialists to provide to the PCP and CCHP written reports of care provided under a standing referral.
17. Members can be referred to out-of-network practitioners when appropriate specialty care is not available within the network.
18. All services for out-of-network providers shall be coordinated adequately and timely.
19. CCHP shall coordinate payment with out-of-network providers and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

20. Members can be referred to an out-of-network HIV/AIDS specialist when an appropriate HIV/AIDS specialist, or qualified nurse practitioner, or physician assistant under the supervision of an HIV/AIDS specialist is not available within the network, as determined by PCP in conjunction with the CCHP's Medical Director, as warranted.

Section 8.13 Referral to Non-Participating Specialists

Prior Authorization is required to refer members to non-participating specialists. Non-participating specialists are physicians who are not contracted with Chinese Community Health Plan. Prior Authorization is to be obtained by the process outlined below.

Section 8.14 Prior Authorization

Prior Authorization is intended to ensure that the requested service is covered by the member's benefit, that the provider of the service is participating, and that the services are medically necessary. Services will also be reviewed to ensure that the most appropriate setting is being utilized and to identify those members who may benefit from our case management programs. Prior Authorization is subject to a member's eligibility and covered benefits at the time of service.

Section 8.15 Services Requiring Prior Authorization

The following contains a summary of services requiring prior authorization**.** Physicians should consult the CCHP Provider Manual for more detailed information. Please refer to the Covered Services and Exclusions section of a member's Evidence of Coverage for more information on services that require a prior authorization. **Please note that our prior authorization requirements are subject to change**. If you have questions about services requiring prior authorization, contact the Utilization Management Department.

Service (in alphabetical order)

- All services from Non-Participating Providers
- Acupuncture services (In-network acupuncturist may perform up to 18 acupuncture sessions per calendar year without prior authorization. For additional services, prior authorization is required.)
- Acute Rehabilitation Facilities
- Ambulatory surgery in hospitals other than Chinese Hospital
- Durable Medical Equipment
- Epidural blocks for pain management
- Genetic Testing
- Home Health Care Services
- Hospitalizations (Elective)
- Mammograms **for 2nd or more in a year**. (No authorization required for first mammogram in year)
- Nuclear cardiograms, cardiac imaging
- Nuclear Medicine Studies: Bone, Heart, Liver/spleen, Lung, Thyroid
- Occupational Therapy
- Out-of-Plan Providers (also referred to as non-plan or non-contracted or out-of-network providers)

- Outpatient procedures in physician offices which exceed $500 allowable (according to the Medicare Fee Schedule)
- Outpatient Services from Non-Preferred Providers (as indicated on the Outpatient Services List in this Section)
- PCP referrals in excess of four (4) visits to specialist physicians in a calendar year
- Physical Therapy after initial consultation and 6 follow-up sessions
- Radiology Scans: CAT, MRI, PET
- Skilled Nursing Facility (SNF)
- Speech Therapy
- Transportation (Non-emergency medically necessary ambulance, wheelchair, medi-van, air ambulance)

Section 8.16 Outpatient Services

Outpatient services, including ambulatory services, diagnostic studies and specialty referrals are authorized based upon medical necessity by the UM Department. Referrals to medical group specialists for up to four visits per calendar year do not require authorization. If the medical group cannot provide a needed specialty service, authorization for a non-contracted provider shall be given.

Section 8.17 Emergency Services

Prior authorization is not required for provision of emergency services. Emergency services, including emergency ambulance transportation, are authorized without medical review.

A. Providers shall render services to Members who present themselves to an Emergency Department (ED) for treatment of an emergent or urgent condition. Per federal law, at a minimum, services shall include a Medical Screening Exam (MSE).
B. Per regulatory requirements, CCHP has adopted the “prudent layperson” definition of an emergency medical condition, as follows:
    a. Emergency Medical Condition means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
        i. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
        ii. Serious impairment to bodily function; or
        iii. Serious dysfunction of any bodily organ or part.
C. If it is determined that the Member’s condition was not emergent, CCHP or its downstream delegated medical group is responsible for the MSE, at a minimum based on individual contracts. The Member does not need to be notified of an ED denial. The Member is not financially responsible and shall not be billed for any difference between the amount billed by the Hospital and amount paid.
D. Emergency services can be subject to retrospective review. CCHP may retrospectively review claims and adjust payment if services provided were beyond the scope of the authorization and were not medically necessary. A retrospective billing adjustment of an Emergency Department visit does not require Member

notification because the Member is not financially impacted by the decision, and payment shall be made for the MSE.

a. Hospitals can forward to CCHP any facility costs associated with a visit to an ED that was authorized by a Primary Care Physician (PCP), and judged non-emergent after medical review by a hospital staff physician.
b. If medical review of the claim by CCHP determines that the authorized visit was for a Member with a non-emergency medical condition, then CCHP is financially responsible for the facility and technical components of the visit.
c. Where conflict regarding payment decisions cannot be resolved between Hospital and Delegate, claims can be submitted to CCHP for final adjudication.

PROCEDURES:

1. Final determination of whether or not an emergency medical condition existed can be subject to medical review by a physician; however, the prudent layperson definition shall be utilized in the review.
    a. Medical decision criteria and diagnosis codes may be utilized in the review process; however, under the prudent layperson definition, the review shall also take into account emergency medical conditions that present acutely but result in benign diagnoses. Examples include and are not limited to:
        i. 2 year old with 103° fever, listless, less responsive, vomiting - Otitis Media;
        ii. 38 year old with acute, severe chest pain - Costochondritis;
        iii. 17 year old female with severe lower abdominal pain, vaginal bleeding - Spontaneous Abortion - complete;
        iv. 12 year old with severe shortness of breath, cough - Asthma;
        v. 60 year old with fever to 104°, severe cough, acute shortness of breath - Bronchitis;
        vi. 23 year old pregnant woman with lower abdominal pain, fever, perceived decreased fetal movement - Urinary Tract Infection;
        vii. 12 year old with severe abdominal pain, vomiting fever - Adenitis, Mesenteric; or
        viii. Sudden onset of mental changes or an exacerbation of a known psychiatric diagnosis - Adjustment Disorder.
    b. A physician shall perform review of retrospective billing adjustments or reduction of payments of claims.
2. Prior authorization is not required for the MSE (or COBRA exam) performed at an ED, to the extent necessary to determine the presence or absence of an emergency medical condition, or for services necessary to treat and stabilize an emergency medical condition. If the MSE demonstrates that an emergency medical condition is not present, ED personnel shall contact the PCP or designee for authorization of services or treatment beyond the MSE.
3. CCHP's payment for associated services shall be based on the Member's presentation and the complexity of the medical decision-making as outlined in the American Medical Association (AMA) CPT Guide under 'Emergency Department Services.'
4. In the event that the ED is unable to reach the responsible PCP or designee, the call time and phone number shall be documented in the ED record and the ED shall provide medically necessary care.

5. Authorized ED visits can be subject to review by CCHP to determine if an emergency medical condition was present. If medical review determines that an emergency medical condition was not present, the facility and technical components of the claim will be reviewed for payment. The Hospital can appeal adverse payment decisions for CCHP review.
6. Examples of non-emergent ED visits could include:
    a. Possible fractures (sprain – rule out fracture);
    b. Simple lacerations;
    c. Mild asthma exacerbation;
    d. Small animal bites; or
    e. High fever without systemic symptoms.

Section 8.18 How to Request Prior Authorization

A. As of October 1, 2015, CCHP has transitioned to ICD-10 diagnosis and procedure coding as mandated by the Centers for Medicare and Medicaid Services (CMS).
B. To ensure timely access to specialty care for CCHP Members, CCHP has adopted mandated turnaround timeframes for prior authorization for certain specialty services.
C. PCPs are responsible for providing general medical care for Members and requesting specialty care, diagnostic tests, and other medically necessary services either through CCHP's consultation referral or CCHP's prior authorization processes.
D. The PCP shall review any referral or prior authorization requests from an affiliated mid-level practitioner, i.e. Nurse Practitioner (NP) or Physician Assistant (PA), prior to the submission of the referral. If there are questions about the need for treatment, referral or prior authorization, the PCP shall see the Member.
E. CCHP shall have a process in place when decisions to deny or modify (authorize an amount, duration, or scope that is less than requested) are made by a qualified health care professional with appropriate clinical expertise in the condition and disease.
F. CCHP should evaluate PCP and specialist referral and prior authorization patterns for over and under-utilization.

PROCEDURES:

1. Provider may request authorization for health care services via one of the following methods:
    - Provider Portal- https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx?bc=250fdc7b-5144-44f4-88d9-d86b841d9ebf&serviceid=0ec2e499-26cd-4333-bb08-f97ffc1b75de
    - Fax- Provider completes the Jade/CCHP Service Authorization Form (SAF) with clinical information and faxes to the UM Department at **1-415-398-3669**;
    - Mail- Provider completes the Jade/CCHP Service Authorization Form (SAF) with clinical information and mails to the UM Department:

      445 Grant Avenue, Suite 700
      San Francisco, CA 94108
    - Telephone- Provider calls the UM hotline at 1-877-208-4959 to request authorization for health care services. Provider may send clinical information via fax.

2. For authorization request submitted via fax or mail, Nurse Practitioner or the Physician Assistant can sign and date the referral or Service Authorization Form (SAF) but shall document on the form the name of the PCP or specialist.
3. Referral or Service Authorization Forms (SAF) from the PCP or specialist shall include the following information:
    a. Designation of the referral or service authorization request as either routine or expedited to define the priority of the response. Referrals that are not prioritized are handled as "routine." Referrals that are designated as expedited shall include the supporting documentation regarding the reason the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function;
    b. The diagnosis (ICD-10) and procedure (CPT) codes;
    c. Pertinent clinical information supporting the request; and
    d. Signature of referring physician and date. This may consist of handwritten signature, handwritten initials, unique electronic identifier, or electronic signatures that shall be able to demonstrate appropriate controls to ensure that only the individual indicated may enter a signature.
4. Upon receipt of the referral or Service Authorization Form (SAF), CCHP is responsible for verification of Member eligibility and plan benefits.
5. CCHP shall have a process that facilitates the Member's access to needed specialty care by prior authorizing at a minimum a consult and follow up visit (a total of two visits) for medically necessary specialty care (See Attachment, "Specialty Office Service Authorization Sets").
6. Prior authorization for medically necessary procedures or other services that can be performed in the office, beyond the initial consultation and follow up visit, should be authorized as a set or unit. For example, when approving an ENT consultation for hearing loss, an audiogram should be approved.
    a. **Exceptions** - Prior Authorization is not required and Member may self-refer for the following services. All other services require prior authorization:
        1. Family Planning;
        2. Abortion Services;
        3. Sexually transmitted infection (STI) treatment;
        4. Sensitive and Confidential Services;
        5. HIV Testing and counseling at the Local Health Department;
        6. Immunizations at the Local Health Department;
        7. Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within CCHP Network;
        8. Urgent Care;
        9. Preventative services within CCHP Network;
        10. Urgent support for home and community service-based recipients; and
        11. Other services as specified by the Centers for Medicare and Medicaid Services (CMS).
7. Referrals to out-of-network practitioners require documentation of medical necessity, rationale for the requested out-of-network referral, and prior authorization from CCHP. Once the prior authorization has been obtained, the PCP's office should assist the Member with making the appointment, continue to monitor the Member's progress to

ensure appropriate intervention, and assess the anticipated return of the Member into the network.

8. Decisions for referrals shall be made in a timely fashion not to exceed regulatory turnaround timeframes for determination and notification of Members and practitioners (See Attachment, "UM Timeliness Standards –". All timeframes shall meet regulatory requirements as outlined in Title 42 of the Code of Federal Regulations Sections 438.210, 422.568, 422.570, and 422.572.
9. CCHP shall monitor the PCP's rates of referrals to specialists to:
    a. Monitor for potential over or under utilization of specialists; and
    b. Identify referral requests that are within the scope of practice of the PCP.
10. When CCHP identifies a potential problem with the PCP's referrals to specialists, interventions need to be implemented that address the specific circumstances that were identified during the monitoring process. Interventions, such as written correspondence to the PCP that addresses the identified concern with supporting policy or contract attached, or the Medical Director contacting the PCP to discuss the concern, should be attempted to help educate the PCP.
11. There shall be documented evidence of the corrective action taken by CCHP, including the PCP's response to the intervention. The PCP's referral pattern shall be re-evaluated after a sufficient amount of time (at least sixty (60) days) has elapsed to monitor effectiveness.
12. Specialists are required to forward consultation notes to the PCP within two (2) weeks of the visit.

Section 8.19 Expedited Initial Organization Determinations (EIOD)

This following section pertains to CCHP members enrolled in a Medicare Advantage plan.

A. CCHP processes Expedited Initial Organization Determinations (EIOD) for time sensitive situations for Members when the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
B. The Medicare Advantage member, applicable representatives, or treating practitioner may submit a written request for an EIOD.

PROCEDURES:

1. A Medicare Advantage member, applicable representatives, or a practitioner may request an EIOD when:
    a. The Medicare Advantage member or practitioner believes that waiting for a decision under the standard timeframe could place the Member's life, health, or ability to regain maximum function in serious jeopardy; and
    b. The Medicare Advantage member believes the Health Plan should furnish directly or arrange for services to be provided (when the Medicare Advantage member has not already received the services outside of the Health Plan).
2. EIODs may not be requested for cases in which the only issue involves claims payment for services the Member has already received.
3. The seventy-two (72)-hour timeframe for a determination regarding the requested service(s) commences when CCHP receives the request for an EIOD.

4. An EIOD is automatically provided when the request is made or supported by a practitioner. The practitioner shall indicate in writing that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
5. For a request made by a Medicare Advantage member or applicable representatives, CCHP shall expedite the review of a determination if CCHP finds that applying the standard timeframe may jeopardize the Member's health, life, or ability to regain maximum function.
6. If clinical information is needed from a non-contracted practitioner, CCHP will request this information within twenty-four (24) hours of the initial request for an EIOD.
7. Non-contracted practitioners shall make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist in meeting the required time frame. Regardless of whether or not CCHP shall request clinical information from non-contracted practitioners, CCHP is still responsible for meeting the same timeframe and notification requirements for EIODs.
8. If it is determined that the Member's condition does not warrant an expedited determination, the Member will be verbally notified within seventy-two (72) hours of receipt of the request (includes weekends and holidays) followed by written notification within three (3) calendar days of the verbal notification. The request will automatically be processed within the standard timeframe of fourteen (14) calendar days for Medicare Advantage members for a determination beginning the day the request was received for an EIOD. The Expedited Criteria Not Met notice shall,
9. Explain that the request will be processed using the timeframe for standard determinations;
10. Inform the Medicare Advantage member of the right to file an expedited grievance if he or she disagrees with the decision to not expedite the determination, give instructions for filing an expedited grievance; give the expedited grievance process timeframe, and an explanation of the criteria for expedited reviews;
11. Inform the Medicare Advantage member of the right to resubmit a request for an EIOD if the Medicare Advantage member gets any practitioner's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. The request will be expedited automatically; and
12. Provide instructions about the expedited grievance process and its timeframes.
13. If the request is approved for an EIOD, the determination shall be made in accordance with the following requirements:
14. Whether the decision is to approve, modify, or deny, the Member and practitioner shall be notified of the decision within seventy-two (72) hours of receipt of the request.
15. If the initial notification to the Member of the expedited determination is verbally, then written notification to the Member shall occur within three (3) calendar days of the verbal notification. All verbal communication with Members shall be documented with time, date, and name of contact person with initials of CCHP's staff making the call, with each attempt.
16. If only written notification is given for a modification or denial determination, the Member and practitioner shall receive the notification within seventy-two (72) hours of receipt of the EIOD request.
17. Written communication regarding a modification or denial shall be written in a manner that is understandable and sufficient in detail so that the Member and practitioner can

understand the rationale for the decision. The Notice of Denial of Medical Coverage (NDMC) letter shall include:

18. The specific reason for the denial that takes into account the Member's presenting medical condition, disabilities, and if any, special language requirements;
19. The determination is based upon NCD, LCD, Medicare Coverage Guidelines, InterQual criteria, and/or national and or community standards reflecting best practice;
20. Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member's behalf;
21. A description of both the standard and expedited reconsideration processes that include conditions for obtaining an expedited reconsideration, and the other elements of the appeals process; and
22. The Member's right to submit additional evidence in writing or in person.
23. An extension of no more than fourteen (14) calendar days may be allowed to perform the review under the following circumstances:
    - There is justification for additional information, (e.g., allowing for additional diagnostic procedures or specialty consultations) and there is documentation on how this delay is in the interest of the Member.
    - The practitioner requests an extension of time to provide CCHP with additional information.
    - The practitioner requesting the EIOD is not contracted and the clinical information necessary to make the determination is not submitted within seventy- two (72) hours. An attempt to contact the non-contracted provider will be made within twenty-four (24) hours of receipt.
24. Extensions shall not be used to pend organization determinations while waiting for medical records from contracted Providers.
25. The Member will be notified in writing of the reason for the delay, utilizing the Extension Needed for Additional Information – Expedited and Standard Initial Determination letter, and informed of the right to file an expedited grievance (oral or written) if he or she disagrees with the decision for an extension. The written notification for the extension will include the clinical information needed, or the test or examination required.

Section 8.20 Urgent Authorizations

Urgent requests receive special attention. The UM Department makes every effort to return authorization determinations in a timely manner. Urgent or emergent care should never be delayed while awaiting prior authorization. Please do not hesitate to ask to speak directly to the UM Manager if you have concerns that the process may interfere with the care your patient requires.

During Business Hours: Monday – Friday, 9:00 am to 5:00 pm

a. Outpatient: If a situation is urgent, submit an SAF marked "URGENT" at the top and it will be given priority processing.
b. Inpatient: If there is an urgent need for an inpatient authorization, call the UM Manager at 1-628-228-3252.

Weekends, After Hours, Holidays

On weekends, after hours or holidays, the primary physician or the CCHP Medical Director has the authority to authorize treatment for services that the physician considers urgent/emergent.

The attending physician should then submit a timely SAF to the Utilization Management Department the next business day.

Section 8.21 Authorization Process Turnaround Standards

Outpatient Review

- Utilization decisions are made in a timely manner depending on the urgency of the request. See Section 8.22 “UM Timeliness Standards” for the regulatory turnaround timeframes for determination and notification of Members and practitioners. A tracking system for identifying the status of all authorization requests is established. If an urgent case is denied, the member and practitioner are notified as to how to initiate an expedited appeal at the time they are notified of the denial.

Concurrent Review

- For concurrent review, decisions are made within one working day of obtaining all information and providers are notified by telephone within one working day of the decision.

Retrospective Review

- Medical necessity decisions in retrospective situations are resolved within 30 working days of obtaining all necessary information. Members and providers are informed of retrospective denials within five days of making the decision.

Section 8.22 Utilization Management Timeliness Standards

CCHP requires that all participating providers, including those who are participating in affiliated medical group, are aware of and compliant with the Utilization Management Timeliness Standards for the type of programs in which CCHP members are enrolled. Below are reference tables by program type

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. Note: If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	Additional clinical information required: Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. Note:	Additional information received or incomplete Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for	Additional information received or incomplete Within 48 hours after receipt of information. Note: If oral notification is given, written or electronic notification

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after receipt of information.	approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	must be given no later than 3 calendar days after the initial oral notification.
	Additional information not received: If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. Note: Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after the deadline for extension has ended.	Additional information not received Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	Additional information not received Within 48 hours after the timeframe given to the practitioner & member to supply the information. Note: If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. Exceptions: • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to *Urgent Pre-service* category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to *Non –urgent*	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. Note: If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Pre-service category.			
Standing Referrals to Specialists / Specialty Care Centers - All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the	Within 2 business days of making the decision.

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
		decision (for approval decisions).	
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	Additional clinical information required: Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer:		

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
	Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	Require consultation by an Expert Reviewer: Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Require consultation by an Expert Reviewer: Within 2 business days of making the decision.
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	Additional clinical information required: Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for		

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
	submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	Additional information received or incomplete Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	Additional information received or incomplete Within 15 calendar days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	**Additional information not received** Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	Additional information not received ***Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.***

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	Require consultation by an Expert Reviewer: Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity)	LAP Services Not Delegated: All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request		LAP Services Delegated/Health Plan: All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
2. Non-Urgent (e.g., post-service pend or denial notifications)	2. Request forwarded within two (2) business days of member's request		

Table 8.22.2 A Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)		
Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. Extension Notice: ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written

Table 8.22.2 A Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)		
Type of Request	Decision	Notification Timeframes
	2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination - If No Extension Requested or Needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ Approvals – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request.

Table 8.22.2 A Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)		
Type of Request	Decision	Notification Timeframes
(See footnote)[2]		▪ Denials – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.
Expedited Initial Organization Determination **-** If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must	Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. Extension Notice: ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: ▪ Approvals – Oral or written notice must be given to member and provider no

[2] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

Table 8.22.2 A Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)		
Type of Request	Decision	Notification Timeframes
	make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	later than upon expiration of extension. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider no later than upon expiration of the extension. ▪ Denials – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

Table 8.22.2 B Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS) - Hospital Discharge Appeal Notices			
Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) Within 2 calendar days of admission to a hospital inpatient setting. 2) Not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital. ▪ NOTE: Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge. ▪ When member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO. The DND must include: ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization.

Table 8.22.2 B Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS) - Hospital Discharge Appeal Notices			
Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
	decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).		▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. ▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. ▪ Any other information required by CMS.

Table 8.22.2 C Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS) - Termination of Provider Services			
Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: ▪ Skilled Nursing Facility (SNF) ▪ Home Health Agency (HHA) ▪ Comprehensive Outpatient Rehabilitation Facility (CORF) NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services OR ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative ▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. **Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

ICE CMS UM TAT Final 12/02/02
Revised & Approved 6/5/03, 5/17/04, 7/14/04, 4/26/06, 9/13/07, 6/10/11

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision	Practitioner: Within 24 hours of the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request • The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the		

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
	date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered	Practitioner: Within 24 hours of making the decision Member: None Specified	
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service	Practitioner: Within 24 hours of making the decision Member: None Specified	
	Additional information incomplete or not received • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial		Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
			from the receipt of the request for service Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life	Within 72 hours of receipt of the request	Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request			
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain	Additional clinical information required: Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered • Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request		

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
maximum function. • Additional clinical information required	by the State for the need for additional information and how it is in the Member's interest Additional information received • If requested information is received, decision must be made within 1 working day of receipt of information. Additional information incomplete or not received • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	Practitioner: Within 24 hours of making the decision Member: None specified Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. CA H&SC 1367.01 (h)(3)	Within 5 working days or less, consistent with urgency of Member's medical condition **NOTE:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination CA H&SC 1367.01 (h)(2)	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request	Practitioner: Within 24 hours of receipt of the request (for approvals and denials) Member: Within 24 hours of receipt of the request (for approval decisions)	Member & Practitioner: Within 24 hours of receipt of the request Note: If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of <u>Denial and Modification</u> to Practitioner and Member
Post-Service - Extension Needed • Additional clinical information required	Additional clinical information required (AKA: deferral) • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request	Member & Practitioner: None specified	
	Additional information received • If requested information <u>is received</u>, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information	Member & Practitioner: None Required	<u>Member & Practitioner</u>: Within 30 calendar days from receipt of the information necessary to make the determination
	Additional information incomplete or not received • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information		<u>Member & Practitioner</u>: Within 30 calendar days from receipt of the information necessary to make the determination

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Hospice - Inpatient Care	Within 24 hours of receipt of request	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

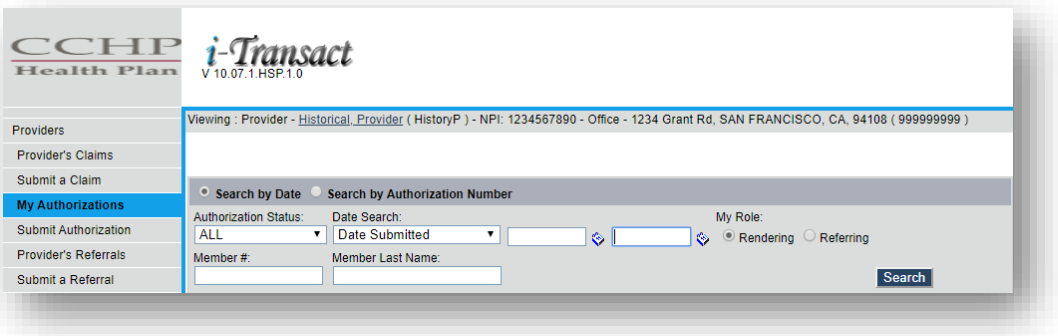
Section 8.23 Instructions for Checking the Status of Authorizations Online

Requests for Prior Authorization can be submitted by fax or mail with the CCHP Service Authorization Form (SAF), online via the portal "**Submit Authorization"** page to the Utilization Management Department, or telephone.

You can view the status of authorization requests that have been received by the UM Department on the Website. To check the status of authorizations:

1. Go to website: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Enter your username and password and click on "Logon".
3. Click "**My Authorizations**" option on the left side bar.
4. You can search by date or by authorization number.
5. Enter "**Member #**", and select the appropriate authorization status and date search.
6. Click on the "Search" button and the "Search by Date" page will list applicable Authorizations (SAF) requests received. Click on the left side of the screen authorization number in blue and a detail explanation of the authorization will be display.

See **"Authorizations"** screenshot below



Section 8.24 Inpatient/Outpatient Case Management

Case management is a comprehensive, multidisciplinary process that coordinates timely, medically appropriate, quality care in the most appropriate setting. Case management maximizes benefit and community resources by providing assessment, problem identification, planning, outcome monitoring, and re-evaluation to meet the needs of a specific, targeted population with complex health care needs. The case manager is the link between the individual, the provider, the payer and the community.

Section 8.25 Inpatient Review

Admissions are reviewed on the first working day following admission, using InterQual criteria. If admission or continued stay does not meet criteria outlined in the guidelines and the individual member circumstance, the Nurse Reviewer will refer the case to the Medical Director.

Medical information is requested before admission, on admission or concurrently and, in some cases, retrospectively to authorize inpatient care. Authorized lengths of stay are determined by medical necessity. Continued stay may not be denied without concurrent review except in the case when a facility fails to provide timely medical information on which to base the review.

- Inpatient review is the process to determine the medical necessity of inpatient services.
- Concurrent Review is a process designed to monitor appropriateness and quality of healthcare in the institutional setting at the time the services are rendered.

Additional Instructions for Medicare Advantage Patients:

A. The facility is responsible for notifying the Medicare Advantage member of their right to a Quality Improvement Organization (QIO) review of discharge decisions by delivering the "Important Message From Medicare About Your Rights" (IM) notice.

B. The IM notice should be given to Medicare Advantage members at the acute inpatient level, this includes acute and rehabilitation facilities, long term acute care hospitals and psychiatric hospitals.

C. Members in facility swing beds or custodial care beds do not receive these notices when receiving services at a lower level of care.

D. The Member shall be notified of decisions to terminate Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services no less than two (2) days before the proposed end of the services.

E. Members do not need a three (3) days acute facility stay prior to admission to a SNF.

PROCEDURES (Inpatient Acute)

1. Acute facility shall notify Members who are inpatient about their acute stay discharge appeal rights. Facilities shall issue the IM notice.
    a. A follow up copy shall be delivered as far in advance of discharge as possible, but no less than two (2) calendar days before the planned date of discharge.
    b. When discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge giving the beneficiary at least four (4) hours to consider their right to request a QIO review.
    c. If delivery of the original IM is within two (2) calendar days of the date of
        i. Discharge, no follow up notice is required.
        ii. (Example: The Member is admitted on a Monday, the IM is delivered on Wednesday, and the Member is discharged on Friday, no follow up notice is required.)
2. A Member has the right to request an expedited review by the QIO, when it has been determined, and the physician concurs that inpatient care is no longer necessary.
    a. Members who fail to make a timely request for an expedited review and are no longer an inpatient, can still request a QIO review within thirty (30) calendar days of the date of discharge, or at any time for good cause.
    b. Upon the QIO notification to an acute facility and/or CCHP of the request for expedited review, the facility shall deliver the Detailed Notice of Discharge to the Member.
    c. The Detailed Notice of Discharge shall be completed with all necessary information requests on form instructions.
    d. If the Member requests, the facility or CCHP shall furnish the Member with a copy of, or access to, any documentation that is sent to the QIO, including written records or any information provided by telephone.
        i. The facility or CCHP shall accommodate the request by no later than the first day after the material is requested.
        ii. CCHP's UM Nurse will coordinate the continued care and discharge plans with the facility's Case Manager.
        iii. Skilled Nursing Facility (SNF), Long Term Acute Care Hospital (LTACH), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services:
3. Practitioners and Members are given written or electronic notification of the decision of non-coverage of further SNF, HHA, or CORF care no later than two (2) calendar days or two (2) visits prior to the proposed termination of services. The Notice of Medicare Non- Coverage (NOMNC) letter may be delivered earlier if the date that coverage will end is known. If the expected length of stay or service is two (2) days or less, the NOMNC letter shall be given on admission. The NOMNC letter shall include:
    a. Member name;

b. Delivery date;
c. Date that coverage of services will end;
d. QIO contact information for a fast track appeal;
e. Member's right to submit evidence to the QIO; and
f. Alternative appeal mechanisms if the Member fails to meet the deadline for a fast track appeal.

4. If the Provider is unable to personally deliver the NOMNC to a person legally acting on behalf of a Member, then the Provider should telephone the representative to advise him or her of the proposed terminated services, appeal rights, and document the call and send written notice via mail.
5. When direct phone contact cannot be made, the notice is sent to the Member's representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt for the NOMNC letter.
6. Once the NOMNC is completed, a copy should be faxed as follows:
    i. Skilled Nursing Facilities (SNF) and Home Health (HH) authorized by CCHP, please fax to (415) 398-3669
7. Upon notification by the QIO that a Member has filed a request for a fast track appeal, the Detailed Explanation of Non-Coverage (DENC) notice shall be sent to the Member by the close of business on the day the QIO notification is received with all the necessary information explaining why services are no longer necessary or no longer covered.

Section 8.26 Discharge Planning

Discharge planning begins on admission when goals and treatment plans are identified. Based upon the member's needs, post hospital services are arranged when the patient is medically stable for discharge.

Section 8.27 Retrospective Review

When inpatient services have been provided without prior authorization, medical information shall be obtained from the provider to determine whether the services were medically necessary. The determination shall be made within 30 days of receipt of all information.

Section 8.28 Denial/Appeal Process

Physician reviewers from the appropriate specialty conduct and document medical appropriateness reviews on any denial file. A psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist reviews any mental health care denials that are based on medical necessity. A description of the reason that the service is denied is documented clearly and the criteria on which the denial is based are available to the practitioner and member on request.

Section 8.29 Conflict of Interest

No person may participate in the review, evaluation or final disposition of any case in which he/she has been professionally involved or where judgment may be compromised. If it is necessary to seek outside physician reviewers in order to eliminate conflict of interest and assure an objective determination, such will be done.

Section 8.30 Coordination of Care Audits

The CCHP Quality Improvement Department conducts medical chart audits to verify documentation of effective communication and coordination of care between the PCP and mental health specialist. Prior to the onsite audit, as a means to monitor the communication between PCP's and mental health specialists, the Quality Improvement nurse reviewer will identify and request charts of patients who have received mental health care services based on paid claims. The nurse reviewer will review and score the chart for proof of documentation of clinical information shared between the mental health specialists and PCP's as mandated by current Department of Managed Health Care regulations.

Section 8.31 Second Opinions

In certain situations, it is appropriate for an additional medical or surgical opinion ("second opinion") to be provided when a treating physician, or CCHP feels this would be helpful in determining a diagnosis or course of treatment.

A. Primary Care Physicians (PCPs), Specialists, and Members (if the practitioner refuses), have the right to request a second opinion from CCHP, regarding proposed medically necessary medical or surgical treatments from an appropriately qualified in network healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition, or conditions associated with the request for a second opinion.

B. Second opinions are authorized when medically necessary and are arranged through CCHP.

C. The mandated timeframes for decisions of a request for a second opinion and subsequent notification to the Member and practitioner are available in the Member's Evidence of Coverage (EOC) and are available to the public, upon request.

PROCEDURES:

1. The Member's request for a second opinion is processed through CCHP prior authorization system. Members should request a second opinion through their PCP or specialist. If the PCP or specialist refuses to submit a request for a second opinion, the Member can submit a request for assistance through CCHP Member Services at (415) 834-2118. CCHP's Member Services staff directs the request to the CCHP Utilization Management Department to be processed.
2. The PCP or specialist submits the request for a second opinion to CCHP including documentation regarding the Member's condition and proposed treatment.
3. If the referral for a second opinion is approved, CCHP will help arrange for the Member to see a practitioner in the appropriate specialty. Agreements with any network or out-of-network practitioner for second opinions shall include the requirement that the consultation report for the second opinion be submitted within three (3) working days of the visit to the Practitioner.
4. If the referral is denied or modified, CCHP provides written notification to the Member, including the rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision. Request may be

denied if the Member insists on an out-of-network practitioner when there is an appropriately qualified practitioner in-network.

5. If there is no physician within the CCHP network that meets the qualifications for a second opinion, CCHP may shall authorize a second opinion by a qualified physician outside CCHP's network and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.
6. CCHP shall provide and coordinate any out-of-network services adequately and timely.
7. Members disagreeing with CCHP's denial of a second opinion may appeal through the CCHP grievance process. In cases where the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, decisions and notification of decisions to practitioners are completed in a timely fashion not to exceed seventy-two (72) hours after receipt of request, whenever possible.
8. In situations where the Member believes that the need for a second opinion is urgent, they can request facilitation by CCHP by contacting CCHP Member Services. CCHP Medical Services reviews such requests, and if determined to be urgent, facilitates the process by working directly with the PCP and the Utilization Management team. If determined by CCHP Medical Services to be not urgent, the Member is referred back to his/her PCP to continue the process.
9. Reasons for providing or authorizing a second opinion include, but are not limited to, the following:
    a. The Member questions the reasonableness or medical necessity of recommended surgical procedures;
    b. The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition;
    c. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/specialist is unable to diagnose the condition and the Member requests an additional diagnostic opinion;
    d. The treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; and
    e. The Member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care.
10. If the Member is requesting a second opinion about care from his or her PCP, the second opinion shall be provided by an appropriately qualified physician of the Member's choice within CCHP network.
11. If the Member is requesting a second opinion about care from a specialist, the second opinion shall be provided by any physician of the same or equivalent specialty of the Member's choice within CCHP network. CCHP. If not authorized, additional medical opinions obtained from a physician not within CCHP network are the responsibility of the Member.
12. The notification to the practitioner that is performing the second opinion shall include the timeframe for completion of the consultation and requirements for submission of the consultation report.

13. The second opinion practitioner is responsible for submitting consultation reports to the Member, requesting practitioner and PCP within three (3) working days of the visit. If the second opinion is deemed urgent, the submission of the consultation report shall be within twenty-four (24) hours of the visit.
14. The PCP is responsible for documenting second opinions and monitoring receipt of consultation reports on the PCP Referral Tracking Log (See Section 8.6 Primary Care Physician (PCP) Referrals - Referral Tracking Log").
15. Mandated timeframes for decision including approval, denial or modification of a non-urgent or urgent or concurrent request for a second opinion and subsequent notification to the Member and practitioner shall follow the regulatory timeframes.
16. If the referral is denied or modified, CCHP provides written notification to the Member including rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision. Member, Member's Representatives, or practitioners appealing on behalf of the Member, disagreeing with a denial of a second opinion, may appeal through the CCHP grievance process.
17. CCHP's Medical Director or physician designee may request a second opinion at any time it is felt to be necessary to support a proposed method of treatment or to provide recommendations for an alternative method of treatment.

Section 8.32 Retroactive Authorizations

For services requiring authorization, the request must be submitted prior to rendering the service, to:

1. Verify medical necessity,
2. Verify the service requested is a covered benefit,
3. Verify member eligibility and enrollment, and
4. Verify the provider and location of service is in network.

Requests for retroactive authorizations will not be approved for any elective and non-emergent services.

NOTE: Claims received for elective and non-emergent services without the required prior authorization by the Utilization Management Department will be denied.

SECTION 9 CLAIMS PROCEDURES

Section 9.1 Timely Filing

For authorized claims, when CCHP is primary, claims must be submitted to CCHP by the deadline specified in your contract. Typically this requires submission of claims no later than 90 days from date of service. Claims submitted after the deadline specified in the provider contract will be denied event if previously authorized and must be written off by the provider.

Secondary claims submission must include a copy of the primary EOB and must be submitted within 90 calendar days of the receipt of the primary payer's EOB.

Claims will not be paid beyond submission deadlines unless there is a special circumstance in which the provider can demonstrate good cause. At no time is the patient responsible for payment of claims submitted after the timeliness deadline.

Section 9.2 Claims Submission

CCHP is contracted with Independent Physician Associations and with providers directly. If you are submitting a claim for services provided under your IPA contract, you must submit them to the IPA who will in turn file them on your behalf. CCHP also has direct contracted providers who submit their claims directly to CCHP for payment.

Section 9.3 Electronic Claims

CCHP prefers that claims be submitted electronically. If you already submit claims electronically to other payers, please contact your clearinghouse vendor and tell them to forward your claims for CCHP members to the electronic claims clearinghouse, Emdeon.

The CCHP Emdeon Payer ID Number is 94302.

Section 9.4 Paper Claims

All paper claims must be submitted on a CMS 1500 or UB04 Form to:

CCHP Claims Department
445 Grant Ave Suite 700
San Francisco, CA 94108

Section 9.5 Claims for Referred Services

For electronic claims, the CCHP specialist physician or mental health specialist (consultant) must indicate the name of the referring CCHP physician on the electronic claim.

For paper claims, the CCHP specialist physician or mental health specialist must indicate the name of the referring CCHP physician on the claim and submit a copy of the CCHP Consultation Referral Form with the claim.

Section 9.6 Claims for Authorized Services

Be sure that a claim for authorized services includes the following:

1. The procedure code(s) that was authorized on the Service Authorization Form (SAF) matches the code on the claim form,
2. The reference number for the authorization, and
3. When submitting a paper claim, attach a copy of the approved SAF.

Section 9.7 Clinical Documentation

CCHP will perform random audits including clinical reviews of PCP and specialist claims billed with 99204, 99205, 99214 and 99215. If selected, a copy of the associated PCP notes or consultation report must be sent to CCHP for review.

Section 9.8 Claims Resubmission Policy

To avoid duplicate claims, please first check the status of your claims either on our Website or by calling the phone number listed in Section 1 to confirm receipt. Resubmission of a claim should be no earlier than 60 days following the original claims.

CCHP contracted health care professionals and facilities can check the status of their claims using the CCHP Provider Portal. Please click on the above Provider Portal link to log-in with your UserID and Password. After checking online, if you have a question about a claim, please call Member Services Center at 1-415-834-2118.

If you need assistance with web access, please call Provider Relations at 1-628-228-3214, Monday through Friday, 9:00 AM to 5:00 PM.

If you are not a contracted provider with CCHP or do not have web access and would like to check claims status, please call Member Services Center at 1-415-834-2118.

Section 9.9 Refunds

When submitting a refund, please include a copy of the remittance advice, an explanation why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer's remittance advice (if applicable).

Section 9.10 Processing Timeliness Standards

CCHP processes claims according to the following State and Federal regulatory claims payment standards:

Commercial claims – 95% of all claims – complete claims, contested claims and denials will be processed within 45 working days.

Medicare Advantage 30-day claims – at least 95% of clean MA claims from unaffiliated (non-contracting) providers will be processed within 30 calendar days from date of receipt.

Medicare Advantage 60-day claims – at least 95% of all other MA claims (unclean claims, member liability denials and claims for affiliated, contracted providers) will be processed within 60 calendar days from date of receipt.

CCHP processes also comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.39 shall be subject to any Provider remedies, including interest payments provided for in California statute and/or provider agreements, if it fails to meet the standards specified in these policies and procedures.

Section 9.11 Checking the Status of Claims

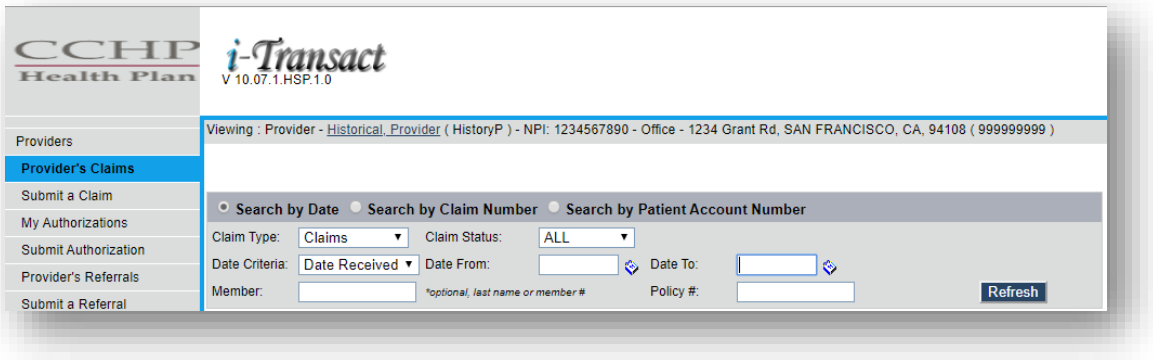
Claims status can be checked 24 hours a day online at:
https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
Refer to Section 9.11 Website Instructions for Checking the Status of Claims for Web access instructions. To inquire about claims by telephone, refer to Section 1, Key Contacts and Resources. CCHP maintains sufficient claims processing/tracking/payment systems capability to: comply with applicable State and federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.

Section 9.12 Website Instructions for Checking the Status of Claims

Contracted providers with internet access can use the Web to check the status of any previous month's claims paid by Jade, CCHP and Chinese Hospital. To check the status of claims:

1. Go to https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Enter your username and password and click on "Logon".
3. Click "Provider's Claims" (naming will depend on the type of account) option on the left side bar.
4. You may search by date or claim number.
5. Enter the CCHP Member ID under "**Member** #" or enter the old CCHP Member ID without the asterisk under the "Policy #" (Example: 00011122201).
6. On the "search by date" page, you have the option to narrow the information being searched by the claim status and date criteria.

See "Claims search" screenshot below.



7. Click on the "Refresh" button and the "Search by Date" page will list applicable claims.
8. For more details, click on the claim number in blue and you will see the entire claim summary.
9. Please click on "view" in next to the claim number for the Evidence of Payment (EOP).

Section 9.13 Provider Dispute Resolution Procedure

CCHP has a Provider Dispute Resolution (PDR) process that ensures provider disputes are handled in a fast, fair and cost effective manner. A provider dispute is a written notice from a provider that:

- Challenges, appeals or requests reconsideration of a claim (including a bundled group of similar claims) that has been denied, adjusted or contested, or
- Challenges a request for reimbursement for an overpayment of a claim, or
- Seeks resolution of a billing determination or other contractual dispute.

Providers have 365 days from the date of the CCHP's action or inaction to submit a provider dispute. If a provider disputes the failure to take action on a claim, the provider has 365 days from the last date on which the Plan could have either paid, denied or contested the claim (consistent with claims payment timeliness rules) to submit the dispute. CCHP will respond to the dispute in a timely manner in accordance with State and Federal Guidelines.

CCHP will resolve each provider dispute within 45 business days following receipt of the dispute, and will provide the provider with a written determination stating the reasons for the determination.

Non-Contracted Provider Dispute Resolution Process for CMS Medicare Advantage Plan Members

A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the Medicare Advantage member regardless of the outcome of the appeal. The health plan cannot undertake a review until or unless such form/documentation is obtained.

Section 9.14 How to Submit Provider Disputes

1. Provider Dispute Form
    a. Providers must use a Provider Dispute Resolution Request Form. You may download the PDR Request Form and Instructions for Submitting Provider Disputes at **www.cchphealthplan.com/cchp-providers-dispute-process.** You may also contact Provider Relations at telephone number listed in Section 1.
2. Disputes may be mailed to:
    Chinese Community Health Plan
    Attention: Provider Dispute Resolution Area
    445 Grant Avenue, Suite 700
    San Francisco, CA 94108
3. Disputes can be faxed to: 415-955-8815
4. Acknowledgement of Provider Disputes
    a. CCHP will acknowledge receipt of a provider dispute within 15 business days of receipt. Provider disputes received electronically must be acknowledged within 2 working days from the date of receipt.
5. Resolution Timeframe
    a. CCHP will resolve each provider dispute within 45 business days following receipt of the dispute, and will provide the provider with a written determination stating the reasons for the determination.
6. Download details of the **CMS Non-Contracted Provider Dispute Process** here.

7. Download the **Waiver of Liability Statement** here.

SECTION 10 PHARMACY INFORMATION

Section 10.1 Pharmacy Benefit Administered by MedImpact Healthcare Systems

Most Chinese Community Health Plan (CCHP) members have prescription drug coverage. CCHP contracts with MedImpact Healthcare Systems, a pharmacy benefit management (PBM) company to administer its prescription drug benefit.

When you have a question about coverage for a particular drug or require assistance on behalf of a CCHP member regarding a prior authorization or non-formulary request, please contact CCHP Member Services.

CCHP Member Services is available to take your calls from 8:00 a.m. to 8:00 p.m., seven days a week. You can reach Member Services Center by calling toll-free at 1-888-775-7888 or locally 1-415-834-2118. TTY users can call 1-877-681-8898.

In addition, CCHP has a pharmacist available to discuss concerns regarding drugs that are not on the formulary or to assist you in finding an alternative drug that is on the formulary. CCHP has a Pharmacy and Therapeutics Committee that reviews new drugs as well as requests for additions to the formulary. If you have concerns or suggestions about particular drugs that are not on the formulary, please contact the CCHP Pharmacist at the number listed in Section 1.

Section 10.2 Drug Formulary

CCHP uses a drug formulary (list of covered drugs). Please refer to the applicable CCHP Formulary for drugs covered by CCHP based on the member's enrolled plan, available at: www.cchphealthplan.com/cchp-providers-formulary-pharmacy.

The formulary is based on a multiple tier incentive design. The formulary lists preferred generic drugs, which have a first tier copayment and preferred brand name drugs with a second tier copayment. Depending on their pharmacy benefit, some members also have a third tier copayment for covered specialty drugs and injectables.

Section 10.3 Prior Authorization

When a drug on the formulary indicates that prior authorization is required, or when a physician wants to prescribe a drug that is not listed on the formulary, you should first determine if an alternative drug that is on the formulary is an option for your patient. If an alternative drug is not an option, you can request a prior authorization by calling:

- For your CCHP Medicare patients, call CCHP Member Services at 1-888-775-7888, seven days a week from 8:00 a.m. to 8:00 p.m.
- For your CCHP Commercial patients, call MedImpact Healthcare Systems at 1-800-788-2949, 24 hours a day, seven days a week

You can also download and complete Form No. 61-211 from our website and fax requests directly to MedImpact Healthcare Systems at 1-858-790-7100, 24 hours a day, seven days a week.

Table 10.3.1 Prior Authorization Timeliness Standards

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Written/Electronic)	Written/Electronic Notification of Denial to Practitioner and Member
Standard (Non-urgent)	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. Note: If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 24 hours after receipt of the request.**	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of	Within 24 hours of receipt of the request. Note: If oral notification is given within 24 hours of request, written or

		the request (for approval decisions). Document date and time of oral notifications.	electronic notification must be given no later than 3 calendar days after the oral notification.

Section 10.4 Pharmacy Network

CCHP members must receive prescriptions from a CCHP network pharmacy, which comprises the MedImpact Healthcare Systems network and includes most common pharmacies such as Walgreens, Rite Aid, and CVS. For a CCHP Pharmacy Directory listing all the local pharmacies, please refer to **our CCHP website.**

Chinese Hospital is part of the CCHP pharmacy network and offers culturally sensitive, bilingual outpatient pharmacy services. CCHP members who fill prescriptions at Chinese Hospital can receive a 90-day supply for maintenance drugs at a discounted copayment equivalent to the copayments for two 30-day supplies.

Section 10.5 Mail Order Prescription Drug Program

CCHP members also have the option to receive prescription drugs for maintenance medications by mail through Costco. Through this mail order pharmacy, members can receive a 90-day supply for maintenance drugs at a discounted copayment equivalent to the copayments for two 30-day supplies.

For patients interested in filling prescriptions by mail, refer them to Chinese Community Health Plan's Member Services Department at 415-834-2118.

SECTION 11 QUALITY IMPROVEMENT PROGRAM

Section 11.1 Quality Improvement Program

Chinese Community Health Plan (CCHP) has established a Quality Improvement Program (QIP) to provide for the delivery of high quality care and services to its members. All programs having a direct or indirect influence on the quality and outcome of clinical care and services provided to enrollees are consistently and systematically monitored and evaluated. The process is documented. When issues for improvement are identified, recommendations are implemented, and the effects studied.

Overview

- The role, structure, functions of the Quality Improvement Committee.
- The Quality Improvement Committee (QIC) is responsible for the implementation of the Quality Improvement Program. The QIC reports to the Board of Directors and works in conjunction with the Compliance Committee
- The QIC receives recommendations from the Chinese Community Health Care Association's Quality Improvement/ Utilization Review Committee on a quarterly basis or more frequently as necessary.
- Quality Improvement Program, Policies and Procedures, Annual Summary and Evaluation Report, and Work Plan will be reviewed and approved, and if necessary revised and submitted annually to the QIC.
- Quality Improvement Quarterly Reports from contracting medical groups are submitted to the QIC and are reviewed and approved on a quarterly basis.
- Upon member/practitioner request, a description of the program and report of progress made in meeting the goals will be provided.
- The Quality Improvement Work Plan is developed and implemented each year by the QIC and includes the following: scope, goals, objective, projects and plans for the year, and a follow up of previously identified issues. The Work plan describes time frames, assigns responsibility, and reports on effectiveness, outcomes, and makes recommendations to the QIC. The QIC reports progress on the QI Work Plan to the Board.

Quality Improvement Activities include but are not limited to the following:

- Accessibility of services
- Availability of practitioners
- Member Satisfaction
- Practitioner Satisfaction
- Adverse outcomes/sentinel events
- Contracted services performance
- Monitoring language documentation
- Utilization of services meets professionally recognized standards of practice

Audits, Surveys, Studies may include but are not limited to the following:

- Participation in the Healthcare Effectiveness Data and Information Set (HEDIS)
- Member/Provider Satisfaction
- Medical Office Audits

- Medical Record Audits
- Health of Seniors
- Centers for Medicare and Medicaid Services' (CMS) Annual Required Studies
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Other areas include:

- Health Education Programs/Promotion
- Credentials Program
- Grievance and Appeal Resolution Program

A. The following procedures are required:
    1. Submission of an annual Quality Improvement Program Description
    2. Submission of an annual Quality Improvement Plan listing annual goals and/or objectives.
    3. Annual submission of QI Program evaluation
    4. Submission of quarterly and annual reports, which document activities and results for all delegated activities (Credentialing, Quality Improvement, Utilization Management/Case Management, Member Rights and Responsibilities) HEDIS, access and quality scores
    5. Quarterly submission of Quality Improvement Committee minutes
    6. Annual submission of member and provider satisfaction survey results (if applicable)
    7. The integration of QIS activities with the Utilization Management activities including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. Specific policies and procedures related to the Utilization Management functions can be found in Section 6.
    8. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by CCHP's governing body and periodically evaluated and updated.
    9. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QRS committee(s) and staff within CCHP.
    10. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
    11. A description of the system for provider review of QRS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QRS study outcomes.
    12. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.
    13. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include

methods to ensure that members are able to obtain appointments within established standards.

14. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.
15. Description of the activities designed to assure the provision of case management, coordination and continuity of care services.
16. Quality Improvement Annual Report submission to the Board.

B. CCHP will develop an annual quality improvement report for submission to DHS on an annual basis. The annual report shall include:
    1. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of the HEDIS measures; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.
    2. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.
    3. An assessment of subcontractor's performance of delegated quality improvement activities if any. In the case where Plan or Plan Sponsor is selected for an external quality of care review by state or federal regulators, the ASO will cooperate with any entity qualified to conduct such reviews in accordance with Title 22, CCR, Section 53915 (d) and Title 42, USC, Section 1396a(30)(C). ASO shall also cooperate with and assist the External Quality Review Organization (EQRO) designated by the State in the conduct of this review.

Section 11.2 Correct Coding Initiative

CCHP physicians play a critical role in the payment our health plan receives from the Centers for Medicare and Medicaid Services (CMS) for taking care of our Senior and Senior Select patients. Payment is based on records that show how sick the patient is through correct and complete coding of services provided to that patient.

To ensure that CCHP receives the highest level of payment from CMS for every member, CCHP must rely on health care providers for accuracy and specificity in diagnostic coding.

The CMS Risk Adjustment Payment System (RAPS) is a clinical coding system that allows CMS to predict the future cost of a member's care and to calculate the proper payment to health plans like CCHP. The coding system is used to determine the category of severity and cost for different disorders. This grouping of disorders is similar to the Diagnostically Related Groups (DRG's) used for inpatients; but this one includes chronic conditions for outpatients and is called Hierarchical Condition Categories (HCC). CMS uses this system to adjust Medicare payments to health plans for their expected costs. For example, health plans that have mostly healthy members are paid less than plans with an average risk, while health plans that have a high number of very sick patients are paid even more.

What you need to do:

Please comply with the following medical record documentation guidelines.

Section 11.3 Medical Record Documentation

- Ensure medical record documentation includes *all* conditions and co-morbidities being treated and managed. Your records should be clear, complete, legible and timely.
- **Include** the member's identification on each page of the medical record, date of service, the signature of the person(s) doing the treatment, reason for the visit, care rendered, clinical assessment and diagnosis, and follow-up care plan.
- **Include the provider's credentials on the medical record**, either written next to his/her signature or using a pre-printed stamp with the provider's name on the practice's stationery. Examples: "M.D.", "D.O.", "N.P.", or "P.A." Note: "R.N." or "M.A." is not accepted.

Section 11.4 Claims Coding and Diagnoses Submissions

- **Report and submit all diagnoses** that impact the patient's evaluation, care and treatment; reason for the visit; co-existing acute conditions; chronic conditions or relevant past conditions.
- **Code all claims** for CCHP Senior Program and Senior Select Program members to the highest level of specificity using the 4th and/or 5th digit codes, whenever possible. Specificity of coding is based on the accuracy of information written in the medical records.
- CCHP will **perform random audits** including clinical reviews of PCP and specialist claims billed with 99204, 99205, 99214 and 99215. If selected, a copy of the associated PCP notes or consultation report must be sent to CCHP for review.

Section 11.5 HEDIS (Healthcare Effectiveness Data and Information Set)

The **Healthcare Effectiveness Data and Information Set** (HEDIS) is an annual performance measurement created by the National Committee for Quality Assurance (NCQA) and used to help establish accountability and improve the quality of health care. Chinese Community Health Plan is required by our contract with the Centers for Medicare and Medicaid Services (CMS) to report HEDIS measurements.

HEDIS is one of the most widely used set of health care performance measures in the United States. Health plans also use HEDIS results to identify areas that need quality improvement efforts. These measures are designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes.

On an annual basis, CCHP will prepare a set of Health Plan Employer Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA) and DHCS developed performance measures selected by DHCS for evaluation of health plan performance.

1. On an annual basis, CCHP shall submit the Health Plan Employer Data and Information Set (HEDIS®) Compliance Audit™) to DHCS as required by State regulation. Compliance Audits will be performed by an EQRO as contracted and paid for by the State.
2. CCHP shall calculate and report all EAS performance measures at the county level.
    a. HEDIS rates are to be calculated by CCHP and verified by the DHS-selected EQRO. Rates for DHS-developed performance measures will be calculated by the EQRO.
    b. CCHP shall meet or exceed the DHS-established Minimum Performance Level (MPL) for each HEDIS measure.

Section 11.6 Cooperation with HEDIS Chart Review Abstractions

Many HEDIS measures are scored using claims data; however, additional information that may only be found in a member's chart is often needed. During HEDIS season, typically March to June, chart reviewers may contact providers to set up appointments to view charts and scan appropriate supporting documentation. We may also request that you either mail or fax copies of certain chart components for off-site review. Without this supporting documentation, it is impossible to follow the HEDIS compliance standards that are required of Chinese Community Health Plan (CCHP).

Chinese Community Health Plan require providers to cooperate with HEDIS chart review and abstraction. Participating in quality management activities is specified in your provider contract; you do not need to get special patient permission for the chart data abstraction process. HEDIS data collection is a HIPAA protected activity covered under Payment and Operations policies.

Section 11.3 How to Improve HEDIS Scores

1. Understand the specifications established for each measure. Review the Quick Reference Guide on the following pages. If you have questions, please contact the CCHP Quality Improvement Department.
2. Educate patients and reinforce the importance of screenings during the appointment.
3. Request patient information from specialists.
4. Schedule the screening or next appointment at the current visit.
5. Chart documentation must reflect services billed. It is critical that the corresponding codes are billed for each HEDIS measure.
6. Submit claims data for each and every service rendered. Use the specified CPT and ICD-10 codes for each HEDIS measure.

Section 11.4 Common HEDIS Measures and Required Documentation

Measure	Chart Documentation Requirements
Body Mass Index (BMI)	Once a year for members 18-74 years of age: $\text{BMI} = \frac{\text{Weight (lbs) x 703}}{\text{Height (in) x Height (in)}}$

Measure	Chart Documentation Requirements
Breast Cancer Screening	Mammogram every 1-2 years for women 40-69 years of age
Care for Older Adults	Annually for ≥ 65 years of age: • Advance Care Planning • Medication Review • Functional Status Assessment • Pain Screening
Cervical Cancer Screening	Pap smear every 1-3 years for women 21-64 years of age
Chlamydia Screening in Women	Once a year for sexually active women 16-24 years of age
Cholesterol Management for Patients with Cardiovascular Conditions	For 18-75 years of age with cardiovascular conditions: • Annual LDL-C screening • LDL-C control (<100mg/dL)
Colorectal Cancer Screening	Screening for 50-75 years of age: • Annual fecal occult blood test, ***or*** • Flexible sigmoidoscopy every 5 years, ***or*** • Colonoscopy in last 10 years
Comprehensive Diabetes Care	Annually for members 18-75 years of age with diabetes: • HbA1c testing and controlled (<7 unless contraindicated) • Eye exam • LDL screening and controlled (<100 mg/dL) • BP control <130/80 • Medical attention for nephropathy
Medication Reconciliation Post-Discharge	For members ≥ 65 years of age, in-patient discharge medications are reconciled or reviewed within 30 days of discharge
Osteoporosis Management in Women	1. Women ≥ 65 years of age received a bone density test to check for osteoporosis. 2. Women ≥ 65 years of age received the following within six months after a fracture: • Bone mineral density (BMD) test ***or*** • Prescription for a drug to treat or prevent osteoporosis

Measure	Chart Documentation Requirements
Pneumonia Vaccine	Members ≥ 65 years of age received a pneumococcal vaccine
Rheumatoid Arthritis Management	Members ≥ 18 years of age with rheumatoid arthritis received at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD)
Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	Members ≥ 40 years of age with a new diagnosis or newly active COPD received appropriate spirometry testing to confirm the diagnosis.
Childhood Immunization	Vaccinated by 2nd birthday: • 4 Diphtheria, tetanus and acellular pertussis (DTaP) • 3 Polio (IPV) • 1 Measles, Mumps, and Rubella (MMR) • 3 H Influenza type B (HIB) • 2 Influenza (flu) • 2 Hepatitis A (HepA) • 3 Hepatitis B (HepB) • 4 Pneumococcal conjugate (PVC) • 2-3 Rotavirus (RV) • 1 Varicella (VZV)
Immunization for Adolescents	Vaccinated by 13th birthday: • 1 Meningococcal vaccine • 1 Tetanus, diphtheria toxoid and acellular pertussis vaccine (Tdap) ***or*** 1 Tetanus and diphtheriatoxoid (Td)
Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents	Annually for 3-17 years of age: • BMI percentile or BMI percentile plotted on an age-growth chart for members < 16 years of age • BMI value for adolescents 16–17 years of age • Counseling or referral for physical activity • Counseling or referral for nutrition education

Section 11.5 Advance Directive

The Patient Self-Determination Act (PSDA) requires that health care facilities and provider organizations, including primary care practitioners that serve patients with Medicare, Medicaid, Medi-Medi or other federally funded health care programs, educate and or discuss Advance Directive(s) with each patient age 18 years or older.

As a CCHP contracted or affiliated provider, under the PSDA and CCHP's contractual and regulatory requirements, patient medical records must include a notation as to whether or not an advance directive has been completed.

Section 11.6 Participating Physician Responsibilities in Advance Directive Planning

For CCHP members age 18 and older, participating physicians are required to:

1. Ask patients if they have completed an Advance Directive and if so, ask the member for an executed copy which must be placed in the patient's medical record. This document must be used in the event a patient cannot express themselves or speak on their own behalf with regard to their preferences and directives for health care services.
2. Provide information regarding advance directives to patients to educate them about their rights to create an advance directive.
3. Document in the patient's medical record that the member has been informed about their right to create an advance directive and document whether the member has executed an advance directive.
4. Document in the member's record if the patient refuses information on advance directives.

CCHP recommends that participating physicians integrate the following best practices in their office policies and operations:

1. Provide each member (over 18 years of age) with written information such as the booklet contained in this section and a blank copy of an Advance Directive that can be completed and signed.
2. Encourage patients to share their Advance Directive(s) and their preferences (including copies of the document) with their health providers, and their close family members, so that their pre-declared personal directives and preferences for their medical care would be followed in the event that they cannot communicate them at a critical time.

Section 11.7 Advance Directive Resources

Included in this Section is a booklet entitled "Your Right to Make Decisions about Medical Treatment" and an Advance Directive Form for patient distribution.

For additional information about advance directives, including information in Chinese and Spanish, go to **http://www.coalitionccc.org**

SECTION 12 PROVIDER INCENTIVE PROGRAM

Section 12.1 Program Description

Program Summary

This incentive program transforms nationally accepted evidence-based medicine standards from regulatory organizations and the Centers for Medicare and Medicaid Services (CMS) into incentive payments for Primary Care Physicians (PCP). Incentive payments will be based directly on performance in quarterly report cards and two semi- annual payments. The report card will show the physician's performance in each measure so that the physician can assess which quality standards are being met and where improvement opportunities exist. Please see the *Payment Summary* below for details on how and when payments will be made.

Please note that nationally accredited standards used to determine quality of care are constantly changing. As such, this incentive program will be reviewed annually and may change in accordance with these regulatory and quality organizations, such as CMS, California Integrated Healthcare Association (IHA), and National Committee for Quality Assurance (NCQA).

The source of funding for this program is from CCHP's net operating margin and is subject to the availability of funds. CCHP may add, remove, and/or revise measures prior to the beginning of each new measurement year and on rare occasion, as needed during the year to meet the intent and purpose of the program. Changes will be made based on member needs, provider feedback, evolving health plan needs, and quality performance goals.

Program Goals

- Align compensation with changing organizational goals and needs of patients, physicians, and health plans
- Improve data transparency with providers including making actionable insights available
- Distinguish priority performance metrics that are aligned with the line of business that is relevant

Measurement Data Sources

The incentive program uses medical, vision, laboratory, pharmacy claims, and laboratory data as primary sources to identify members who meet the numerator and denominator criteria for each measure. Some sources may also include integrated data feeds from EMRs and other CCHP contracted vendors. In some instances, values are extracted through a software program called CareAnalyzer® and through proprietary CCHP dashboards and reporting. DST Health Solutions CareAnalyzer®

is an integrated system, which combines claims and encounter data into a single tool to proactively identify high-risk members for care management, engage providers on quality and efficiency to strategically meet NCQA HEDIS® requirements and improve quality performance.

Section 12.2 Program Eligibility and Enrollment

Eligibility Criteria

Providers who meet ALL of the following eligibility criteria are enrolled in CCHP's Primary Care Physician (PCP) Incentive Program:

- The physician is registered with CCHP or Jade Health Care Medical Group (Jade) as a PCP.
- Practices in at least one of the following specialties:
  - Family Medicine
  - General Practice
  - Internal Medicine
- The PCP is in good standing with CCHP and Jade (no active investigations, suspensions, or potential fraudulent activity).
- PCP must have a minimum monthly average panel size of 50 members within the CCHP and Jade network.

Exclusions

- PCP with a monthly average panel size of less than 50 members within the CCHP and Jade network.
- Members in other provider network are not included in this program as other contracted groups may administer a separate provider incentive program.
- Physicians that are not registered with CCHP or Jade as a PCP or are not currently active with CCHP or Jade as of the date of semi-annual payments.

Providers must agree to the following:

- Participate fully in the incentive program and any quality improvement activities necessary to evaluate performance and improvement.

- Accept CCHP's determination of the incentive payment amount and the underlying data and methodology used to determine this value. Appeals to the program methodology, calculations, and/or payment amounts must be completed within 30 days of receipt of semi-annual payments. Appeals received by CCHP beyond this timeframe will not be honored.

- Accept that the program provides bonuses only for treatment and care of CCHP members assigned to his/her panel.

- This program is subject to change on an annual basis and it is the physician's responsibility to keep up-to-date on the program.

- Submit approval for CCHP to use email address, and when necessary, attests to willingness to utilize secure email for secure delivery of program reports or other health plan communication with patient health information (PHI) as required by HIPAA.

- Participate fully in medical record requests from Quality Improvement and Health Management team to support program administration and performance assessment.

Section 12.3 Payment Summary

Payment Philosophy

Payment amount varies predictably with provider's performance across quality measures, based on a predetermined formula. The following terms are defined:

Targeted PMPM	The Targeted per member per month (PMPM) represents payment amounts available in aggregate from CCHP net operating income for commercial and Medicare lines of business for each payment period as determined by CCHP and Jade management annually, or at other frequency as needed. For 2018, Targeted PMPM is $4.00.
Average Panel Size	The average number of members assigned to PCP panel per month during the measurement period. For example: Jan: 620 Feb: 590 Mar: 595 Apr: 720 May: 700 Jun: 700 Average Panel Size: 654.2

Relative Risk Factor	The risk adjustment factor is the relative risk factor for the corresponding line of business and includes both demographic (e.g. age and sex) and clinical factors (e.g. disease states, comorbidities). For the commercial members, the risk factor is based on the Commercial Risk Adjustment Factor (RAF) as determined in the ACA model. For the Medicare members, the risk factor is based on the Medicare Risk Adjustment Factor (RAF). The relative risk factor is calculated as the PCP panel's risk factor relative to that of the average CCHP & Jade member's risk factor within each line of business. If the panel has a higher risk than the average member, then the factor will increase the overall available payment. If the panel has a lower risk than the average member, then the factor will decrease the overall available payment. For example: If average risk score of Medicare member is 0.99, and Provider A has panel risk score of 1.1, relative risk factor equals 1.11.
Payment Cap	Maximum payment determined using Targeted PMPM of $4.00 per member per month. To approximate maximum payment, multiply Average Panel Size Count x Targeted PMPM rate x 12 months x Relative Risk Factor (the approximation assumes your panel is static over the 12 months). For example: ○ 50 = 50 * $4.00 * 12 months * 1.11 = $2,667 ○ 200 = $10,667 ○ 400 = $21,333 ○ 800 = $42,667
Minimum Panel Size	To receive payment, a PCP must have a minimum average of 50 members per line of business over the measurement period.
Quality Threshold	Minimum of **50%** Composite Score across all measures required to be eligible for payment

Attainment Threshold	Internal and external quality performance benchmarks are used to calculate attainment scores for each individual measure. CCHP and Jade management reserve the right to assess and determine the appropriate benchmarks annually or at other frequency as needed. For commercial measures: • California Integrated Healthcare Association 50th and 75th Percentile • InterQual criteria • PCPs 50th Percentile For Medicare measures: • CMS 3 Star and 4 Star cutpoints • InterQual criteria • PCPs 50th Percentile
Quality Benchmarks	Internal and external quality performance benchmarks are used to calculate attainment and improvement scores for each individual measure. CCHP and Jade management reserve the right to assess and determine the appropriate benchmarks annually or other frequency as needed. For commercial measures: • California Integrated Healthcare Association 95th Percentile • InterQual criteria • PCPs 90th Percentile For Medicare measures: • CMS 5 Star cutpoints • InterQual criteria • PCPs 90th Percentile
Attainment Score	Attainment scoring incentivizes PCPs that demonstrate marked performance relative to external benchmarks. Prior year data will be provided to PCPs to show baseline performance score at the individual measure level. For new providers joining CCHP and Jade, providers will only be eligible for attainment scoring in their first year.

Improvement Score	Improvement scoring incentivizes PCPs that demonstrate improvement from one measurement year to the next. Some PCPs may not perform well in a particular measure, but may achieve significant improvement warranting credit for their efforts. Prior year data will be provided to PCPs to show baseline performance score at the individual measure level. For new providers joining CCHP and Jade, providers will not be eligible for improvement scoring in their first year.
Composite Score	Overall composite score across all measures for each line of business. At the measure level, PCPs will receive Final Scores based on the higher of Attainment Score or Improvement Score. For new providers joining CCHP and Jade, PCPs will not be eligible for Improvement Scores in their first year. Quality Threshold and Minimum Panel Size requirements must be met for payment.

Payment Schedule

- Two payments will be made for each performance year:

    1) July of the performance year (based on January 1 through June 30 of the performance year) using all claims submitted, approved, paid, and transmitted to CCHP by the first July check run.

    2) May of the following year (based on January 1 through December 31 of the performance year) using all claims submitted, approved, paid, and transmitted to CCHP by the last April check run.

The payment lag allows CCHP to account for claims submission delays of up to 90 days after the service date to CCHP or other contracted entities. Only 50% of the Payment Cap is distributed in the first payment in July calculated using only the Semi-annual measure scores and using 50% of the Targeted PMPM. For the Annual payment, there will be a true up using the full Payment Cap (100%) and Targeted PMPM (100%) calculated for performance captured across the entire program year. In other words, the final Annual payment will deduct payments from the Semi-annual distribution. For negative totals after the true up, there will not be a recovery effort from the PCP, but participation in educational outreach i s mandatory by provider and practice staff prior to renewed eligibility for subsequent measurement year participation.

Section 12.4 Payment Calculation

Step One: Calculate Maximum Payment (also known as Payment Cap)

1. Calculate average number of members per month for Commercial and Medicare lines of business (LOB) in measurement period to determine if PCP exceeds Minimum Panel Size.

2. For each LOB, calculate total number of months in measurement period.

3. For each LOB, calculate average risk score for PCP and for average risk score in aggregate for CCHP & Jade network.

4. For each LOB, divide average risk score by aggregate risk score to arrive at relative risk score.

5. For each LOB, calculate Targeted PMPM x total number of months X relative risk score to arrive at Maximum Payment Cap.
    a. For Semi-annual payment, Targeted PMPM is $2.00.
    b. For Annual payment, Targeted PMPM is $4.00.

Step Two: Calculate individual measure scores and assign higher of Attainment Score vs. Improvement Score.

1. Certain measures will apply to only Commercial LOB or Medicare LOB, and some measures will apply to both Commercial LOB and Medicare LOB.

2. Calculate the raw performance percentage for each measure.
    a. "Numerator" = defined in Measure Descriptions for specific measure
    b. "Eligible" = number of members eligible for specific measure
    c. "Raw performance" = Numerator / Eligible

3. Calculate Attainment Score (see Figure 1)

a. Assign 10 points to full Attainment Range between Attainment Threshold and Benchmark such that PCP raw performance on measure scores distributes equally across 9 sub-ranges each worth 1 point. Raw performance equaling Attainment Threshold will receive 1 point; raw performance meeting or exceeding Benchmark will receive the maximum of 10 points.
b. Attainment Threshold and Benchmarks will be assigned for each measure.
c. For specific measures where lower performance is desired (e.g. inpatient utilization), the directionality is opposite, but the assignment of points and sub-ranges is the same.

4. Calculate Improvement Score (see Figure 1)

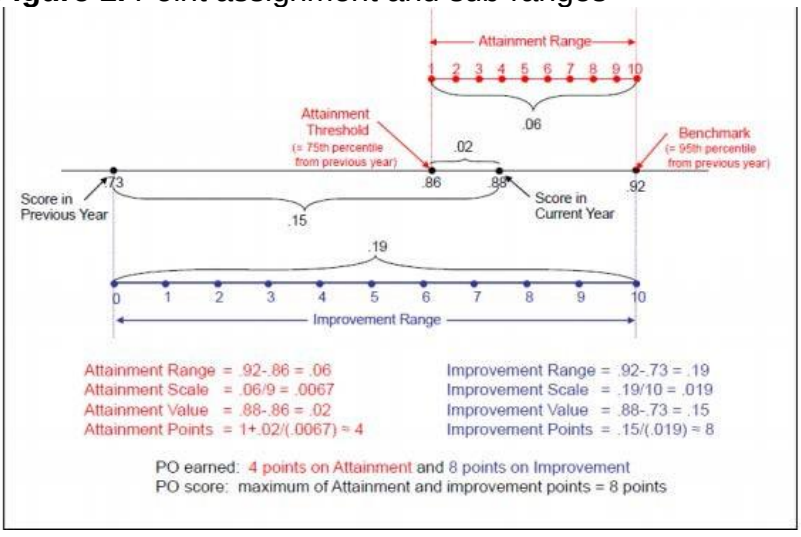
a. Assign 10 points to full Improvement Range between score in previous measurement year and Benchmark such that PCP raw performance on measure scores distributes equally across 10 sub-ranges each worth 1 point.

Raw performance equaling same score as last year will receive 0 points; raw performance meeting or exceeding Benchmark will receive the maximum of 10 points.

b. Benchmarks will be assigned for each measure.
c. For PCPs where there is no baseline measurement score, they will not be eligible for a calculated improvement score.
d. For specific measures where lower performance is desired (e.g. inpatient utilization), the directionality is opposite, but the assignment of points and sub-ranges is the same.

5. Determine for a given measure the higher of the Attainment Score vs. Improvement Score.

Figure 1. Point assignment and sub-ranges



Step Three: Calculate Composite Score and Payment.

1. For each LOB, sum up the total points received by PCP across all measures.

2. For each LOB, calculate Composite Score by dividing PCP's total points by total possible points.

3. For each LOB, determine if PCP meets or exceeds Quality Threshold of 50%.

4. For each LOB, calculate LOB Payment by multiplying Composite Score with Maximum Payment Cap. Overall Payment is each LOB Payment summed.

Step Four: Calculate True-up (for Annual Payment only).

1. Calculate Overall Payment from Annual Performance minus Overall Payment from Semi-Annual Performance to determine actual payment for CCHP Finance.

Section 12.5 Measure Descriptions

1. Breast Cancer Screening

Description	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
Denominator	The eligible population.
Numerator	One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 77% Medicare: 70%
Quality Benchmark	Commercial: 89% Medicare: 84%
Goal Directionality	Higher is better
Data Source	Medical claims

2. Colorectal Cancer Screening

Description	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.
Denominator	The eligible population.
Numerator	One or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test during the measurement year. • Flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year. • Colonoscopy during the measurement year or the 9 years prior to the measurement year.

Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 61% Medicare: 63%
Quality Benchmark	Commercial: 81% Medicare: 80%
Goal Directionality	Higher is better
Data Source	Medical and laboratory claims, and laboratory results

3. Diabetic Care Eye Exam

Description	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who
Denominator	The eligible population.
Numerator	Screening or monitoring for diabetic retinal disease as identified by one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50% Medicare: 59%
Quality Benchmark	Commercial: 60% Medicare: 81%
Goal Directionality	Higher is better
Data Source	Medical and vision claims

4. Diabetic Care Blood Sugar Control

Description	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who have HbA1c ≤9.0%
Denominator	The eligible population.
Numerator	The member is numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%. The member is not numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 60% Medicare: 64%
Quality Benchmark	Commercial: 71% Medicare: 80%
Goal Directionality	Higher is better
Data Source	Medical and laboratory claims, laboratory results, EMR data feed

5. Endocrinologist Visit for Uncontrolled Diabetics

Description	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who have HbA1c control (>9.0%) and have seen an endocrinologist in the measurement year or a PCP within 30 days from the A1c >9.0% lab result with a diagnosis of diabetes.
Denominator	The eligible population.
Numerator	The member is numerator compliant if the member has seen an in-network endocrinologist during the measurement year or a PCP within 30 days from the A1c>9.0% lab result with a diagnosis of diabetes.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50th percentile Medicare: 50th percentile
Quality Benchmark	Commercial: 90th percentile Medicare: 90th percentile
Goal Directionality	Higher is better
Data Source	Medical claims, laboratory results

6. Statin Use in Diabetics

Description	The percentage of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period.
Denominator	Number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills during the measurement period.
Numerator	Number of enrolled beneficiaries in the denominator who received a statin medication fill during the measurement period.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 75% Medicare: 75%
Quality Benchmark	Commercial: 80% Medicare: 90%
Goal Directionality	Higher is better
Data Source	Medical and pharmacy claims

7. Statin Therapy for Patients With Cardiovascular Disease

Description	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
Denominator	The eligible population.
Numerator	The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 75% Medicare: 75%
Quality Benchmark	Commercial: 82% Medicare: 90%
Goal Directionality	Higher is better

Data Source	Medical and pharmacy claims

8. Controlling High Blood Pressure

Description	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and who's BP was adequately controlled.
Denominator	The eligible population.
Numerator	The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria: • Members 18–59 years whose BP was <140/90 mm Hg. • Members 60–85 years who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg. • Members 60–85 years who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 47% Medicare: 67%
Quality Benchmark	Commercial: 84% Medicare: 86%
Goal Directionality	Higher is better
Data Source	Medical claims, EMR data feed

9. Medication Therapy Management Comprehensive Medication Review

Description	The percentage of members who meet CCHP Medicare Advantage Medication Therapy Management Criteria that receive a medication review by a pharmacist during the measurement year.
Denominator	Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period.
Numerator	The number of members in the denominator who have received a comprehensive medication review by a CCHP or OutcomesMTM retail pharmacist during measurement year.
Lines of Business	Medicare
Attainment Threshold	Medicare: 59%
Quality Benchmark	Medicare: 75%
Goal Directionality	Higher is better
Data Source	Medical and pharmacy claims, and OutcomesMTM claims

10. Post-discharge Medication Reconciliation

Description	The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). Medication reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Denominator	The eligible population.

Numerator	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).
Lines of Business	Medicare
Attainment Threshold	Medicare: 37%
Quality Benchmark	Medicare: 68%
Goal Directionality	Higher is better
Data Source	Medical claims, and OutcomesMTM claims

11. Medical Assistance With Smoking and Tobacco Use Cessation

Description	The measure collectively assesses different facets of providing medical assistance with smoking and tobacco use cessation.
Denominator	The eligible population identified by member surveys or claims data as a smoker and/or tobacco user.
Numerator	The number of members in the denominator who received advice on quitting, cessation medications, or cessation strategies.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50% Medicare: 50%
Quality Benchmark	Commercial: 90% Medicare: 90%
Goal Directionality	Higher is better
Data Source	Medical and pharmacy claims, member surveys

12. Hepatitis B Screening or Vaccination

Description	The percentage of members 18 years of age and older who have received a Hepatitis B screening test or at least one Hepatitis B vaccination.
Denominator	The eligible population excluding members who are diagnosed, have had a Hepatitis B vaccination, or have received a Hepatitis B core or surface antibody screening test prior to beginning of year or enrollment.
Numerator	The number of members in the denominator who have received a Hepatitis B screening test or at least one Hepatitis B vaccination during the measurement year.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50th percentile Medicare: 50th percentile
Quality Benchmark	Commercial: 90th percentile Medicare: 90th percentile
Goal Directionality	Higher is better
Data Source	Medical, pharmacy, and laboratory claims, and laboratory results

13. Flu Vaccination

Description	The percentage of members 18 years of age and older who received an influenza vaccination between July 1 of the prior year and June 30 of the measurement year.

Denominator	The eligible population.
Numerator	The number of members in the denominator who have received an influenza vaccination between July 1 of the prior year and June 30 of the measurement year.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50% Medicare: 68%
Quality Benchmark	Commercial: 59% Medicare: 77%
Goal Directionality	Higher is better
Data Source	Medical and pharmacy claims

14. Acute Hospital Utilization

Description	For members 18 years of age and older, the number of acute inpatient and observation stay admits during the measurement year normalized to member months.
Denominator	The number of eligible member months attributed to primary care provider during measurement period, normalized per 1000.
Numerator	All acute inpatient and observation admits during the measurement year, de-duplicating any acute-to-acute direct transfers or observation to inpatient transfers, and excluding inpatient and observation stay discharges with: • A principal diagnosis of mental health, chemical dependency, or rehabilitation related stay • A principal diagnosis of live-born infant or newborn care • A maternity-related principal diagnosis or stay
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 55/1000 Medicare: 215/1000
Quality Benchmark	Commercial: 48/1000 Medicare: 171/1000
Data Source	Medical claims

15. Plan All Cause Readmissions

Description	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.
Denominator	The eligible hospital discharges.
Numerator	At least one acute readmission for any diagnosis within 30 days of the Discharge Date.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 12% Medicare: 11%
Quality Benchmark	Commercial: 8% Medicare: 6%
Data Source	Medical claims

16. Emergency Department Utilization

Description	For members 18 years of age and older, the number of emergency department (ED) visits during the measurement year.
Denominator	The number of eligible member months attributed to primary care provider during measurement period, normalized per 1000.
Numerator	The number of ED visits, excluding visits that result in an inpatient stay.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 187/1000 Medicare: 441/1000
Quality Benchmark	Commercial: 145/1000 Medicare: 374/1000
Data Source	Medical claims

17. Generic Prescribing Rate

Description	The percentage of all generic brand medications prescribed and filled during the measurement year.
Denominator	The number of prescriptions (extrapolated to InterQual criteria) prescribed and filled during the measurement year.
Numerator	The number of generic prescriptions (InterQual criteria) prescribed and filled during the measurement year.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50th percentile Medicare: 50th percentile
Quality Benchmark	Commercial: 90th percentile Medicare: 90th percentile
Goal Directionality	Higher is better
Data Source	Pharmacy claims

18. Adults' Access to Preventive/Ambulatory Health Services

Description	The percentage of members 20 years and older who had an ambulatory or preventive care visit.
Denominator	The eligible population.
Numerator	One or more ambulatory or preventive care visits during the measurement year.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50th percentile Medicare: 50th percentile
Quality Benchmark	Commercial: 90th percentile Medicare: 90th percentile
Goal Directionality	Higher is better
Data Source	Medical claims

19. Risk Adjustment Capture of Total Opportunity

Description	The percentage of Risk Adjustment Factor scores that are captured in the measurement year of the total suspected conditions including those that are chronic conditions or potential

Denominator	The Risk Adjustment Factor scores of all suspected conditions for all members with the status of either confirmed or outstanding.
Numerator	The Risk Adjustment Factor scores of all conditions for all members that have the status of confirmed by any provider.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50th percentile Medicare: 50th percentile
Quality Benchmark	Commercial: 90th percentile Medicare: 90th percentile
Goal Directionality	Higher is better
Data Source	Medical claims, Health Fidelity conditions

20. Chinese Hospital Utilization for Inpatient & Outpatient Procedures

Description	For members 18 years of age and older, the percentage of inpatient and outpatient encounters and procedures (e.g. surgery, admissions, radiology/imaging) completed at Chinese Hospital.
Denominator	The number of inpatient and outpatient encounters and procedures (e.g. surgery, admissions, and radiology/imaging) completed during measurement year at in-network facilities, excluding pathology and
Numerator	The number of inpatient and outpatient encounters and procedures completed at Chinese Hospital during measurement year.
Lines of Business	Commercial & Medicare
Attainment Threshold	Commercial: 50th percentile Medicare: 50th percentile
Quality Benchmark	Commercial: 90th percentile Medicare: 90th percentile
Goal Directionality	Higher is better
Data Source	Medical facility claims

SECTION 13 MEMBER RIGHTS AND RESPONSIBILITIES

Section 13.1 Member Notification of Rights and Responsibilities

CCHP members are notified of their Rights and Responsibilities. These rights and responsibilities are extended to all CCHP members regardless of their access to providers who are either directly associated with CCHP or through a Delegated entity such as through an Independent Physician Association (IPA).

A. For the purpose of this policy, a “Delegate” is defined as a medical group, IPA or any contracted organization delegated to provide services to CCHP Members.

B. Members have the right to quality care when accessing services covered by CCHP. CCHP believes that Members, Providers, practitioners, and Delegates have a role in assuring the quality of care received.

C. CCHP adopted and continues to use the “Consumer Bill of Rights and Responsibilities,” promulgated by the President of the United States, as the basis for its statement of Members’ Rights and Responsibilities.

D. CCHP requires Providers and practitioners to understand and abide by CCHP's Members' Rights and Responsibilities when providing services to Members.

E. CCHP informs Members of their Members' Rights and Responsibilities in the Annual Member Notice upon enrollment and annually thereafter or upon request in a manner appropriate to their condition, individual communication style, and ability to understand.

F. It is CCHP's policy to respect and recognize Members' rights. The following statements are included in the Annual Member Notice.

A. All CCHP Members have the right to:

1. Courteous and considerate treatment; to be treated with respect and recognition of their dignity and right to privacy.
2. Receive information about CCHP, its services, its practitioners / providers, and members' rights and responsibilities.
3. Make recommendations regarding CCHP's member rights and responsibilities policy.
4. Be informed about their available health plan benefits, including a clear explanation about how to obtain services.
5. Receive appropriate preventive health services as indicated in their Evidence of Coverage (EOC).
6. Receive upon request, names, specialties, and titles of the professionals responsible for their care.
7. Amend their own health care information that CCHP has when they consider it is incorrect or incomplete.
8. Participate with practitioners in the decision making regarding their health care.
9. Inspect and copy their own medical information used to make decisions about their health care.
10. Request a confidential or candid discussion with CCHP's qualified Medical Management staff regarding one's health matter and appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
11. Receive reasonable information regarding the risk for a given treatment, the length of disability and the qualifications of the care provider prior to giving consent for any procedure.
12. Additional medical or surgical opinions from out-of–network providers, in situations when your treating physician or the Plan feels this would be helpful in determining a diagnosis or course of treatment (with an approved referral).
13. Be represented by parents, guardians, family members or other conservators for those who are unable to fully participate in their treatment decisions.
14. Be fully informed of CCHP's grievance procedure and how to use it without fear of prejudicial treatment from their health care provider.
15. Voice complaints or appeals about CCHP or the care provided.
16. A timely response to request for services, complaints and inquiries regarding their health benefits and services.
17. Request a copy of CCHP's Notice of Privacy Practices

B. Members are responsible:

1. For knowing and understanding their health benefits and services and how to obtain them.
2. For contacting their physician or CCHP coordinator with any questions or concerns regarding health benefits or services.
3. To provide, to the extent possible, information that CCHP and its practitioners / providers need in order to care for them.
4. To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
5. For cooperating with those providing health care services; however, they have the right to refuse medical treatment.
6. To follow the plans and instructions for care that they have agreed upon with their practitioners.
7. To provide CCHP with information when another source responsible to pay for health care is involved, such as liability insurance after a proper accident. In these cases, members have the responsibility to cooperate with their health plan for proper reimbursement of injury treatment by the other source to their health plan.

PROCEDURES:

1. Members' Rights and Responsibilities notification procedures include:
    a. Members' Rights and Responsibilities are communicated to new Members through the Post-Enrollment Kits. The Member Enrollment Kit contains CCHP's statement of Members' Rights and Responsibilities.
    b. The Members' Rights and Responsibilities is on the website at www.cchphealthplan.com and a paper copy is available to all Members and/or potential Members upon request by calling CCHP Member Services at (888)775-7888/TTY (877) 681-8898. Any updates to the Member's Rights and Responsibilities are provided in at least annually through an annual member notice.
    c. Members' Rights and Responsibilities, including the grievance and appeals process, are communicated to all CCHP practitioners through the annual update and distribution of the CCHP Policy and Procedure Manual. New practitioners receive the CCHP Policy and Procedure Manual within the first month of joining CCHP. Information on policy changes or updates may be included in Provider Newsletters.
    d. CCHP staff who have direct contact with members are trained on Members' Rights and Responsibilities, including the grievance system, and are able to communicate those rights and responsibilities effectively.
2. Providers and practitioners are encouraged to help Members understand their rights and responsibilities as outlined above, encourage Members to appropriately utilize their covered benefits, and encourage Members to contact CCHP Member Services at (888)775-7888/TTY (877) 681-8898 if they have questions concerning their benefits.
3. Appeal and Grievance Rights:
    a. All staff who have contact with CCHP Members may inform Members of their right to submit written comments, documents or other information relating to their case during the triage of the case. Members are informed of this right through the acknowledgment letter directing the Member to the Member Notice or Evidence of Coverage for information on appeals and grievances.

b. CCHP processes appeal requests only after confirming that the requesting party is the Member, or the Member's authorized representative, per federal regulations. CCHP recognizes the term authorized party to include: a Member (or authorized representative), an assignee that is non-contracted, but has provided services, and formally waives the right to payment from the Member, the legal representative of a Member's estate, and any other Provider or entity, other than CCHP, having an interest in the case.

SECTION 14 MEMBER APPEALS AND GRIEVANCES

Section 14.1 Providing Members with Appeal and Grievance Information

There may be times when members have a complaint or disagree with a decision that was made by CCHP or by a contracted provider about benefit coverage, services or non-payment of care/service. Members may also express concerns about an experience they had with some aspect of their care/service. In these instances, members, or their designated representative (who may be their physician acting on their behalf) have the right to file an appeal and/or a grievance.

CCHP requires that all participating providers are aware of the existence of CCHP's member appeal and grievance procedures. If a member expresses a complaint or concern, CCHP providers are responsible for informing them of their right to file a complaint with CCHP. The Department of Managed Health Care regulates the appeals and grievances process and monitors results for State and Federal compliance.

Included in this section are Complaint forms. Please refer members to CCHP Member Services or provide them with information on how to file a complaint as described on the following pages. Please note that there are separate procedures and information for Commercial Members and Medicare Advantage Members.

An **appeal** is a complaint about a coverage decision, including a denial of payment for a service received, or a denial in providing a service a member feels they are entitled to as a CCHP member. Coverage decisions that may be appealed include a denial of payment for any health care services they received, or a denial of a service that they believe should have been arranged for, furnished, or paid for by CCHP.

A **grievance** is a complaint about a problem a member observes or experiences, including complaints about the quality of services that they receive, complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar concerns.

Section 14.2 Medicare Advantage Member Appeal and Grievance Process

You will find a summary of the Appeal and Grievance process for members of our CCHP Senior Program HMO and CCHP Senior Select Program HMO SNP including a downloadable, bilingual complaint form and the ability to submit a complaint online at:

www.cchphealthplan.com/use-secure-line-grievance-form

Section 14.3 Commercial Group and Individual Plan Member Appeal and Grievance Process

You will find a summary of the appeal and grievance process for members of our Commercial Group and Individual plans including a downloadable, bilingual complaint form and the ability to submit a complaint online at: www.cchphealthplan.com/use-secure-line-grievance-form

Section 14.4 How to File a Complaint – Appeal or Grievance

Contact the CCHP Member Services Department for assistance in filing a verbal or written grievance or appeal. The Member Services staff can assist members or a provider acting on their behalf in filing a grievance or appeal. We have a complaint form, which can be used to file a grievance or an appeal which is available from Member Services, or you may download and print the form from our website, or you can file a complaint online using our secure online complaint form. However, you do not have to use our complaint form to file a grievance or appeal; you may call Member Services, send us a letter or fax, or come to our office. With or without the form, please provide a brief explanation of the issue and submit it in one of the following ways:

By Telephone:	415-834-2118 or (TTY) 1-877-681-8888
By Fax:	415-397-2129
In Person:	CCHP Member Services 845 Jackson Street San Francisco, CA 94133
By Mail:	CCHP Member Services 445 Grant Ave, Suite 700 San Francisco, CA 94108
Online:	www.cchphealthplan.com/use-secure-line-grievance-form

SECTION 15 PROVIDERS' RIGHTS AND RESPONSIBILITIES

This policy applies to all CCHP Plan (Commercial, Covered CA and Medicare – Medicaid Plan) Providers.

POLICY:

1. All Network Providers, including those contracted directly with CCHP or through an affiliated Medical Group, are obligated to participate in and work with CCHP programs, services, standards, policies and procedures required by CCHP.
2. Providers have the right to know what they can expect when working with CCHP.
3. It is CCHP policy to respect and recognize all Providers' rights as follows:
    a. As a Provider within the CCHP network, you have the right to:
        i. Receive information about CCHP, including available programs and services, staff and staff qualifications, and operational requirements;
        ii. Receive information about how CCHP coordinates its interventions with treatment plans for individual patients;
        iii. Receive support from CCHP to make decisions interactively with patients regarding their health care;
        iv. Receive contact information for staff responsible for managing and communicating with the Provider's patients;
        v. Receive clinical performance data and Member experience data or results, as applicable when requested.
        vi. Receive courteous and respectful treatment from CCHP staff; and,
        vii. Complain about CCHP, including but not limited to: staff, policies, processes and procedures as outlined in Appeal and Grievance Resolution Process for Providers - Health Plan.
    b. It is CCHP policy that all Providers directly contracting with CCHP have the following credentialing rights:
        i. Review information submitted to support your credentialing application;
        ii. Correct erroneous information during the credentialing process;
        iii. Be informed of the status of your credentialing or credentialing application upon request; and
        iv. Be notified of these credentialing rights.
4. It is CCHP policy that Providers' have certain responsibilities.
    a. As a Provider contracting with the CCHP network, you have the responsibility to:
        i. Be familiar with, ask questions about and comply with all CCHP Policies and Procedures; and
        ii. Comply with all regulations and medical standards set forth by the appropriate regulatory agencies to ensure appropriate medical care is provided to all CCHP Members.

PROCEDURES:

1. Providers are notified of their rights and responsibilities as follows:
    a. Provider's rights and responsibilities are communicated in the Provider's contractual agreement with CCHP and/or other Provider entities within the CCHP network;

b. New Providers receive the CCHP Policy and Procedure Manual; and Benefit Manual within the first month of joining CCHP;
c. Providers can access on the CCHP website at CCHP www.cchphealthplan.com interim Manual updates as changes to existing policies and procedures and/or new policies and procedures arise throughout the year;
d. Providers receive bi-annual Provider Newsletters to communicate new ideas, information, program, benefit, policies or regulatory changes; and
e. Changes to policies and programs as well as new policies and programs are communicated to Providers through written correspondence, such as letters and memos, and also posted on the CCHP website, as applicable.

2. Providers may communicate with CCHP regarding any complaints, issues or concerns they may have in relation to the above rights and responsibilities, as outlined in Policy "Appeal and Grievance Resolution Process for Providers":
    a. CCHP Provider Relations Team at 1-628-228-3214
    b. CCHP Website –www.cchphealthplan.com
3. Providers are informed of the consequences of failing to comply with the above rights and responsibilities within the CCHP Provider Policy and Procedure Manual in addition to their contractual agreement.

SECTION 16 COMPLIANCE PROGRAM

Section 16.1 Overview of the CCHP Compliance Program

I. Introduction

Chinese Community Health Plan ("CCHP") has been, and continues to be committed to conducting its business in full compliance with all federal, state and local laws, which include but not limited to the regulations and guidance set forth by: the Centers for Medicare and Medicaid Services ("CMS"); the Department of Managed Health Care ("DMHC"); and the California Department of Health Care Services ("DHCS"), or their agencies and related oversight agencies. CCHP has developed its Compliance Program as a comprehensive statement of the responsibilities and obligations of all employees, delegates, and vendors of CCHP. This Compliance Program is intended to apply to CCHP's business arrangements with any of its First-Tier, Downstream, and/or Related entities ("FDR"), including physicians, hospitals, medical groups, and other entities that may be impacted by federal or state laws relating to waste, fraud and/or abuse.

Compliance makes good business sense and as an organization, CCHP is committed to ensuring compliance. In an increasingly competitive marketplace, CCHP can thrive and prosper only if its reputation for quality and ethical service and its record of for providing excellent care is beyond question. The Compliance Program assists in supporting CCHP's reputation and is a plan of action that gives CCHP's employees, officers, trustees, and board members; as well as its contracted providers and/or engaged consultants, with specific direction and guidance in detecting and resolving non-compliance issues.

CCHP has adopted and implemented this described Compliance Program in order to effectively prevent, detect, and correct non-compliance, as well as measures that will prevent, detect, and correct fraud, waste, and abuse. CCHP is fully committed to ensuring that the Compliance Program is fully implemented, is effective, and becomes a part of daily business operations. Each employee and FDR's performance evaluation will explicitly assess and measure their understanding and adherence to the provisions of the Compliance Manual.

II. CCHP's Mission, Vision, and Values

CCHP and its Board of Trustees have high priority to create and reinforce a corporate culture that embraces compliance, ethics, integrity, and excellence. This culture will thrive only if the employees; management and officers; as well as its providers and affiliated organizations, (1) are familiar with CCHP's Compliance Program; (2) understand their role in fostering CCHP Culture of Compliance, Ethics, Integrity, and Excellence; and (3) have truly made a personal commitment to have it guide their activities.

CCHP has a mission to improve the health of our community by delivering high-quality, affordable healthcare through culturally competent and linguistically appropriate services.

In pursuit of its mission, CCHP believes in the following value statements:

- CCHP recognizes the unique and intrinsic value of each individual and will conduct business with persons, regardless of race, creed, color, sexual orientation or economic status;
- CCHP treats all enrollees, customers, providers and anyone else we serve with compassion, kindness and honesty;
- CCHP acts with honesty, integrity and fairness in the way it conduct business and works with the community; and
- CCHP's colleagues are valuable individuals of its health plan team and pledge to treat one another with loyalty, respect, and dignity.

III. Elements of CCHP's Compliance Program

The Compliance Program includes the following seven core elements and components:

1. Written Policies and Procedures ("P&Ps") and Standards of Conducts

    a. Written Policies and Procedures

    CCHP has developed Compliance P&Ps that detail specific operations of the Compliance Program. These P&Ps are distributed to employees, Board Members, and FDRs (via email, hard copy, or other means of electronic method where individuals have access to view the P&Ps.

    b. Standards of Conducts

    CCHP has adapted five Standards of Conducts to provide an affirmative statement for every trustee, director, officer, employee, contractor, physician, and provider of their ethical responsibilities within CCHP and place individuals and contracted entities on notice that they are held responsible for abiding by the articulated standards, which is the foundation of the Compliance Program. CCHP's Standards of Conducts are as follows:

        i. Legal Compliance
        ii. Business Ethics
        iii. Confidentiality And Protection Of Assets
        iv. Conflicts Of Interest
        v. Respect For Others

2. Compliance Officer and Compliance Committee

    a. Compliance Officer

    CCHP employs a Compliance Officer that is vested with the day-to-day operations of the CCHP Compliance Program. The Compliance Officer is responsible for implementing the Compliance Program and defines the program structure, educational requirements, reporting and compliant mechanisms, response and

correction procedures, and compliance expectations of all personnel and FDRs, in accordance with regulatory requirements. The Compliance Officer has authority to provide direct reports to the CEO and Board.

The Compliance Officer is expected to provide regular report to the Senior Management Team and quarterly reports to the Compliance Committee about the Compliance Program and compliance issues, including issues identified, investigated and resolved.

b. Compliance Committee

CCHP has a Compliance Committee that includes the Compliance Officer, members of the Board, members of Senior Management, and the CEO of CCHP.

The Corporate Compliance Committee's principal role is to provide advice and support for implementing the Compliance Program, to be a forum for discussion of compliance policies and to provide assistance to the Office of Compliance in issue resolution. The Committee has the following responsibilities:

- To review compliance standards recommended by the Compliance Officer or the Board of Trustees;
- To ensure the implementation of training and education programs for all employees;
- To ensure the Compliance Officer is developing internal systems to carry out standards, policies and procedures;
- To support the adherence of the Standards of Conduct and of confidential reporting;
- To ensure the systematic assessments of compliance risk areas by departments are being conducted;
- To ensure management develops and implements recommendations resulting from the assessments;
- To ensure the Compliance Officer is establishing annual goals and priorities in the form of an annual work plan;
- To assist in researching, responding to and resolving compliance issues, as requested; and
- To make recommendations to the Compliance Officer concerning program improvement.

3. Effective Training and Education

CCHP Compliance Department has and will continue to implement effective training and education programs between the Compliance Department and CCHP employees, CCHP CEO, its Board Members, its Senior Management Team, and to CCHP's FDRs, contracted provider organizations, direct providers, as well as their respective downstream or participating providers and entities. Such training as described below must occur within 90 days of hire/appointment or contracting and at

a minimum of annually thereafter. These trainings will include at least the following items:

a. CCHP's Compliance Program and its related P&Ps;
b. General Compliance;
c. Fraud, Waste, and Abuse; and
d. Health Insurance Portability and Accountability Act provisions.

4. Effective Lines of Communication

CCHP has P&Ps to ensure an effective line of communication is kept confidential between the Compliance Officer, Compliance Committee, the Board, FDRs, and employees. CCHP adapts a non-retaliation policy for good faith reporting. There are several methods available to report compliance concerns, including, but not limited to directly with CCHP's supervisors, managers, or directors, the Compliance Officer, or anonymously via the Compliance Hotline.

The CCHP Compliance hotline is an integral part of CCHP's Compliance Program. The CCHP Compliance hotline, at 415-955-8810, provides employees, agents, enrollees and FDR's an avenue to report service concerns, violations of the Standards of Conducts or CCHP P&Ps, or any non-compliance, in a confidential and anonymous manner. The caller is not required to identify him or herself when disclosing a concern and the hotline is unable to track the incoming caller identification.

5. Well-Publicized Disciplinary Standards
CCHP encourage good faith participation in the Compliance Program by all affected individuals. These standards include policies that:

a. Articulate expectations for reporting compliance issues and assist in their resolution;
b. Identify noncompliance or unethical behavior; and
c. Provide for timely, consistent, and effective enforcement of the stands when noncompliance or unethical behavior is determined.

CCHP adapts CCHP's Human Resources P&Ps in addressing disciplinary actions against any suspected violations of CCHP's Compliance Program.

6. Effective Routine Monitoring and Auditing and Identification of Compliance Risks
The CCHP Compliance Program, includes an integrated system of Compliance Department oversight for routine monitoring and identification of compliance risks within CCHP operational areas.

a. FDR Auditing and Monitoring
CCHP's Compliance Department is responsible to ensure all FDRs comply with CCHP's Compliance Program. Annual attestations are requested from

each FDR to ensure all applicable regulatory requirements are met. Audits are conducted to validate attestations are accurate.

Additionally, the Compliance Department coordinates and works with each operational area to audit and monitor delegated entities.

b. Internal Monitoring and Auditing
Under the direction of the Compliance Officer, CCHP's Compliance Department conducts ongoing auditing and monitoring activities of all operational areas to ensure compliance with regulatory requirements. Audits and monitoring activities will be based on an Annual Risk Assessment that is shared with the Compliance Committee. The Risk Assessment is subject to change based on the identified risk that may arise throughout the year. Audits will be conducted utilizing industry audit protocols and audit tools.

7. Prompt Response to Compliance Issues
CCHP's Compliance Program has established and implemented procedures and a system to prompt respond to compliance issues as they raise to include:

a. Investigating potential compliance problems as identified in the course of self-evaluations and audits;
b. Correcting such problems promptly and thoroughly to reduce the potential for recurrence; and
c. Ensure ongoing compliance with regulatory requirements.

If CCHP discovers evidence of misconduct related to payment or delivery of items or services (especially those relating to a Medicare or a Medicaid member), it must conduct a timely, reasonable inquiry into that conduct.
CCHP will then proceed to conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to this potential violation of law or regulations as described in this training.

IV. Review and Approval of CCHP's Compliance Program

Per CMS guidance, Medicare Managed Care Manual, Chapter 21, Section 50.2.3, the Compliance Committee of the Board of Trustee is to review and approve the CCHP Compliance Program on an annual basis.

V. Index of CCHP Compliance Program P&Ps

CCHP COMPLIANCE PROGRAM MANUAL	
COM 1.1	Compliance Program Manual Distribution
COM 1.2	Compliance Program Training
COM 1.3	Employee/ FDR Screening
COM 1.4	Communications and Awareness
COM 1.5	Operating the CCHP Confidential Message Line
COM 1.6	Investigations/ Enforcement/ Discipline
COM 1.7	Return of Overpayments
COM 1.8	Monitoring/ Auditing
COM 1.9	Responding to Subpoenas and Search Warrants
COM 1.10	Responding to Government Investigations
COM 2.1	Senior Marketing Materials/ Personnel
COM 2.2	Selective Marketing and Enrollment
COM 2.3	Election Process
COM 2.4	Benefits and Beneficiary Protections
COM 2.5	Quality Assessment and Performance Improvements
COM 2.6	Cost Sharing
COM 2.7	Grievance and Appeals
COM 2.8	Senior Disenrollment
COM 2.9	Non-Interference and Patient-Physician Communication
COM 2.10	Provider Selection and Credentialing
COM 2.11	Physician Incentive Plans
COM 2.12	Data Collection and Submission
COM 2.13	Provider Subcontracting
COM 2.14	Anti-Kickback Statute
COM 2.15	Gifts and Business Courtesies
COM 2.16	Self-Referral Laws
COM 2.17	Emergency Services
COM 2.18	Records Management
COM 2.19	Fraud, Waste and Abuse Program
COM 2.20	Conflict of Interest Disclosure & Recusal

CCHP COMPLIANCE PROGRAM MANUAL	
PRIV 1.1	Privacy and Security Handbook Distribution
PRIV 1.2	Program Training
PRIV 1.3	Confidentiality Statement
PRIV 1.4	Amendment of Protected Health Information
PRIV 1.5	Operating the CCHP Confidential Privacy
PRIV 1.6	Release of Information Policy
PRIV 1.7	Search Warrant Policy
PRIV 1.8	Safeguard Protected Health
PRIV 1.9	Fax Policy
PRIV 1.10	Privacy Complaint Policy
PRIV 1.11	Privacy Mitigation Policy
PRIV 1.12	Non-retaliation Policy
PRIV 1.13	Sanction Policy
PRIV 1.14	Administrative, Technical and Physical Safeguards
PRIV 1.15	De-Identification of Health Information and Use
PRIV 1.16	CCHP Business Associates
SEC 2.1	Access Authorization Policy
SEC 2.2	Access Establishment Policy
SEC 2.3	Access Modification Policy
SEC 2.4	Data Backup Plan
SEC 2.5	E-mail
SEC 2.6	Emergency Access Procedures
SEC 2.7	Emergency Mode Operation Plan
SEC 2.8	Health Information Disaster Plan
SEC 2.9	Health Information Physical Security Plan
SEC 2.10	Internal Audit Policy
SEC 2.11	Internet Security Policy
SEC 2.12	Media Controls Policy
SEC. 2.13	Personnel Security Policy
SEC 2.14	Portable Computer Policy
SEC 2.15	Report Procedure
SEC 2.16	Response Procedure to Security Breach
SEC 2.17	Sanction Policy
SEC 2.18	Termination Procedure
SEC 2.19	Workstation Use Policy

Section 16.2 General Compliance and Fraud, Waste, and Abuse (FWA) Training Required for Providers and Office Staff

Chinese Community Health Plan (CCHP) and their contracted providers and medical groups, affiliated provider entities or contractors, must ensure that all health care providers and staff, as well as pharmacies and vendors who render care to CCHP or transact business with CCHP in any capacity, including data related to them, participate in ongoing compliance and FWA

training, within 90-days of hire or contracting and annually thereafter and document completion. This is a mandatory training, required by the Centers for Medicare and Medicaid Services (CMS) and supported by CCHP Compliance Program.

CMS Free WBTs located at:

Medicare Parts C and D General Compliance Training:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf

Combatting Medicare Parts C and D Fraud, Waste, and Abuse:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf

Provider shall maintain and CCHP has the right to inspect all records related to administration or delivery of CCHP benefits to include but not limited to: attendance records for General Compliance and FWA Training, Standards of Conduct Training, Compliance Policy Training, monthly evidence of OIG and GSA/SAM screening records, and medical records, for a period of 10 years.

Section 16.3 Fraud, Waste and Abuse Program Policy

TITLE: Fraud, Waste and Abuse Program

PURPOSE:

To establish the requirement that compliance with fraud prevention and reporting is everyone's responsibility. CCHP has developed a Fraud, Waste and Abuse Program (FWA) to comply with the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage requirements in preventing and detecting fraud in federal and state funded programs, as well as to comply to its obligations under the California Knox Keene Act pursuant to §1348, the California Department of Managed Health Care, and as described in the Code of Federal Regulations, Title 42, Part 423, Code of Federal Regulations, Title 42, Part 455, §455.2, and the Federal False Claims Act, US Code, Title 31.

POLICY:

1. The objective of CCHP's FWA Program is to identify and reduce costs caused by fraudulent activities and to protect consumers, Members, health care providers and others in the delivery of health care services.
2. Providers are educated regarding the federal and state false claims statutes and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.
3. CCHP has created a Compliance Committee (CC) to oversee its FWA and to manage all instances of suspected fraud.
4. CCHP reports its fraud prevention activities and suspected fraud to regulatory and law enforcement agencies as required by law.

5. Providers must adhere to federal and California State laws, including but not limited to False Claims laws.
6. Providers with CCHP will comply with federal and California State laws in regards to the detection, reporting, and investigation of suspected fraud, waste and/or abuse, to have all mandated Compliance Plans and functions in place pursuant to applicable Federal and California regulations and statutes, and to adhere to CCHP's Medicare Advantage contracts with the Centers for Medicare and Medicaid Services.

DEFINITIONS:

1. A complaint of fraud, waste and/or abuse is a statement, oral or written, alleging that a practitioner, supplier, or beneficiary received a benefit to which they are not otherwise entitled. Included are allegations of misrepresentations and violations of Medicare, Medicaid or other health care program requirements applicable to persons applying for covered services, as well as the lack thereof of such covered services.
2. Fraud and abuse differ in that:
   A. Abuse applies to practices that are inconsistent with sound fiscal, business, medical or recipient practices and result in an unnecessary cost to a health care program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Mistakes that are repeated after discovery or represent an on-going pattern could constitute abuse.
   B. Fraud is an intentional or knowing misrepresentation made by a person with the knowledge (or knowingly) that the deception could result in some unauthorized benefit to him/herself or another person. It includes any portion that constitutes fraud under applicable federal or state law. Mistakes that are not committed knowingly or that are a result of negligence are not fraud, but could constitute abuse.

PROCEDURE:

1. CCHP's FWA Program is designed to deter, identify, investigate and resolve potential fraudulent activities that may occur in CCHP daily operations, both internally and externally.
2. The Corporate Compliance Officer is responsible for ensuring that the objectives of CCHP's Fraud, Waste and Abuse Program are carried out, and for preventing, detecting and investigating fraud-related issues in a timely manner. To accomplish this, the Corporate Compliance Officer designates and oversees the Compliance Department to perform the following responsibilities:
   A. Developing fraud training programs to educate staff, Providers, practitioners, Members and down-stream entities on prevention, deterrence and detection of fraud, waste and abuse.
   B. Identifying, detecting, thoroughly investigating, managing and resolving all suspected instances of fraud, waste, and abuse, waste and abuse internally and externally.
   C. Cooperating with, reporting and referring suspected fraud, waste and abuse to the appropriate governmental and law enforcement agencies, as applicable, including exchange of information as appropriate.
3. Both CCHP and Providers have responsibilities for fraud prevention.

4. CCHP responsibilities include, but are not limited to the following:
   A. Training CCHP staff, Providers, practitioners, Members and vendors on fraud, the CCHP Fraud, Waste and Abuse Program, and fraud prevention activities at least annually.
   B. Communicating its FWA and efforts through the CCHP Provider Policy and Procedure Manual, CCHP Provider Newsletter, targeted mailings, or in-service meetings.
   C. Continuous monitoring and oversight, both internally and externally, of daily operational activities to detect and/or deter fraudulent behavior. Such activities include, but are not limited to:
      1) Monitoring of Member grievances
      2) Monitoring of Provider and physician grievances
      3) Claims Audits and monitoring activities
      4) Review of Providers' financial statements
      5) Medical Management Audits
      6) Utilization Management monitoring activities
      7) Quality Management monitoring activities
      8) Case Management Oversight activities
      9) Pharmacy Audits
      10) Encounter Data Reporting Edits
      11) Chart Audits
      12) Clinical Audits
   D. Investigating and resolving all reported and/or detected suspected instances of fraud and taking action against confirmed suspected fraud, waste, and abuse including but not limited to reporting to law enforcement agencies, termination of the CCHP contract (if a Provider, direct contracting practitioner, or vendor), and/or removal of a participating practitioner from the CCHP network. CCHP reports suspected fraud to the following entities, as deemed appropriate and required by law:
      1) The Centers for Medicare and Medicaid Services (CMS)
      2) The Federal Office of the Inspector General (Medicaid/Medicare Fraud)
      3) Medical Board of California (MBOC)
      4) Local law enforcement agencies
      5) Submitting periodic reports to CMS as required by law.
      6) Encouraging and supporting Provider activities related to fraud prevention and detection.
5. The Providers' responsibilities for fraud prevention and detection include, but are not limited to, the following:
   A. Training Provider staff, contracting physicians and other affiliated or ancillary providers, and vendors on CCHP and Provider's Fraud, Waste and Abuse Program and fraud, waste and abuse prevention activities and false claims laws at least annually.
   B. Verifying and documenting the presence/absence of contracted individuals and/or entities by accessing the following online site prior to contracting and monthly thereafter: www.oig.hhs.gov/fraud/exclusions.asp.
   C. Terminating the CCHP network participation of individuals and entities who appear on the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE).

D. Developing a FWA Program, implementing fraud, waste and abuse prevention activities and communicating such program and activities to contractors and subcontractors.
E. Communicating awareness, including:
    1) Identification of fraud, waste and abuse schemes.
    2) Detection methods and monitoring activities to contracted and subcontracted entities of CCHP.
F. Notifying CCHP of suspected fraudulent behavior and asking for assistance in completing investigations.
G. Taking action against suspected or confirmed fraud, waste and abuse including referring such instances to law enforcement and reporting activity to CCHP.
H. Policing and/or monitoring own activities and operations to detect and/or deter or prevent fraudulent behavior.
I. Cooperating with CCHP in fraud, waste and abuse detection and awareness activities, including monitoring, reporting, etc., as well as cooperating with CCHP in fraud, waste and abuse investigations to the extent permitted by law.
J. Prompt return of identified overpayments of state and/or federal claims.

6. Reporting Concerns Regarding Fraud, Waste Abuse and False Alarms
A. CCHP takes issues regarding false claims and fraud, waste and abuse seriously. CCHP providers, and their contractors or agents of CCHP's providers are to be aware of the laws regarding fraud, waste and abuse and false claims and to identify and resolve any issues immediately. Affiliated providers' employees, managers, and contractors are to report concerns to their immediate supervisor when appropriate.
B. CCHP provides the following ways in which to report alleged and/or suspected fraud, waste and/or abuse directly to the plan:
    (1) In writing to:
        Corporate Compliance Officer
        Chinese Community Health Plan
        445 Grant Avenue, Ste. 700
        San Francisco, CA 94108
    (2) By E-mail to: Daniel.Quan@cchphealthplan.com
    (3) By telephone to the confidential Corporate Compliance Hotline: 1-415-955-8810
    (4) By fax to: 1-415-955-8818
A. The Suspected Noncompliance/Fraud Report Form is to be completed when reporting concerns regarding fraud, waste, abuse and false claims (Attachment A). The form is also available on the CCHP website.
B. The following information is needed in order for the CCHP Compliance Department to investigate suspected fraud, waste and/or abuse:
    1) The date the report is being completed
    2) The date of the incident
    3) Person's name. Although an individual may choose to report anonymously, it is very helpful for the CCHP Compliance Department to hear the allegations directly from the individual. If a person chose to give their name, please provide a contact number.
    4) The organization

5) Type of Allegation
6) Who the fraud involves. If you know the name of the individual and/or their ID #, please provide this information.
7) Is there documentation that can be used as evidence?
8) Is documentation attached to the report?
9) Has this been previously reported?
10) A description of the potential fraudulent activity.
11) Has law enforcement been contacted?
12) Has a regulatory agency been contacted?

Information reported to the CCHP Fraud Prevention Program will remain confidential to the extent possible by law.

Section 16.4 HIPAA Protected Health Information

PURPOSE:

To establish guidance regarding each provider's responsibility related to identifiable Member information. This policy addresses an intentional or unintentional breach of Member confidentiality, including oral, written and electronic communication. This definition will safeguard Member privacy and help minimize exposure and/or liability to Members, providers, facilities and CCHP.

Providers must comply with the federal Health Insurance Portability and Accountability Act ("HIPAA") laws and regulations including, but not limited to the privacy and security of Members' protected health information ("PHI") as required by the Health Insurance Portability and Accountability Act ("HIPAA"), Standards for Privacy of Members' Identifiable Health Information, 45 CFR Parts 160 and 164; the administrative, physical, and technical safeguards of the HIPAA Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) as part of the American Recovery and Reinvestment Act of 2009; and any and all Federal regulations and interpretive guidelines promulgated there under. HIPAA Omnibus Rule, January 25, 2013, made all the changes into law.

POLICY:

1. Providers must make reasonable efforts to safeguard the privacy and security of Members' PHI and are responsible for adhering to this policy by using only the minimum information necessary to perform his or her responsibilities, regardless of the extent of access provided or available.
2. Providers are allowed to release Member PHI to CCHP, without prior authorization from the Member, if the information is for treatment, payment or health care operations related to CCHP plans or programs.
3. Providers must notify CCHP, their Members; the Centers for Medicare and Medicaid (CMS); and the U.S. Department of Health & Human Services (DHHS) of any suspected or actual breach regarding the privacy and security of a Member's PHI within prescribed timelines and through electronic submission formats.

DEFINITION:

“Protected Health Information” or “PHI” means any information, whether oral or recorded in any form or medium that relates to the past, present, or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI shall have the meaning given to such term under HIPAA and HIPAA regulations, as the same may be amended periodically.

PROCEDURE:

1. Each provider is responsible for obtaining their own education and providing training to their office staff on member privacy and member rights in compliance with US Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Service (CMS), mandates training on PHI and its protection. (45 C.F.R. § 164.530(b)).
2. Each provider is responsible for compliance with Protected Health Information policies and principles.
3. Permitted Uses and Disclosures
   A. Except as otherwise required by law, Providers are allowed to release the minimum necessary Member information, including PHI, without Member authorization, to CCHP for treatment, payment, or health care operations related to CCHP plans or programs.
   B. Outside requests for a copy of the *entire medical record* is common but such disclosures should be avoided unless specifically authorized by the patient or client. A reasonable exception is when an outside provider is requesting the entire record for continuity of care.
   C. Activities which are for purposes directly connected with the administration of services include, but are not limited to:
      1) Establishing eligibility and methods of reimbursement;
      2) Determining the amount of medical assistance;
      3) Arranging or providing services for Members;
      4) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of CCHP plans or programs;
      5) Conducting or assisting in an audit related to the administration of CCHP plans or programs.
4. Reporting of Improper Disclosures
   A. Providers are required to report unauthorized disclosures to:
      1) The U.S. Department of Health & Human Services (DHHS) for breaches of unsecured PHI, sent electronically without unreasonable delay and in no case later than sixty (60) days from discovery of a breach affecting 500 or more individuals; and, electronic notice sent annually by March 1st for DHHS defined breaches that have occurred during the previous year that affected fewer than 500 individuals.
      2) All security breaches that require a security breach notification to more than five hundred (500) California residents as a result of a single breach of the security system shall electronically submit a single sample copy of that

security breach notification, excluding any personally identifiable information, to the California Office of the Attorney General.

3) The CCHP Member(s) who's PHI has been breached in accordance with CMS and DHHS requirements. Affected members must be provided with written notification without unreasonable delay and in no case later than sixty (60) days following the discovery of a breach.
4) The CCHP Corporate Compliance Officer must be notified immediately upon having reason to suspect that an unauthorized disclosure may have occurred, and typically prior to beginning the process of verifying that an unauthorized disclosure has occurred or determining the scope of any such unauthorized disclosure, and regardless of the potential risk of harm posed by the unauthorized disclosure.

Corporate Compliance Officer
Chinese Community Health Plan
445 Grant Ave., Ste. 700
San Francisco, CA 94108
Fax: (415) 955.8818
E-mail: Danel.Quan@cchphealtplan.com

5. Providers must take prompt corrective action to mitigate and cure the cause(s) of the unauthorized disclosure.

6. In accordance with Section 7.2 - Duty to Detect and Report Incidents - of the Covered California Privacy & Security Participant Guide:
    - All Covered California staff, contractors and vendors who have access to Covered California data systems, services or networks, or access to any confidential information (PII, PHI, FTI) that is collected, maintained, used or disclosed by Covered California, must immediately report any incident that may affect the confidentiality, security or integrity of the data or the systems.
    - This includes suspected incidents. You should not wait to confirm the incident happened, or to investigate what happened, but must immediately report any suspected incident
    - When you report an incident, Covered California Information Privacy Office staff can then take immediate actions to prevent harm and will direct you on what actions you need to take
    - The duty to report includes both security and privacy incidents Section 7.3 – Security Incidents (from the same document)

    A Security incident is defined as any real or potential attempt (successful or unsuccessful) to access and/or adversely affect Covered California data, systems, services or networks, including online data, systems, services and networks, and including but not limited to any effect on data availability, loss of data, disclosure of proprietary information, illegal access and misuse or escalation of authorized access.

Examples of security incidents include, but are not limited to:

- Denial of Service – an attack that prevents or impairs the authorized use of networks, systems, or applications by exhausting resources
- Malicious Code – a virus, worm, Trojan horse, or other code-based malicious entity that successfully infects a host
- Unauthorized Wireless Devices Detection – connecting an unauthorized wireless access point into a Covered California computer system
- Unauthorized Access – a person gains electronic or physical access without permission to a network, system, application, data, or other IT resource
- Inappropriate Usage – a person violates acceptable use of any network or computer policies
- Lost or Stolen Asset – a Covered California or CoveredCA.com asset is lost or personal belongings of a Covered California employee or contractor are stolen at a work location

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