PROVIDER MANUAL

CCHP Health Plan

Balance by CCHP

PROVIDER MANUAL

Table of Contents

SECTION 1
INTRODUCTION AND BACKGROUND

Section 1.1 Purpose of the Manual

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

Section 1.2 Welcome to CCHP & Balance by CCHP

Established in 1986, Chinese Community Health Plan (CCHP) is the health plan subsidiary of the Chinese Hospital Association. CCHP Health Plan offers coverage to individuals and families (on and off Covered California exchange), employer groups, and to seniors through Medicare Advantage plans. Our service area continues to grow and currently includes the counties of San Francisco, San Mateo and Alameda.

CCHP plans are offered under two brand names: CCHP for Medicare Advantage plans and Balance by CCHP for individuals and families (on and off Covered California exchange), and employer groups. For the purposes of this provider manual, CCHP is used to reference the health plan overall. Information for each can be found under dedicated websites for each:

CCHP	**Balance By CCHP**
www.cchphealthplan.com	www.balancebycchp.com

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 in 1986 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 growing network. Our service area consists of San Francisco, San Mateo and Alameda County.

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 regulated by the Department of Managed Heath Care (DMHC). CCHP offers a variety of commercial products for small and large group employers. CCHP is also one of the first plans to provide coverage through the State based exchange "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 D-SNP) and an integrated Medicare Advantage Prescription Drug Plan (Part D). CCHP's Senior Program (HMO) and Senior Value Program are for people with Medicare Parts A and B. CCHP's Senior Select Program (HMO D-SNP, Dually Eligible Special Needs Plan) is for people with Medi-Cal and Medicare Parts A and B. For the Senior Select Program, CCHP maintains a State Medicaid Agency Agreement under the oversight of the California Department of Health Care Services (DHCS). 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 16 community organizations. The board is a true reflection of the community it has been serving for over 125 years.

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

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
- Marketing
- Financial
- Pharmacy & Therapeutics (P&T)
- Member Advisory
- Corporate Compliance

Section 1.7 How to Contact Us - Helpful Resources

General Information		**Email/Phone**
Main Office	445 Grant Avenue San Francisco, CA 94108	1-415-955-8800
Website	www.cchphealthplan.com www.balancebycchp.com	
Hours of Operation	Monday – Friday 9 a.m.- 5:00 p.m.	
Eligibility and Benefits		**Email/Phone**
Member Eligibility and Benefits Verification	Create an account on CCHP's Provider Portal to view eligibility information: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx If you have issues logging in please contact the Provider Relations Team at: Provider.Relations@cchphealthplan.com	memberservices@cchphealthplan.com 1-888-775-7888 (toll free)
Provider Relations & Network Management		**Email/Phone**
General Provider Inquiries and Provider Portal Questions	Create a CCHP Provider Portal account: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx If you have issues logging in please contact the Provider Relations Team.	Provider.Relations@cchphealthplan.com 1-628-228-3485
Provider Network Information	CCHP providers can be found on both of our websites: **CCHP:** https://cchphealthplan.com/provider-search/ **Balance by CCHP:** https://balancebycchp.com/provider-search/	Provider.Relations@cchphealthplan.com 1-628-228-3485

	If you encounter any inaccuracies, please contact the Provider Relations team.	
Utilization Management		**Email/Phone**
Service, Consultation Referral, and Prior Authorization Requests	Inpatient Fax: 1-628-228-3495 Outpatient Fax: 1-415-398-3669 Please note that in some cases, UM decisions may be delegated to an independent physician association (IPA). See Section 8.2.	cchp.um@cchphealthplan.com 1-415-955-8835
View and Submit Authorizations Online	View and Submit Authorizations on CCHP's Provider Portal: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx If you have issues logging in please contact the Provider Relations team at: Provider.Relations@cchphealthplan.com	
Contracting		**Email/Phone**
Provider Contracting	For questions about contracts and contract statuses	CCHP.Contracting@cchphealthplan.com
Claims		**Email/Phone**
Check Claims Status	To review your 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 the Provider Relations team at: Provider.Relations@cchphealthplan.com	

Claims General Inquiries	Upon reviewing claims in the Provider Portal, if you still have questions or require additional information regarding denial reasons, payment amounts, or EOP requests, please reach out to us at: providerinquiry@cchphealthplan.com. Inquiries will be acknowledged within 5 business days, triaged, and sent to the appropriate CCHP team for review. Status updates will be provided for managed inquiries.	
Submit Electronic Claims	For electronic submissions, then please direct them to CCHP's **Payer ID 94302**	
Submit Paper Claims	Paper claims can be mailed to: CCHP Claims Department Post Office Box 1599 San Leandro, CA 94577	
Provider Disputes		**Email/Phone**
Provider Dispute Inquiries	To check on the status of a provider dispute or for any general dispute inquiries	provider.disputes@cchphealthplan.com 1-628-228-3214
Provider Dispute Forms & Instructions	Please see the Provider Resources – Provider Dispute Process section at: **CCHP:** https://cchphealthplan.com/provider-resources/#claims **Balance By CCHP:** https://balancebycchp.com/providers/provider-resources/	

Submit a Provider Dispute (Dispute must be submitted on Dispute Form)	Disputes can be mailed to: CCHP Provider Dispute Resolution 445 Grant Avenue San Francisco, CA 94108 Fax: 1-415-955-8815	
Pharmacy		**Email/Phone**
Request Prior Authorization for RX	Senior & Senior Select: CCHP Member Services	1-888-775-7888
	Commercial Program: MedImpact Healthcare Systems	1-800-788-2949
Formulary Questions	Pharmacy Manager	pharmacy@cchphealthplan.com 1-628-228-3334
CCHP Formularies Pharmacy Directory	**CCHP** https://cchphealthplan.com/provider-resources/#pharmacy **Balance By CCHP** https://balancebycchp.com/providers/provider-resources/	
Sales		**Email/Phone**
Sales Department	Commercial Line of Business:	Sales@BalanceByCCHP.com 1-888-371-3060
	Medicare Line of Business:	Sales@cchphealthplan.com 1-888-681-3888
Compliance		**Email/Phone**
Report Suspected Fraud, Waste, Abuse, Privacy, or Security Issues	Compliance Hotline – Confidential **or** CCHP Compliance Officer	1-415-955-8810 1-628-228-3393

SECTION 2
PRODUCTS AND BENEFITS

Section 2.1 Programs and Products

CCHP operates under two brand names: CCHP and Balance by CCHP. They are differentiated by lines of business. Both CCHP and Balance plans can be purchased through a broker/agent or directly with the plan. There is a website for each:

www.cchphealthplan.com | **www.balancebycchp.com**

Balance by CCHP offers a variety of commercial products for employers off all sizes as well as products for individuals and families (on and off Covered California exchange). Our plans are for companies based in San Francisco or San Mateo County. Understanding today's distributed nature of workforces around the Bay Area, we extend the coverage area to Alameda and Contra Costa counties for employees who reside there.

- **Balance by CCHP Commercial Products** for employer groups, individuals and families. There are several plans with different choices of copayments and optional dental and vision riders.

In addition, under the CCHP brand are Medicare Advantage Plans including Part D drug coverage. The following programs are offered:

- **CCHP Senior and Value Program HMO** are Medicare Advantage plans 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 (D-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 and is available only for San Francisco residents.

Section 2.2 Service Area

CCHP's Service Area includes counties of San Francisco, San Mateo and Alameda. The Service Area for CCHP Senior Select Program members is the City and County of San Francisco only. For details go to: https://cchphealthplan.com/plan-documents/

Section 2.3 Primary Care Physicians

CCHP members must select a primary care physician (PCP) to coordinate their care.

For those that are not under a PPO plan:

The PCP coordinates all care including referrals to specialists. The member must use plan physicians, providers, and facilities for their care with the exception of emergency care. For services not available from the CCHP physician panel, prior authorization must be sought from the Utilization Management Department or delegates (See Section 8.2).

Section 2.4 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. For Balance, go to www.balancebycchp.com. Benefits are subject to change from time to time. Providers must verify a member's benefits and eligibility prior to rendering services as well as 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 8.13 Services Requiring Prior Authorization" for services requiring 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 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:

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 the 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 2.7 Summary of Preventive Services Covered Without Copayments

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 a participating OB/GYN.

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	
Anemia, Prevention – Counseling by PCP[2]	B				x
Anemia, Screening[3]	B			x	
Anemia, Screening– Hemoglobin/Hematocrit in Childhood[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 Mutation Testing[10]	B		x		
Breastfeeding, Counseling by PCP Regarding Mental Interventions[11]	B		x	x	
Cervical Cancer Screening[12]	B		x		
Chlamydial Infection, Screening[13]	A		x	x	
Colorectal Cancer, Screening[14]	A	x	x		
Congenital Hypothyroidism, Screening[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	
Type 2 Diabetes Mellitus in Adults, Screening[32]	B	x	x		
Visual Impairment in Children Younger than Age 5 Years, Screening[33]	I				x

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 than 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 age 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 2.8 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 2.9 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 may require 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 Account

The CCHP Provider Portal houses various key services for providers including, but not limited to, the ability to maintain claim information, view authorizations, submit authorizations, verify member eligibility, and view checks. Providers are requested to create a CCHP Provider Portal Account to streamline communications with CCHP.

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.

- **Balance by 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 our sales representatives. Employees are eligible to enroll in Balance by 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.

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

- **CCHP Senior Program HMO and CCHP Senior Value Program HMO** are Medicare Advantage plans 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 a 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 an enrollee requests a CCHP representative's assistance in selecting a PCP, the CCHP staff will use the following criteria tactfully to help the 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 CCHP members, go to our Website and access the provider portal 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

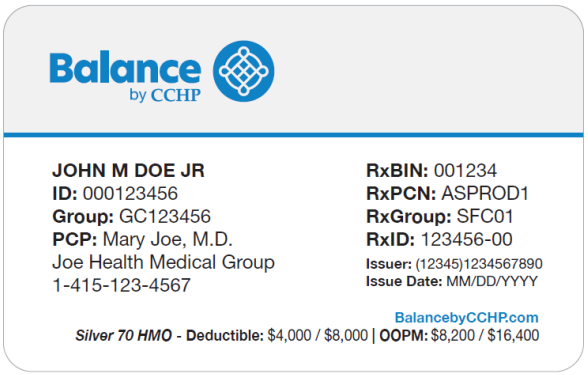
2. Enter your username and password and click on “Logon”.
3. For CCHP Member Eligibility Search, select the “**Check Eligibility**” option on the left side bar.
4. You can search by CCHP Member ID, Policy #, Last Name, First Name, and Date of Birth (DOB).
5. After you entered the member information, the coverage dates will be under the effective and expiration date.
6. For a summary of the member’s benefits and copayments, please click on “**view**” under Benefits.
7. For member’s PCP and Medical Group information, please click on “**view**” under Member Facesheet.

Section 4.4 Member ID Cards

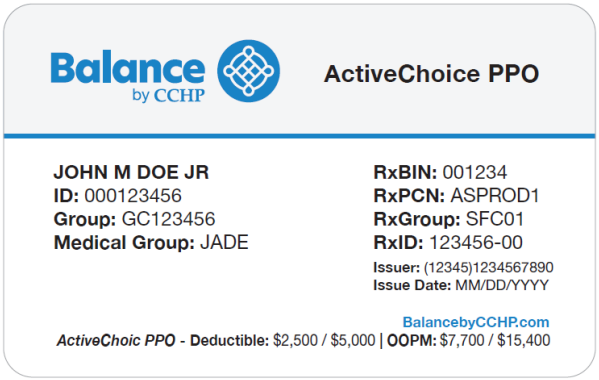
Please ask patients to present their CCHP ID Card each time they present for services. The ID Card is not proof of eligibility. It is for identification purposes only; however it contains information to assist you in verifying eligibility on our website. If a member does not have an ID Card, you can 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:

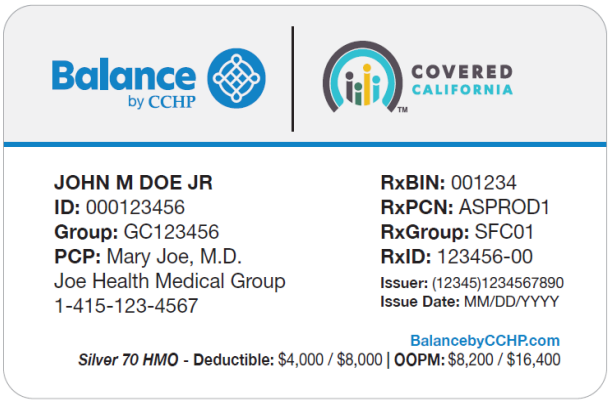
Balance by CCHP Commercial (HMO) Program ID Card
(Employer Group and Individual/Family Plan)



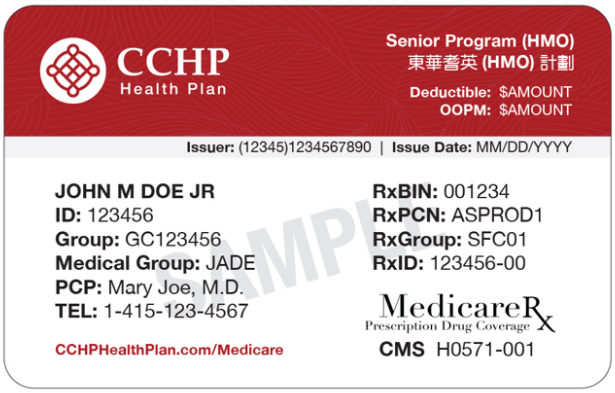
CCHP Commercial (PPO) Program ID Card
(Employer Group and Individual/Family Plan)



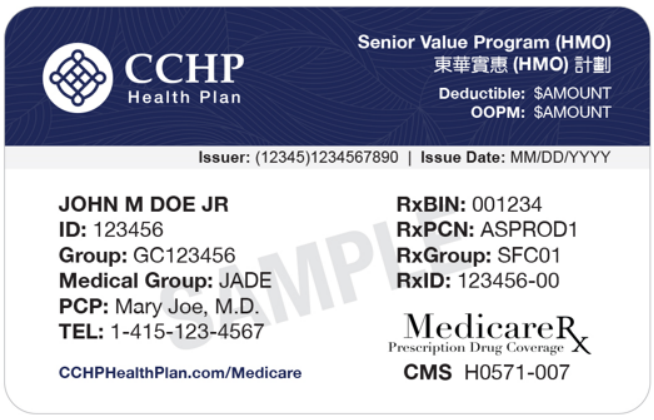
CCHP Covered California (HMO) Program ID Card
(Covered California)



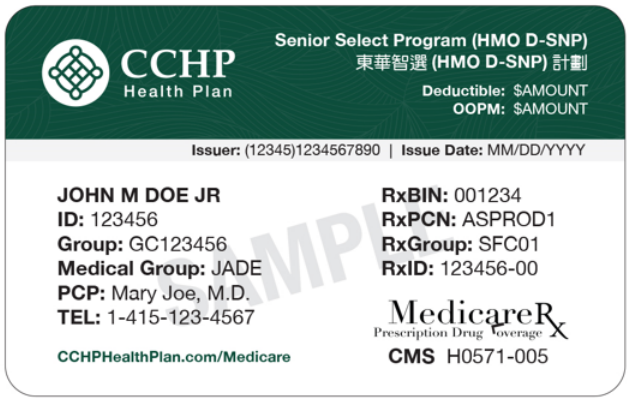
CCHP Senior Program (HMO) ID Card
(Medicare Advantage Members with Medicare Parts A + B)



CCHP Senior Value 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 physicians available to provide care to CCHP members directly or via affiliated medical groups. Some practices may participate in more than one network at a time.

Below is a representation of current network coverages:

CARRIER/LINE OF BUSINESS	SERVICE AREA
Balance Commercial HMO & PPO (Individual, Family, On and Off Exchange)	
CCHP Direct	San Francisco, San Mateo
Jade Health Care Medical Group	San Francisco, San Mateo
Hill Physicians Medical Group	San Francisco, San Mateo
Balance Commercial HMO (Small Group, Large Group)	
CCHP Direct	San Francisco, San Mateo
Jade Health Care Medical Group	San Francisco, San Mateo
Hill Physicians Medical Group	San Francisco, San Mateo, Alameda, Contra Costa, Marin
CCHP Medicare (MAPD HMO Senior, Senior Value)	
CCHP Direct	San Francisco, San Mateo
Jade Health Care Medical Group	San Francisco, San Mateo
Access Primary Care Medical Group	San Francisco, San Mateo
Hill Physicians Medical Group	San Francisco, San Mateo, Alameda
CCHP Medicare (D-SNP HMO Senior Select)	
CCHP Direct	San Francisco
Jade Health Care Medical Group	San Francisco
Access Primary Care Medical Group	San Francisco
Hill Physicians Medical Group	San Francisco

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:
   - Access Primary Care Medical Group (Access)
   - Jade Health Care Medical Group (Jade)
   - Hill Physicians Medical Group (HPMG)

   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 their care.
C. To ensure that CCHP complies with state regulations, providers must provide information to CCHP to update CCHP's Provider Directory.
D. Providers will use the Provider Directory to 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 require CCHP to ensure that its contracted network satisfies the following practitioner to member ratios:
   - Primary Care Physician (MD and DO) to member ratios must be at minimum 1:2,000
   - Physician Extender (NP and PA) to member ratios may not exceed 1:1,000
C. The provider directory is available for all of CCHP's product lines. The printed provider directory is updated on a quarterly basis and the online provider directory is updated monthly. If an inaccuracy is found, directories will be updated within a week following an investigation.
D. The online Provider Directory can be accessed:

   CCHP Health Plan: https://cchphealthplan.com/provider-search/

   Balance by CCHP: https://balancebycchp.com/provider-search/

E. CCHP will provide a printed copy of the directory at request:

   Telephone Number: 1**-888-775-7888**
   Email Address: memberservices@cchphealthplan.com
   Address: **Member Services Department**
   445 Grant Ave, San Francisco, CA 94108

F. CCHP's Provider Directory lists the following provider information (if applicable):
   - Name
   - Office Name
   - Office Addresses
   - Telephone Number
   - Provider Type
   - Specialty
   - Board Certification
   - National Provider Identification Number
   - California License Number
   - California License Type
   - Office Email Address
   - Affiliated and Contracted provider group(s)
   - Provider Language(s)
   - Education
   - Panel Status
   - Referral Required
   - The Provider Group and Admitting Privileges at hospitals contracted with CCHP
   - Gender Affirming Care

G. Provider obligation regarding panel status:
   - CCHP requires a five (5) business day notification from providers when not accepting new patients
   - CCHP requires a five (5) business day notification from providers who were previously not accepting new patients, but are currently accepting new patients
   - CCHP requires all contracted providers who are not accepting new patients to direct an enrollee or potential enrollee seeking to become a new patient to CCHP to find a provider and to report any potential directory inaccuracy

H. Plan oversight and provider obligation regarding updating provider information:
   - CCHP will notify providers annually at the minimum to update their information
   - CCHP requires an affirmative response acknowledging update notifications to be received, except for general acute care hospitals
   - CCHP requires all notified providers to confirm their directory information is current and accurate or otherwise update their directory information
   - CCHP takes no more than fifteen (15) business days to verify the information of a notified provider who does not respond within thirty (30) business days
   - If CCHP cannot verify a provider's information, CCHP will notify the provider of pending directory removal ten (10) business days prior to removal
   - CCHP removes non-responsive providers from CCHP's Provider Directory at the next required update, except for general acute care hospitals

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

CCHP Health Plan
Telephone: 1-628-228-3485
Email: provider.relations@cchphealthplan.com
Form: https://cchphealthplan.com/report-provider-directory-changes-and-inaccuracies-form/

Balance by CCHP
Telephone: 1-628-228-3485
Email: provider.relations@balancebycchp.com
Form: https://balancebycchp.com/provider-directory-updates/

J. Physicians who employ mid-level practitioners or licensed providers such as but not limited to nurse practitioners, physician assistants, physical therapists, and optometrists, must adhere to the following requirements:
    a. All mid-level practitioners and licensed providers rendering care to CCHP patients must be credentialed
    b. Services provided by mid-level practitioners and 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
K. The credentialing process includes a request for the names and license numbers of health professionals employed by participating physicians. Once the credentialing process is completed and the provider is approved, they can be added to the provider directory.
L. CCHP contracts with the following hospitals:
    - Chinese Hospital
    - Alameda Health System (Alameda Hospital, Highland Hospital, John George Psychiatric Hospital, San Leandro Hospital)
    - Sutter Alta Bates (Herrick and Summit Campus)
    - Sutter CPMC (Davies, Mission Bernal, Pacific Heights, and Van Ness Campus)
    - UCSF (St. Francis Memorial Hospital, St. Mary's Medical Center, UCSF Benioff Children's Hospital SF, UCSF Medical Center at Mission Bay, UCSF Medical Center at Mt. Zion, and UCSF Medical Center at Parnassus)
    - Sequoia Hospital
    - Eden Medical Center
    - Seton Medical Center
    - Mills-Peninsula Medical Center
    - Stanford Medical Center
    - Stanford Health Care – Tri-Valley
M. **Chinese Hospital** (https://chinesehospital-sf.org/) offers a wide range of medical, surgical, and diagnostic services. Chinese Hospital is the preferred hospital for CCHP patients when appropriate. As a result, patients referred to Chinese Hospital for outpatient or inpatient care can expect a short turnaround time.

Chinese Hospital Available Services

SPECIALTIES	SERVICES
General Med-Surg	• Acute Renal Failure • Alcohol withdrawal • Anemia • Fluid and electrolyte disorders • Diabetes mellitus with complications • Diabetic Ketoacidosis (DKA) • Venous Thromboembolism (VTE): DVT and PE
Cardiology	• Atrial Fibrillation with RVR • Acute Decompensated HFrEF • Congestive Heart Failure • Syncope and presyncope • Pacemaker insertion
Otolaryngology (ENT)	• General ENT surgeries • Thyroidectomy
General Surgery	• General Surgery • Cholecystectomy • Colectomy • Bowel obstruction • Appendectomy • Mastectomy
Gastrointestinal	• Upper Gastrointestinal Bleeding • Lower Gastrointestinal Bleeding • Acute Pancreatitis • Biliary tract disease • General GI • Endoscopy • Colonoscopy • ERCP
Pulmonology/Respiratory Care	• COPD and bronchiectasis • Asthma • COVID • Respiratory failure; insufficiency • Tracheostomy • Ventilator Dependent • Pulmonary function tests

SPECIALTIES	SERVICES
Infectious Disease	• Cellulitis and Diabetic Foot Infection • Clostridium difficile • Pneumonia • Skin and subcutaneous tissue infection • Urinary tract infection Sepsis and septic shock • Telemedicine consult
Medical Imaging	• Magnetic resonance imaging (MRI) – All MRI, MR Angiography studies with the exception of Breast, Prostrate, Cardiac exams. • Computed tomography (CT) – All CT, CTA, Low-Dose Chest with the exception of cardiac CT • Mammography – All screening and diagnostic mammography, needle localization. • Nuclear medicine – All exams – we do not have PET. • Ultrasound – All studies with the exception of renal insufficiency, renal stenosis (Doppler) TIPS (liver), venous insufficiency, ankle/brachial indices (ABI), OB is limited to emergent studies ordered through the ED. • X-ray – All exams. • Fluoroscopy – All exams • DEXA/Bone Density – All exams. • Interventional radiology – we do not have a dedicated IR • service line, we perform very limited studies: T-tube placement, shoulder arthrograms
Neurology	• Primary Stroke or TIA • Telemedicine Stroke/Neurology
Orthopedic Surgery	• General orthopedic surgery • Osteoarthritis • Spine Surgery • Hand Surgery
Ophthalmology	• General Ophthalmology • Cataract Surgery
Oncology	• Inpatient infusion • Outpatient infusion • (Note: see Infusion Center Services below)
Urology	• General Urology surgery • Lithotripsy
GYN	• General GYN
Dialysis	• Inpatient only

UNAVAILABLE SERVICES

- Burn
- Cardiac Cath
- Cardiovascular Surgery
- Electrophysiology
- Neuro surgery
- Neuro-interventional
- NICU
- OB
- Pediatrics
- Psychiatry
- Radiation Therapy
- Transplant
- Vascular Surgery

Infusion Center Scope of Practice

DIAGNOSIS	CHEMO REGIMEN	DRUGS
Adjuvant CRC	Folfox	Oxaliplatin, 5-FU, Leucovorin
mCRC	mFolfox, Folfiri, Folfoxiri, Irinotecan monoTx	Same as above + irinotecan, +/- Bev for mFolfox and Folfiri
NSCLC	Adeno, non-squam	Pembro/Carbo/Pemetrexed
NSCLC	Squamous	Pembro/Carbo/paclitaxel
NSCLC	Squamous	Cisplat/gem +/- necitumumab
NSCLC	2nd line	Nivolumab
NSCLC	PD-L1 TPS > 50%	Pembrolizumab monoTx
NSCLC		Atezolizumab
NSCLC	Single agents	Pemetrexed, docetaxel
Adjuvant NSCLC		Cisplatin + (pemetrexed, docetaxel, vinorelbine)
Stage III Lung CA, unresectable	Single agent	Durvalumab
SCLC		Atezolizumab/carbo/etoposide
Pancreatic	mFolfirinox	Oxaliplatin, 5-FU, Leucovorin, irinotecan
Pancreatic	mPACT	Gem + nab-paclitaxel
Pancreatic		Continuous infusion 5-FU + XRT
DLBCL	R-CHOP	Rituximab, Cytoxan, Doxorubicin, vincristine, prednisone
Follicular lymphoma	RB	Rituximab, bendamustine
Adjuvant breast	TAC	Docetaxel, doxorubicin, Cytoxan
Adjuvant HER-2 + breast		Trastuzumab +/- pertuzumab
MBC HER-2 +		T-DM1 in the past, T-DXd for next new case

MBC		Nab-paclitaxel
MBC HER-2 -		General: taxanes, anthracyclines, gemcitabine, vinorelbine, eribulin
Myeloma		bortezomib
Myeloma		carfilzomib
Myeloma		daratumumab
Bladder, NPC		Gem + Cisplat, mitomycin (bladder)
Hodgkin's lymphoma	ABVD	Dacarbazine, doxorubicin, bleomycin, vinblastine
Ovarian CA		Liposomal doxorubicin, carbo/tax/Bev, Topotecan weekly
Ovarian CA		IP Cisplatin + paclitaxel
SCCHN		Cetuximab, cisplat/5FU
AML	5+2 (for poor PS)	Daunorubicin/ida + cytarabine
AML/MDS		Decitabine, azacitidine
Gastric CA	mDCF	Docetaxel, cisplatin, 5-FU
Gastric CA		Ramucirumab
Gastric CA, HER2+	TOGA	Trastuzumab/cisplat/5-FU or capecitabine
RCC		temsirolimus
Prostate		Docetaxel, cabazitaxel

CRC = colorectal cancer
NSCLC = non-small cell lung cancer
SCLC = small cell lung cancer
DLBCL = diffuse large B-Cell lymphoma
MBC = metastatic breast cancer
NPC = nasopharyngeal carcinoma
SCCHN = squamous cell carcinoma of head and neck
AML = acute myeloid leukemia
MDS = myelodysplastic syndrome
RCC = renal cell carcinoma
ITP = immune thrombocytopeni

DIAGNOSIS	INJECTABLE
Thyroid eye disease	Tepezza (teprotumumab)
MDS anemia	Luspatercept
ESRD anemia	Darbepoetin, epoetin
neutropenia	Filgrastim, pegfilgrastim
Crohn's, ulcerative colitis	Infliximab, vedolizumab
Asthma	Omalizumab, mepolizumab, dupilumab
Osteoporosis	Denosumab, romosozumab, zoledronic acid
Bone metastasis	Denosumab, zoledronic acid
ITP	Romiplostim
Breast CA	Fulvestrant
Breast CA, Prostate CA	Goserelin, Leuprolide
Iron deficiency anemia	Iron sucrose
Supplement to pemetrexed treatment	Cyanocobalamin B12 IM injection

OTHER DIAGNOSIS	TREATMENT
Anemia	Blood Transfusions
Thrombocytopenia	Platelet transfusions
Infections	Abx: daptomycin, vancomycin, ertapenem, ceftriaxone, aztreonam
Hydration therapy	IV fluids i.e. NS
Catheter care	Heparin flush
ITP, Chronic inflammatory demyelinating polyneuropathy	IV immune globulin (IVIG)

N. CCHP members requiring Oncology services to be referred to Chinese Hospital for these services when appropriate.

CCHP members referred to centers other than Chinese Hospital for Oncology services will be redirected to Chinese Hospital when:

1. A Cancer diagnosis has not yet been established.
2. Treatment at another center has not yet commenced.
3. The member consents to transfer of treatment to Chinese Hospital.

In instances where Oncology therapy has already commenced AND the member does not consent to transferring therapy to Chinese Hospital, member will be approved to continue/complete therapy at the other center.

O. For services not available at Chinese Hospital, the Utilization Management Department

will make a determination as to where necessary services can be provided.

P. CCHP contracts with several outpatient facilities. Please refer to Section 5.4 Preferred Ancillary Provider & Facilities List for ancillary providers and facilities well suited to serve CCHP members.
Q. Laboratory services must be performed at a CCHP associated facility. Complete a laboratory requisition and direct the member to a CCHP preferred laboratory-drawing site.
R. 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 Chinese Hospital Outpatient Center at 386 Gellert Boulevard. Please refer CCHP members to these facilities.
S. 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 five (5) business days. Some examples of these changes include practice locations, phone numbers, Tax Identification Numbers (TIN), claims payment addresses, hours of operation, and panel statuses.

Please notify the Provider Relations team of these changes via email at provider.relations@cchphealthplan.com or by phone at (628) 228-3485.

If you are a provider who has a CCHP Direct Contract and want to terminate your participation with CCHP you must submit a termination notice in writing to CCHP in the time frames stated in your respective Participating Provider Agreement. The contact addresses are below:

Address:
ATTN: CCHP Contracting Department.
Chinese Community Health Plan
445 Grant Avenue
San Francisco, CA 94108

Email:
CCHP.Contracting@cchphealthplan.com

If you are a participating provider contracted through one of CCHP's affiliated medical groups, including but not limited to Access Primary Care Medical Group, Jade Health Care Medical Group, or Hill Physicians Medical Group, please notify their respective credentialing or network contracting departments.

Section 5.4 Preferred Ancillary Provider & Facilities List

CCHP has a list of contracted providers who can be seen by members belonging to any IPA.

CCHP Direct Contract Provider List (Ancillary)

The following list is accurate as of 10/25/2024: *** Preferred Providers** **# Telehealth**

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Acupuncture	**Chinese Hospital / East West Services (445 Grant Ave)***	(415) 795-8100	445 Grant Ave San Francisco, CA 94108	San Francisco
	Chinese Hospital / East West Services (386 Gellert Blvd)*	(650) 761-3542	386 Gellert Blvd Daly City, CA 94015	San Mateo
	Chinese Hospital / East West Services (888 Paris St)*	(628) 228-2280	888 Paris Street San Francisco, CA 94112	San Francisco
	Vincent Zhou, LAC	(415) 340-3260	2451 Judah Street San Francisco, CA 94122	San Francisco
		(650) 580 8697	1838 El Camino Real Suite 101 Burlingame, CA 94010	San Mateo
		(650) 867-1238	333 Gellert Blvd, Suite 222 Daly City, CA 94015	San Mateo
ASC (Ambulatory Surgery Centers)	**Chinese Hospital***	(415) 982-2400	845 Jackson Street San Francisco, CA 94133	San Francisco
	Aspen Surgery Center	(925) 210-8400	133 La Casa Via, Suite 150 Walnut Creek, CA 94598	Contra Costa
	Campus Surgery Center	(650) 351-7616	901 Campus Drive, #102 Daly City, CA 94015	San Mateo
	Golden Gate Endoscopy Center	(415) 379-7500	3370 Geary Blvd San Francisco, CA 94118	San Francisco
	Mid Peninsula Endoscopy Center	(650) 373-1970	1720 El Camino Real, # 100 Burlingame, CA 94010	San Mateo
	Mission Valley Eye Medical Center	(510) 796-4500	39263 Mission Blvd Fremont, CA 94539	Alameda
	Premier Surgery Center	(925) 691-5000	2222 East Street #200 Concord, CA 94520	Contra Costa
	Presidio Surgery Center	(415) 346-1218	1635 Divisadero Street, #200 San Francisco, CA 94115	San Francisco
	San Francisco Endoscopy Center	(415) 345-0100	3468 California Street San Francisco, CA 94118	San Francisco
	UCSF Orthopaedic Institute	(415) 353-2808	1500 Owens Street San Francisco, CA 94158	Alameda, Contra Costa, San Francisco, and San Mateo
Behavioral Health	**Comprehensive Psychiatric Services#**	(510) 7443-688	39899 Balentine Drive Suite 200 Newark, CA 94560	Alameda
		(925) 223-6157	5924 Stoneridge Drive Suite 210 Pleasanton, CA 94588	Alameda
		(925) 944-9711	3100 Oak Road, Suite 270 Walnut Creek, CA 94597	Contra Costa
		(415) 928-1221	2211 Post Street, Suite 200 San Francisco, CA 94115	San Francisco

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
		(650) 301-4960	611 Gateway Blvd, Suite 210 South San Francisco CA 94080	San Mateo
	Kadiant	(866) 523-4268	Home-Based Services	Alameda, Contra Costa, San Francisco, and San Mateo
Chiropractic	Candice So	(415) 912-1716	1237 Van Ness Ave, #300 San Francisco, CA 94109	San Francisco
	Kenneth So	(415) 912-1716	1237 Van Ness Ave, #300 San Francisco, CA 94109	San Francisco
	Lau Chiropractic	(415) 681-3883	2335 Irving Street San Francisco, CA 94122	San Francisco
Dentistry	Delta Dental	—	https://www.deltadental.com/us/en/member/find-a-dentist.html	Alameda, Contra Costa, San Francisco, and San Mateo
Diabetic Supplies	Byram Healthcare	(877) 902-9726	—	Alameda, Contra Costa, San Francisco, and San Mateo
	CHME	(800) 906-0626	—	
	Sincere Care Management	(415) 752-3288	—	
Dialysis	DaVita Chinatown Dialysis	(833) 370-2086	636 Clay Street San Francisco, CA 94111	San Francisco
	DaVita Concord Dialysis Center	(833) 344-2545	2300 Stanwell Drive, # C Concord, CA 94520	Contra Costa
	DaVita El Cerrito Dialysis	(833) 370-2088	10690 San Pablo Ave El Cerrito, CA 94530	Contra Costa
	DaVita Golden Gate Dialysis	(833) 354-3507	2700 Geary Blvd, Ste A San Francisco, CA 94118	San Francisco
	DaVita Mills Dialysis	(833) 394-0683	100 S San Mateo Drive San Mateo, CA 94401	San Mateo
	DaVita Oakland Dialysis	(833) 368-2698	5354 Claremont Ave Oakland, CA 94618	Alameda
	DaVita Oakland Laurel Dialysis	(833) 431-3323	3814 MacArthur Blvd, Ste 201 Oakland, CA 94619	Alameda
	DaVita Richmond Dialysis	(833) 349-2526	4200 Macdonald Ave A Richmond, CA 94805	Contra Costa
	DaVita San Francisco Dialysis	(833) 370-2080	1499 Webster Street San Francisco, CA 94115	San Francisco
	DaVita South San Francisco At Home	(833) 384-2711	74 Camaritas Ave South San Francisco CA 94080	San Mateo
	DaVita Westlake Daly City Dialysis Center	(833) 349-2337	2201 Junipero Serra Blvd Ste A Daly City, CA 94014	San Mateo
	Satellite Healthcare Oakland	(510) 433-8340	3330 Telegraph Ave Oakland, CA 94609	Alameda
	Satellite Healthcare San Carlos	(650) 366-0789	1125 Industrial Rd G San Carlos, CA 94070	San Mateo
	Satellite Healthcare San Francisco	(415) 653-5800	1700 California St, # 260 San Francisco, CA 94109	San Francisco
	Satellite Healthcare San Francisco Geary	(415) 410-2900	3716 Geary Blvd San Francisco, CA 94118	San Francisco
	Satellite Healthcare San Mateo	(650) 377-0888	2000 S El Camino Real Floor 1 San Mateo, CA 94403	San Mateo
	Satellite Healthcare South San Francisco	(650) 616-7788	205 Kenwood Way South San Francisco, CA	San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
			94080	
	WellBound Daly City	(650) 550-3600	2001 Junipero Serra Blvd #535 Daly City, CA 94014	San Mateo
	WellBound Emeryville	(510) 985-9660	2000 Powell St, #140 Emeryville, CA 94608	Alameda
	WellBound San Leandro	(510) 383-9602	1040 Davis St, #101 San Leandro, CA 94577	Alameda
Durable Medical Equipment	**CHME***	(800) 906-0626	—	Alameda, Contra Costa, San Francisco, and San Mateo
	Sincere Care Management*	(415) 752-3288	—	
	Apria Healthcare	(888) 492-7742	—	
	Byram Healthcare	(877) 902-9726	—	
	Freedom Mobility Center	(510) 799-9920	—	
	Hygeia Health	(714) 515-7571	—	
	M&M Medical Supplies	(650) 758-1320	—	
	Pumping Essentials	(866) 688-4203	—	
	Sunrise Medical Supplies	**Alameda County** Oakland: (510) 893-1168 **San Francisco County** San Francisco: (415) 666-0933	—	Alameda and San Francisco
Emergency Care	CEP America	(800) 498-7157	—	San Francisco and San Mateo
Emergency Medical Transportation (EMT)	Royal Ambulance	(877) 995-6161	—	San Francisco and San Mateo
Gastroenterology	InSite Digestive Health Care	(415) 749-6900	2186 Geary Blvd, Ste 320 San Francisco, CA 94115 1850 Sullivan Ave, #520 Daly City, CA 94015	San Francisco and San Mateo
Hearing Aids	NationsHearing	(877) 439-2665	—	San Francisco and San Mateo
Home Health Services	21st century Home Health Services	(415) 801-2651	1633 Old Bayshore Hwy, #216 Burlingame, CA 94010	San Mateo
	AccentCare Home Health	(800) 734-1604	3170 Crow Canyon Pl Suite 270 San Ramon, CA 94583	Contra Costa
	American Care Quest	(415) 885-9100	819 Cowan Road, Suite C Burlingame, CA 94010	San Mateo
	Asian American Home Health	(510) 835-3268	1301 Marina Village Pkwy Ste 103, Alameda, CA 94501	Alameda
	Aspire Home Health	(510) 359-4556	3524 Breakwater Ave Ste A-130 Hayward, CA 94545	Alameda
	Aveanna Healthcare	(510) 568-2201	333 Hegenberger Road Suite 201 Oakland, CA 94621	Alameda
	BayHealth	(925) 3446-505	7027 Dublin Blvd, Suite 100 Dublin CA 94568	Alameda
	Carelink Home Health	(650) 375-8223	851 Burlway Rd, #502 Burlingame, CA 94010	San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Home Health Services	Crossroads Home Health Care & Hospice	(415) 682-2111	1109 Vicente Street, Ste 101 San Francisco, CA 94116	San Francisco
	Golden Pacific	(510) 373-2799	1151 Harbor Bay Pkwy #201Alameda, CA 94502	Alameda
	Harmony Home Health Services – San Francisco / Daly City	(415) 829-9008	295 89th St, #307 Daly City, CA 94015	San Mateo
	Health Now Home Healthcare	(415) 813-4885	Home-Based Services	Alameda and San Francisco
	HealthFlex Home Health Services	(888) 708-3539	Home-Based Services	Alameda and San Mateo
	HomeAssist Home Health Services	(855) 571-4663	355 Gellert Blvd, Ste 257 Daly City, CA 94015	San Mateo
	Mary's Help Home Health Services	(707) 645-7447	3469 Tennessee Street Vallejo, CA 94591	Contra Costa
	Self-Help for the Elderly	(415) 677-7600	**Alameda County** 2400 MacArthur Boulevard Oakland, CA 94602 **San Francisco County** 777 Stockton Street San Francisco, CA 94108 5757 Geary Boulevard San Francisco, CA 94121 1483 Mason Street San Francisco, CA 94133 737 Folsom Street San Francisco, CA 94107 131 Lenox Way San Francisco, CA 94127 801 Howard Street San Francisco, CA 94103 5050 Mission Street, Suite C San Francisco, CA 94112 500 Raymond Ave San Francisco, CA 94134 848 Kearny Street, #306 San Francisco, CA 94108 2601 40th Avenue San Francisco, CA 94116 3133 Taraval Street San Francisco, CA 94116 **San Mateo County** 50 East Fifth Avenue San Mateo, CA 94401 450 Poplar Avenue Millbrae, CA 94030	Alameda, San Francisco, and San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Home Health Services	Sutter Care at Home	**Alameda County** Alameda: (888) 395-2200 San Leandro: (855) 532-2700 **Contra Costa County** Concord: (925) 677-4240 **San Francisco County** San Francisco: (415) 749-4200 **San Mateo County** San Mateo: (650) 685-2800	**Alameda County** 1105 Atlantic Avenue Alameda, CA 94501 2953 Teagarden Street San Leandro, CA 94577 **Contra Costa County** 5099 Commercial Cir, #205 Concord, CA 94520 **San Francisco County** 2340 Clay St, #2a San Francisco, CA 94115 **San Mateo County** 1700 S Amphlett Blvd, #300 San Mateo, CA 94402	Alameda, Contra Costa, San Francisco, and San Mateo
	TrueMed Home Health	(650) 588-8331	400 Oyster Point Blvd, #201 South San Francisco CA 94080	San Mateo
	Vital Home Health Care	(510) 575-9898	1090 La Playa Drive, Suite 288 Hayward, CA 94545	Alameda
Home Infusion	AmeriPharma	(877) 778-0318	—	Alameda, Contra Costa, San Francisco, and San Mateo
	Option Care Health	**Alameda County** Hayward: (510) 264-5454 **San Francisco County** San Francisco: (800) 824-8400 **San Mateo County** Redwood City: (510) 264-1237	**Alameda County** 25901 Industrial Blvd Building E Hayward, CA 94545 **San Francisco County** 1700 California St, Suite 480 San Francisco, CA 94109 **San Mateo County** 2890 El Camino Real, Ste B Redwood City, CA 94061	Alameda, San Francisco, and San Mateo
	Soleo Health	(510) 362-7360	1324 W Winton Avenue Hayward, CA 94545	Alameda
Hospice	Bristol Hospice	**Alameda County** Pleasanton: (510) 573-4404 **Contra Costa County** Walnut Creek: (925) 400-9530	**Alameda County** 5820 Stoneridge Mall Road Suite 209 Pleasanton, CA 94588 **Contra Costa County** 1220 Oakland Blvd, Suite 350 Walnut Creek, CA 94596	Alameda and Contra Costa
	By the Bay Health	(415) 626-5900	180 Redwood Street, #350 San Francisco, CA 94102	San Francisco

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Hospice	Crossroads Home Health Care & Hospice	**Alameda County** Oakland: (510) 638-8033 **San Francisco County** San Francisco: (415) 682-2111	**Alameda County** 333 Hegenberger Road Oakland, CA 94621 **San Francisco County** 1109 Vicente Street, #101 San Francisco, CA 94116	Alameda and San Francisco
	Suncrest Hospice	**Contra Costa County** Walnut Creek: (925) 357-8262 **San Mateo County** Daly City: (415) 795-8824	**Contra Costa County** 1777 Botelho Dr, #240 Walnut Creek, CA 94596 **San Mateo County** 355 Gellert Blvd, #140 Daly City, CA 94015	Contra Costa and San Mateo
	Sutter Care at Home Hospice – San Francisco	(415) 749-4201	2340 Clay St, #2b San Francisco, CA 94115	San Francisco
	Vital Hospice Care	(510) 575-9898	1090 La Playa Drive Suite 289 Hayward, CA 94545	Alameda
	VITAS Healthcare	(415) 874-4400	1388 Sutter St, #700 San Francisco, CA 94109	San Francisco
Hospital	**Chinese Hospital***	(415) 982-2400	845 Jackson Street San Francisco, CA 94133	Alameda, Contra Costa, San Francisco, and San Mateo
	AHMC Seton Medical Center	(650) 992-4000	1900 Sullivan Ave Daly City, CA 94015	San Mateo
	Alameda Hospital	(510) 522-3700	2070 Clinton Ave Alameda, CA 94501	Alameda
	Alta Bates Summit Medical Center – Alta Bates Campus	(510) 204-4444	2450 Ashby Ave Berkeley, CA 94705	Alameda
	Alta Bates Summit Medical Center – Herrick Campus	(510) 204-4444	2001 Dwight Way Berkeley, CA 94704	Alameda
	Alta Bates Summit Medical Center – Summit Campus	(510) 655-4000	350 Hawthorne Ave Oakland, CA 94609	Alameda
	California Pacific Medical Center – Davies Campus	(415) 600-6000	Castro & Duboce Street San Francisco, CA 94114	San Francisco
	California Pacific Medical Center – Mission Bernal Campus	(415) 600-6000	3555 Cesar Chavez Street San Francisco, CA 94110	San Francisco
	California Pacific Medical Center – Pacific Heights Campus	(415) 600-6000	2333 Buchanan Street San Francisco, CA 94115	San Francisco
	California Pacific Medical Center – Van Ness Campus	(415) 600-6000	1101 Van Ness Avenue San Francisco, CA 94109	San Francisco
	Eden Medical Center	(510) 537-1234	20103 Lake Chabot Road Castro Valley, CA 94546	Alameda
	Highland Hospital	(510) 437-4800	1411 E 31st Street Oakland, CA 94602	Alameda

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Hospital	John George Psychiatric Hospital	(510) 346-1300	2060 Fairmont Drive San Leandro, CA 94578	Alameda
	Mills-Peninsula Medical Center	(650) 696-5400	1501 Trousdale Drive Burlingame, CA 94010	San Mateo
	San Leandro Hospital	(510) 357-6500	13855 E. 14th Street San Leandro, CA 94578	Alameda
	Sequoia Hospital	(650) 369-5811	170 Alameda de las Pulgas Redwood City, CA 94062	San Mateo
	St. Francis Memorial Hospital	(415) 353-6000	900 Hyde Street San Francisco, CA 94109	San Francisco
	St. Mary's Medical Center	(415) 668-1000	450 Stanyan Street San Francisco, CA 94117	San Francisco
	Stanford Health Care - Tri-Valley	(925) 847-3000	5555 W Las Positas Blvd Pleasanton, CA 94588	Alameda, Contra Costa, San Francisco, and San Mateo
	Stanford Medical Center	(650) 723-4000	300 Pasteur Drive Palo Alto, CA 94305	Alameda, Contra Costa, San Francisco, and San Mateo
	UCSF Benioff Children's Hospital San Francisco	(415) 476-1000	1975 4th Street San Francisco, CA 94158	Alameda, Contra Costa, San Francisco, and San Mateo
	UCSF Medical Center at Mission Bay	(415) 353-3000	1975 4th Street San Francisco, CA 94158	Alameda, Contra Costa, San Francisco, and San Mateo
	UCSF Medical Center at Mt. Zion	(415) 567-6600	1600 Divisadero Street San Francisco, CA 94115	Alameda, Contra Costa, San Francisco, and San Mateo
	UCSF Medical Center at Parnassus	(415) 476-1000	505 Parnassus Ave San Francisco, CA 94143	Alameda, Contra Costa, San Francisco, and San Mateo
Labs and Imaging	**Chinese Hospital***	(415) 677-2328	845 Jackson Street San Francisco, CA 94133	San Francisco
	Chinese Hospital Outpatient Center (386 Gellert Blvd)*	(650) 761-3550	386 Gellert Boulevard Daly City, CA 94015	San Mateo
	Bioreference Laboratories	(510) 792-2505 (415) 402-0650 (415) 441-2565	**Alameda County** 556 Mowry Ave, Suite #102 Fremont, CA 94538 **San Francisco County** 950 Stockton Street, Ste 201 San Francisco, CA 94108 2320 Sutter Street, Ste 204 San Francisco, CA 94115	Alameda and San Francisco
	Laboratory Corporation of America	—	https://www.labcorp.com/labs-and-appointments	Alameda, Contra Costa, San Francisco, and San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Labs and Imaging	Quest Diagnostics	(866) 697-8378	https://www.questdiagnostics.com/locations/search	Alameda, Contra Costa, San Francisco, and San Mateo
	Radnet Imaging Center	(310) 445-2800	https://www.radnet.com/northern-california/locations	Alameda, Contra Costa, and San Francisco
	SimonMed Imaging	(866) 614-8555	https://www.simonmed.com/locations/	San Francisco and San Mateo
Mental Health	**Comprehensive Psychiatric Services#**	**Alameda County** Newark: (510) 744-3688 Pleasanton: (925) 223-6157 **Contra Costa County** Walnut Creek: (925) 944-9711 **San Francisco County** San Francisco: (415) 928-1221 **San Mateo County** South San Francisco: (650) 301-4960	**Alameda County** 39899 Balentine Drive Suite 200 Newark, CA 94560 5924 Stoneridge Drive Suite 210 Pleasanton, CA 94588 **Contra Costa County** 3100 Oak Road, Suite 270 Walnut Creek, CA 94597 **San Francisco County** 2211 Post Street, Suite 200 San Francisco, CA 94115 **San Mateo County** 611 Gateway Boulevard Suite 210 South San Francisco CA 94080	Alameda, Contra Costa, San Francisco, and San Mateo
	David Lai, PHD (Psychologist)	(415) 608-7092	2485 Clay Street, #103 San Francisco, CA 94115	San Francisco
	Kadiant#	(866) 523-4268	Home-Based Services	Alameda, Contra Costa, San Francisco, and San Mateo
	Ling Orgel, PHD#	(415) 775-5998	Telehealth Only	San Francisco
	Richmond Area Multi-Services (RAMS)#	(415) 800-0699	4355 Geary Blvd San Francisco, CA 94118	San Francisco
	Scott Stutz MFT#	(916) 532-6397	Telehealth Only	Alameda, Contra Costa, San Francisco, and San Mateo
	Sutter Health (Psychiatrist - Sutter Pacific Medical Group)#	(415) 600-5959	601 Duboce Ave, Ste 250 San Francisco, CA 94107	San Francisco
Non-Emergency Medical Transportation (NEMT)	**ILI Medical Transportation***	(415) 672-2446	—	San Francisco and San Mateo
	MediChair Transportation	(415) 745-0202	—	San Francisco and San Mateo
	Uber Health	—	—	Alameda,

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
				Contra Costa, San Francisco, and San Mateo
Occupational Therapy	Sensational Kidz OT	(650) 731-5439	3100 Noriega Street San Francisco, CA 94122	San Francisco
Optometry	**Chinese Hospital Optometry* (386 Gellert Blvd)**	(650) 761-3521	386 Gellert Boulevard Daly City, CA 94015	San Mateo
	Avon Kwong, OD	(415) 982-0388	611 Broadway San Francisco CA 94133	San Francisco
	Clifford & Bradford Chang, OD	(415) 982-1700	929 Clay Street, Ste 203 San Francisco, CA 94108	San Francisco
	Crystal Clear Vision Center	(415) 677-9930	Turk Murphy Ln San Francisco, CA 94133	San Francisco
	Senoch Tong, OD	(415) 781-4524	899 Washington Street #6 San Francisco, CA 94108	San Francisco
	VSP Vision	(800) 877-7195	https://www.vsp.com/eye-doctor	Alameda, Contra Costa, San Francisco, and San Mateo
Orthotics and Prosthetics	**Hanger Prosthetics & Orthotics West***	(877) 442-6437	—	Alameda, Contra Costa, San Francisco, and San Mateo
	Sincere Care Management	(415) 752-3288	—	Alameda, Contra Costa, San Francisco, and San Mateo
Physical Therapy	**Chinatown Physical Therapy & Rehabilitation***	(415) 433-3318	728 Pacific Ave, STE 301 San Francisco, CA 94133	San Francisco
	Peninsula Orthopedic Associates*	(650) 756-5630	1850 Sullivan Ave, #330 Daly City, CA 94015	San Mateo
	Peninsula Sports Medicine and Rehabilitation Center*	(650) 755 8830	2945 Junipero Serra Blvd Daly City, CA 94014	San Mateo
	Robin Wong Physical Therapy*	(415) 421-5678	818 Jackson Street San Francisco, CA 94133	San Francisco
	Select Physical Therapy*	(800) 331-8840	https://www.selectphysicaltherapy.com/contact/find-a-location/	Alameda, San Francisco, and San Mateo
	JC Simpson & Associates RPT	(415) 433 3457	450 Sutter St, # 1003 San Francisco, CA 94108	San Francisco
	Lands End Physical Therapy	(415) 294-0266	44 Gough Street Floor 3 Ste 308 San Francisco CA 94103	San Francisco
	Motion SF Physical Therapy	(415) 418-6775	1202 Vicente Street San Francisco, CA 94116	San Francisco
Rx - Mail Order Pharmacy	MedImpact Direct	(855) 873-8739	—	Alameda, Contra Costa, San Francisco, and San Mateo
Rx - Preferred Pharmacy	**Chinese Hospital Pharmacy***	(415) 677-2430	845 Jackson Street 1/F San Francisco, CA 94133	San Francisco
	Chinese Hospital	(650) 761-3560	386 Gellert Boulevard	San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
	Pharmacy (386 Gellert Blvd)*		Daly City, CA 94015	
Skilled Nursing Facility	**Pacific Heights Transitional Care Center ***	(415) 563-7600	2707 Pine Street San Francisco, CA 94115	San Francisco
	San Francisco Campus for Jewish Living*	(415) 334-2500	302 Silver Avenue San Francisco, CA 94112	San Francisco
	The Avenues Transitional Care Center*	(415) 661-8787	2043 19th Avenue San Francisco, CA 94116	San Francisco
	AHMC Seton Medical Center - Coastside	(650) 563-7100	600 Marine Blvd, Moss Beach, CA 94038	San Mateo
	Bellaken Garden	(510) 536-1838	2780 26th Avenue Oakland, CA 94601	Alameda
	Berkeley Pines Care Center	(510) 649-6670	2223 Ashby Avenue Berkeley, CA 94705	Alameda
	California Pacific Medical Center – Davies Campus (SNF Unit)	(415) 600-6000	Castro & Duboce Street San Francisco, CA 94114	San Francisco
	Fairmont Rehabilitation and Wellness – (SNF Unit)	(510) 895-4200	15400 Foothill Blvd San Leandro, CA 94578	Alameda
	Golden Heights Healthcare	(650) 755-9515	35 Escuela Drive Daly City, CA 94015	San Mateo
	Golden Pavilion Healthcare	(650) 994-3203	99 Escuela Drive Daly City, CA 94015	San Mateo
	Grant Cuesta Sub-Acute and Rehabilitation Center	(650) 968-2990	1949 Grant Rd Mountain View, CA 94040	San Mateo
	Lawton Skilled Nursing & Rehabilitation Center	(415) 566-1200	1575 7th Ave San Francisco, CA 94122	San Francisco
	Los Altos Sub-Acute and Rehabilitation Center	(650) 941-5255	809 Fremont Ave Los Altos, CA 94024	San Mateo
	Marina Garden Nursing Center	(510) 523-2363	3201 Fernside Blvd Alameda, CA 94501	Alameda
	Palo Alto Sub-Acute and Rehabilitation Center	(650) 327-0511	911 Bryant Street Palo Alto, CA 94301	San Mateo
	San Francisco Health Care & Rehab	(415) 563-0565	1477 Grove Street San Francisco, CA 94117	San Francisco
Sleep Medicine	**SleepQuest Inc***	(800) 813-8358	1489 Webster Street # 203 San Francisco, CA 94115	San Francisco
	Westlake Sleep Center*	(650) 757-4813	341 Westlake Ctr, Ste 250 Daly City, CA 94015	San Mateo
	Bay Sleep Clinic	(866) 877-6673	2939 Summit St Oakland, CA 94609	Alameda

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Sleep Medicine	Jiva Health	Main Line: (510) 263-3300	**Alameda County** 2940 Summit St, # 1 Oakland, CA 94609 **Contra Costa County** 5173 Lone Tree Way Antioch, CA 94531 2182 East Street Concord, CA 94520 215 Lennon Ln, Suite 200 Walnut Creek, CA 94598 **San Francisco County** 909 Hyde Street, Suite #317 San Francisco, CA 94109	Alameda, Contra Costa, and San Francisco
	Golden Gate Sleep Center	Main Line: (925) 820-4472	**Alameda County** 39055 Hastings Street, Suite 106 Fremont, CA 94538 **Contra Costa County** 400 El Cerro Blvd, Suite 107 Danville, CA 94526	Alameda and Contra Costa
	Pulmonary Solutions	(408) 492-9504	2396 Walsh Ave A Santa Clara, CA 95051	San Mateo
Speech Therapy	Seven Bridges Speech Pathology	**Alameda County** Oakland: (510) 250-9199 Hayward: (510) 250-9199 Pleasanton: (510) 250-9199 **Contra Costa County** Martinez: (510) 250-9199 Walnut Creek: (510) 250-9199 Pleasant Hill: (510) 250-9199 **San Mateo County** San Mateo: (510) 250-9199 San Bruno: (510) 250-9199	**Alameda County** 345 38th Street Oakland, CA 94609 1638 B Street Hayward, CA 94541 4125 Mohr Ave, Ste G Pleasanton, CA 94566 **Contra Costa County** 300 Lodgepole Court Martinez, CA 94553 675 Ygnacio Valley Road Suite B-212 Walnut Creek, CA 94596 100 Longbrook Way, # 2 Pleasant Hill, CA 94523 **San Mateo County** 2015 Pioneer Court, Suite P2 San Mateo, CA 94403 462 San Mateo Ave, Suite A San Bruno, CA 94066	Alameda, Contra Costa, and San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Sports Medicine & Orthopedics	Burlingame Orthopedics and Sports Medicine Associates	(650) 692-1475	1838 El Camino Real, Suite 100, Burlingame, CA 94010	San Mateo
Urgent Care	Carbon Health Urgent Care	**Alameda County** Alameda: 2690 Fifth St (510) 439-9447 2671 Blanding Ave: (510) 694-4816 Albany: (510) 439-9496 Berkeley: (510) 686-3621 Oakland: (510) 844-4097 **Conta Costa County** Antioch: (925) 204-3715 Concord: (925) 320-0854 Martinez: (925) 293-9163 **San Francisco County** 1390 Market St: (415) 918-5766 1998 Market St: (415) 792-6040 2131 Irving St: (415) 231-2546 3251 20th Ave: (415) 480-1160 **San Mateo County** San Mateo: (650) 769-5612	**Alameda County** 2690 Fifth St Alameda, CA 94501 2671 Blanding Ave Alameda, CA 94501 1080 Monroe St Albany, CA 94706 2920 Telegraph Ave Berkeley, CA 94705 411 Grand Ave Oakland, CA 94610 **Contra Costa County** 5829 Lone Tree Way Antioch, CA 94531 5434 Ygnacio Valley Rd Concord, CA 94521 1125 Arnold Dr Martinez, CA 94553 **San Francisco County** 1390 Market St San Francisco, CA 94102 1998 Market St San Francisco, CA 94102 2131 Irving St San Francisco, CA 94122 3251 20th Ave San Francisco, CA 94132 **San Mateo County** 46 Hillsdale Mall San Mateo, CA 94403	Alameda, Contra Costa, San Francisco, and San Mateo
	GoHealth Urgent Care	**Alameda County** Oakland: (415) 432-7899 **San Francisco County**	**Alameda County** Oakland: 3900 Piedmont Ave Oakland, CA 94611 **San Francisco County** 2288 Market St	

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Urgent Care	GoHealth Urgent Care	2288 Market St: (415) 964-4855 930 Cole St: (415) 964-4789 2895 Diamond St: (415) 964-4866 2395 Lombard St: (415) 796-2242 170 Columbus Ave: (415) 965-8050 199 West Portal Ave: (415) 821-8798 **San Mateo County** Daly City: (650) 270-2394 Redwood City: (650) 381-0616 San Bruno: (650) 270-2395	San Francisco, CA 94114 930 Cole Street San Francisco, CA 94117 2895 Diamond St San Francisco, CA 94131 2395 Lombard St San Francisco, CA 94123 170 Columbus Ave San Francisco, CA 94133 199 West Portal Ave San Francisco, CA 94127 **San Mateo County** Daly City: 325 Gellert Blvd Daly City, CA 94015 Redwood City: 830 Jefferson Ave Redwood City, CA 94063 San Bruno: 1310 El Camino Real San Bruno, CA 94066	Alameda, San Francisco, and San Mateo

SECTION 6
CREDENTIALING AND RE-CREDENTIALING

The Chinese Community Health Plan (CCHP) has developed and adopted a Credentialing Program. The Credentialing Program is updated as necessary and reviewed annually within the Quality Improvement Committee.

Section 6.1 Credentialing Program

PURPOSE

The Credentialing Program selects and evaluates the practitioners who practice within the CCHP delivery system. The purpose of the Credentialing Program is to ensure that performance criteria and standards for credentialing and recredentialing licensed health care providers and organizational providers are met according to state, federal, and other regulatory agencies including contracted HMOs.

GOAL

Ensure patient safety by having all physicians and other health practitioners who provide direct patient care are credentialed when initially joining the association and every three years thereafter on the date of license expiration, date of original credentialing, or in accordance with standards established by state and federal licensing agencies and other accrediting agencies.

SCOPE OF PROGRAM

A. The initial credentialing process is applied to all licensed independent practitioners with whom CCHP contracts or employs and who fall within the scope of CCHP's authority and action.

B. All contracted practitioners participating on the provider panel and published in any external directories shall be credentialed. Practitioners who take call for long term coverage of participating providers; i.e. locum tenens shall be credentialed.

C. Each provider will have a confidential credentials file that contains credentials information as well as quality assurance/utilization information. All information shall be kept current as applicable. All providers agree to report immediately any change in status of the information maintained.

D. Any adverse matters discovered during the business of any program relating to quality of care or utilization is referred to the Quality Improvement (QI) Committee for investigation.

ORGANIZATION STRUCTURE

A. Governing Body

1. The Board of Trustees has the ultimate responsibility for performance of credentialing and membership activities by establishing and supporting the Credentialing and Recredentialing Program.
2. The Board of Trustees has delegated the ongoing and continuous oversight of the Credentialing and Recredentialing Program to the Credentialing Program. The program is delegated to approve credentialing files for new and existing providers.
3. The Board of Trustees has the ultimate responsibility for determining provider membership.
4. The CCHP's Board of Trustees shall annually receive and review the Credentialing Program. Upon determining that the program requires updates to its processes, the program will be revised as needed. The Board of Trustees shall receive written reports from the Credentialing Program on a quarterly basis that delineate the actions taken and recommendations of the Credentialing Program. The Board of Trustees takes appropriate action on the recommendations of the Credentialing Program and provides feedback to the Credentialing Program.
5. The implementation and monitoring of the Credentialing Program is delegated to the CCHP Administrative and Medical Departments.

B. The CCHP Chief Medical Officer, a senior physician, who has an unrestricted license in the State of California, has substantial managed care experience, and has the responsibility for the development and implementation of the Credentialing and Recredentialing Program, reporting activities to the Board of Trustees and providing feedback. The Chief Medical Officer has a substantial time involvement in the process.

C. The Chief Medical Officer has the authority to review and approve clean applications. An application is clean when it meets all of the following criteria:
- A current, valid license to practice medicine in California
- An active DEA certificate (if applicable)
- Verification of medical school completion, residency training and fellowship
- Verification of board certification (in specialty awaiting approval)
- Professional liability insurance that meets the minimum requirements
- Practitioner must not be currently precluded, excluded, expelled or suspended from any State or federally funded program including, but not limited to, the Medicare or Medicaid programs.
- Practitioner must not be listed as an excluded provider on the Officer of Inspector General
- Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including, but not limited to, healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.

D. The CCHP Chief Executive Officer has the responsibility to allocate sufficient resources and staff for credentialing and recredentialing activities.

E. The Credentialing Chair has the following general responsibilities:
1. Preside over all meetings of the Credentialing Program.
2. Designate a plan of action for questions and problems arising from program activities, the person who is to carry out the action and the time frame the action is to be performed in.

3. Notify applicants and members, in writing, of the decisions and recommendations of the Credentialing Program.
4. Notify the Board of an adverse determination, i.e. an applicant does not meet the requirement for membership; a designation determination is denied; a serious quality problem is identified for which the program recommends suspension or termination.

CREDENTIALING PROGRAM FUNCTIONS

A. Credentialing and re-credentialing providers.

B. Designation as primary and/ or specialty provider.

The Credentialing Program will review the application of each new member and determine the designation of the provider as either primary care and/or specialty provider. Specialists must have board certification or the equivalent in education and experience. OB/GYN physicians may qualify as Primary Care physicians using the American College of Obstetricians and Gynecologists published in May 1995 (Attachment B) and show proof of primary care practitioner education at the time of making application to be Primary Care.

C. Organizational Providers include, but is not limited to hospitals, home health agencies, skilled nursing facilities and nursing home, and freestanding surgical centers.

1. Credentialing. Before contracting, confirmation of state and/or federal licensure shall be done; and documentation of review by an approved accrediting body shall be obtained, or if an accrediting body does not approve the entity, the provider shall be subject to an onsite and medical record review.
2. Re-credentialing. At least every three years, confirmation of state and/or federal licensure shall be done and, if applicable, the review and approval by an accreditation body is confirmed; or if not approved by an accrediting body, the provider shall be subject to an onsite and medical record review.

D. Peer Review Function

1. Approve the acceptance or continued membership of physicians (MD/DO), oral surgeons, dentists, podiatrists, and allied and behavioral health practitioners and any other licensed professionals acting within the scope of their licenses or other authorizations to practice.
2. Recommend a waiver or the denial of acceptance of a candidate to the CCHP Board of Directors.
3. Recommend corrective actions; including counseling, financial sanctions or termination in cases of inappropriate quality care to the Board of Trustees
4. Notify contracted Plans of such actions, as may be requested by contract Plan.

E. Disciplinary action and the reporting of such actions to the proper authorities is the responsibility of the Board of Trustees.

F. Delegation

Primary Source Verification

a. The CCHP delegates primary source verification of credentialing/re-credentialing elements to the Council for Affordable Quality Healthcare, Inc (CAQH), a credentials verification organization that is certified by NCQA. Elements that are verified and encompassed by CAQH include:
    1. An attestation by the provider that the information provided is accurate
    2. Board Certification or State License information including issue and expiration dates
    3. The school for the provider's education as well as the graduation year
    4. The work history for the provider as well as gap times
    5. Malpractice insurance amounts including effective and expiration dates
    6. Malpractice History and dates of cases, if applicable
    7. Disciplinary Sanctions and dates of cases, if applicable
    8. Medicare/Medicaid Sanctions and dates of cases, if applicable
    9. Confirmation of listings on OIG or SAM
    10. Confirmation of Medicare Opt-Out statuses
b. The contractor will maintain a file that contains all of the required elements.
c. The CCHP will annually evaluate the delegated agency to ascertain that the delegated activities are being conducted in accordance with the CCHP's standards and state, federal, and other accrediting agency requirements.
d. The CCHP will maintain a file on each provider. The file will contain a copy of primary source verification materials from the delegated agency, member complaints, information from quality reviews, utilization management, member satisfaction, office review, and medical record surveys if applicable.
e. CCHP retains the right, based on quality issues, to approve new practitioners, providers, and sites and to terminate or suspend individual practitioners.

G. Managing Files That Meet Criteria:

The Provider Network Management team will submit all practitioner files to the Credentialing Program for review or clean credentialing and re-credentialing files to the CCHP Chief Medical Officer or the Chair of the Credentialing Program for a decision.

Clean credentialing and re-credentialing files are up-to-date on all primary source verification documents, malpractice insurance, board certifications (if applicable) and no new, pending or recently resolved malpractice lawsuits. Evidence of review and approval is a handwritten signature or handwritten initials in the practitioner's credentialing or recredentialing file. The files will be presented at the following Credentialing Program meeting for Committee approval.

CREDENTIALING PROGRAM

A. Structure

1. The members of the program shall consist of an appropriate range of disciplines, i.e., Pediatrics, Family Practice, OB/GYN, Medicine and Surgery, to assure that each component of clinical performance is monitored and that corrective action is taken when indicated.

- The credentialing process can encompass separate review bodies for each practitioner type (e.g., oral surgeon, psychologist) specialty or multidisciplinary committee with representation from various types of specialties.

2. The chairperson and all members of the program will be appointed annually by the CCHP's Board of Directors for a term of one year. The terms are renewable.
3. The CCHP Chief Executive Officer shall be an ex officio member of the program.
4. The CCHP Quality Improvement Director is a non-voting member of the program.
5. Includes at least one participating provider who has no other role in organization management, i.e. CCHP QI Nurse Reviewer.
6. Includes at least one participating provider who does not have an affiliation with CCHP.

B. Responsibilities

1. Review credentialing files for all practitioners whom CCHP have direct contracts with and who fall within the scope of CCHP's authority and action including those who take call for long term coverage of participating providers (i.e. locum tenens).
2. Selection, evaluation, and credentialing of applicants for membership in the CCHP.
3. Every three years recredential and evaluate members for continuation in CCHP.
4. Evaluation and designation of members as primary care, specialist, or both.
5. Evaluation of the qualifications of members who wished to change their designation.
6. Oversight of delegated activities.
7. Submission of recommendations on membership, designation and qualifications of applicants and members to the Board.
8. Evaluation and ongoing assessment of organizational providers with which CCHP intends to contract.
9. Provide advice and expertise for credentialing decisions
10. Discusses whether providers are meeting reasonable standards of care.
11. Accesses appropriate clinical peer input when discussing standards of care for a particular type of provider.
12. Has final authority to:
    - Approve or disapprove applications by providers for organization participation status
    - Delegate such authority to the senior clinical staff person for approving clean credentialing applications, provided that such designation is documented and provides reasonable guidelines
13. Provides guidance to organization staff on the overall direction of the Credentialing Program

C. Decision Process to Approve or Deny Credentialing File

Once the Credentialing Program has reviewed the credentialing files, each program reviewer must refer to the Program Reviewer's Recommendation sheet to answer the question *Do you approve of the applicant?* And check one of the following options:

- Yes - Approve a provider's credentials
- Yes – Pending action or correction of the following issue(s)
- No – Provide a reason for denial and/or action that need to be taken

- Defer – Further information is required (This option may only be used for new applicants and recredentialing providers)
- Yes – Interim privileges until Credentialing Program meets

The program reviewer, if applicable, must print their name, sign and date the program review on the Program Reviewer's Recommendation for each file they reviewed.

The final credentialing decision shall be made within 60 calendar days of the Credentialing Committee decision. The final credentialing decision will follow the receipt of the completed provider credentialing application. For this process, the Chair of the Program must then sign each of the files reviewed during the Credentialing Program to ensure that the file Program Reviewer has selected an appropriate decision and signed the recommendation sheet.

D. Credentialing Decision Notification

Following the Credentialing Committee's decision, the applicant shall be notified with written notification within 7 business days to verify receipt and to inform them that their application has been completed. They will be notified that their application is awaiting the final credentialing decision.

Following a provider or organization's final credentialing decision, they will be notified within 30 calendar days. The notification will be completed by the party that prepared the credentialing documents (Provider Network Management Department). The notification will be carried out through the same interface that was used by the provider/group to communicate the original request for credentialing and will be written (i.e. if the original request was made through email, the notification would be through email as well).

E. Credentialing Rejection Process

All of CCHP's providers listed on the CCHP Provider Directory must be credentialed. In the situation that a provider or organization is not approved during the credentialing process, they will be referred to the Contracting Department to have their existing contract terminated if applicable. The respective provider or organization will not be incorporated into CCHP's existing provider network and will be prohibited from being listed on the CCHP Provider Directory.

F. Provisional Credentialing

The Chief Medical Officer or Credentialing Program may provisionally credential a new applicant on a one-time basis. It is required that the following elements are obtained and appropriately verified:

- Current, valid medical license in state(s) where treating patients
- Past five years of malpractice history
- Current, signed application and attestation

Only applicants whose education and training were completed within the past 12 months are eligible for this streamlined process.

Provisional credentialing is only valid for 60 calendar days. By that time, CCHP must

complete the full credentialing process using the Chief Medical Officer or Credentialing Program review process, as appropriate. The time limit for provisional credentialing is not defined and only requires that the full process be completed as quickly as possible.

G. Schedule

1. Quarterly or more frequently, if necessary. Conference calls are permitted. The minutes of all meetings, including real-time virtual meetings (e.g., through video conferencing or Web conferences with audio), conference calls, shall be documented and include a list of the attendees. Meetings may not be conducted only through e-mail.
2. If required, the Program Chairman may call a special meeting of the Program. The Chairman shall notify all program members of the date, time, place and purpose of the meeting. Members must be given at least one business day notification of the meeting.

H. Minutes

1. Contemporaneous dated signed and reflects the program's decisions. All attendees at the meeting are documented.
2. An agenda is used at each meeting. (Attachment: Sample Agenda).
3. The minutes shall contain the results of all business discussed at the meeting.
4. Topics include but are not limited to review of credential/recredentialing materials, office and medical record reviews, plan/policy review, program recommendations, and the review and assessment of organizational providers.
5. Minutes shall be produced within two weeks before the next meeting.
6. All records shall be maintained for a period of five years or as required by state and federal law.

I. Confidentiality

Credentialing Program's activities are confidential and are considered neither discoverable nor admissible in a court of law. In addition, the Health Care Membership Act was enacted to provide a mechanism to improve the quality of medical care. The act provides immunity from liability for damages with respect to actions taken in the course of such review. Peer review records and proceeding will be kept confidential according to Section 1157 of the California Evidence Code.

1. Confidentiality Statements are to be annually signed by all physicians, support personnel and guests who attend Credentialing Program meetings.
2. The proceedings and all documents and files of the program are under the direct supervision of the Chief Medical Officer and are maintained in a secure locked area.
3. Members of the Program will not discuss the proceedings or release documents of the Program activities to any individual who is not a member of the Program. Members may not discuss confidential aspects of Program proceedings with physicians or other individuals whose professional activities are subject to review by the Program. The Program may also discuss aspects of the case with others whose expertise is required.

J. Identification

All references to physicians reflected in the Program minutes shall be by Physician number. All references to the patients in the minutes shall be by a de-identified identification number.

K. Conflict of Interest

No program members 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 except to provide information as requested by the Program. If it is necessary to seek outside reviewers in order to eliminate a conflict of interest and assure an objective determination, such will be done.

L. Quorum

The presence in person of 51% of program members shall constitute a quorum for the transaction of business. A majority of votes cast at a meeting duly called, and at which a quorum is present, shall be required to take action. The members present at a meeting may continue to do business until adjournment, notwithstanding the withdrawal of enough members to leave less than a quorum.

M. Voting

Each physician program member shall be entitled to one vote on each matter submitted to a vote at a meeting. Vote by proxy shall not be permitted. Program members may also take action by written ballot. The number of ballots required for a quorum shall be the same as the number of members and votes required at a meeting. In case of a tie vote, the chair shall have the deciding vote.

N. Reporting

Credentialing Program activities will be reported to the CCHP's Board of Trustees through quarterly reports. The program shall notify the QI Committee of members who were credentialed or recredentialed, and if any quality or utilization problems were identified. Reports to include evaluation to Board of Trustees on the effectiveness of the Credentialing Program.

O. HMO Contracts

On written request from a contracted plan, minutes of meetings related to that contracted HMO business, are available for onsite review for verification of delegated responsibilities.

Section 6.2 Practitioner Termination, Appeal Rights, and Fair Hearing

Objectives and Evaluation:

To ensure that providers are entitled to an appeal and fair hearing when reduction, suspension, or termination of a provider's affiliation with CCHP is being considered.

This policy, including applicable processes and procedures, will be reviewed by CCHP and participating providers at least once every three (3) years.

Policy:

A practitioner's status or participation in CCHP's 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, required medical staff privileges, 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.

Practitioners have the right to appeal any decision that impacts their network status or participation with CCHP, in accordance with the appeal procedures provided herein.

The appeal process is available to any participating health care practitioner who wishes to initiate it.

CCHP's appeal process will consist of two levels:

1. A first level appeal that will consist of a review that is not a legal hearing
2. A second level appeal that will consist of a review that includes a legal hearing

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. Practitioners must appeal directly to CCHP for any adverse decisions rendered by CCHP.

Standards:

1. CCHP's Quality Improvement Committee reviews provider appeals for adverse decisions pertaining to network status and participation
2. 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
3. For any provider denied network participation or status, CCHP sends written notification by electronic or certified mail, return receipt or acknowledgement requested, within ten (10) business days of the decision. 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, business, or directive guidelines
    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
    VIII. Felony convictions
c) A statement that the practitioner may request a Level I Appeal conducted by CCHP in accordance with this policy
d) Provider is notified that a request for an appeal must be received in writing and addressed to CCHP's Chief Executive Officer or Chief Medical Officer and received within thirty (30) business 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
    II. A request to exercise the right to present the appeal in person, if desired
e) A copy of the CCHP Level I Appeal process shall be provided with the notice for appeal. The notice will state:
    I. A brief summary of the practitioner's rights at the Level I Appeal
    II. That the Level I Appeal shall take place before CCHP's Quality Improvement Committee
    III. 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
f) If the Level I Appeal is not requested by the practitioner within the timeframe required and in the manner specified, all administrative Level I Appeal rights of the practitioner shall be deemed waived, and the decision made by CCHP's Quality Improvement Committee shall be final

4. In instances where there may be an imminent danger to the health of any individual, CCHP's Chief Medical Officer and/or CCHP's Quality Improvement Committee may summarily restrict or suspend the participating practitioner's privilege to provide patient care services, effective immediately upon written notice to the practitioner. CCHP's Quality Improvement Committee may continue to enforce the reduction or suspension pending further action.
5. Appeal Resolution Timeline:

- Practitioner request for appeal: Within 30 business days of notice

- CCHP scheduling of Level I Appeal: Within 30 business days of request
- Communication of Level I Appeal decision: Within 10 business days of the appeal
- Practitioner request for Level II Appeal: Within 30 business days of Level I Appeal decision
- Scheduling of Level II Appeal: Within 60 calendar days of request
- Communication of final decision: Within 60 calendar days after hearing closure

Section 6.3 Level I Appeal

Scope:

The following applies to all practitioners participating or requesting participation as a provider for CCHP, including but not limited to 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), Speech/Language Therapists (S/LT), 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.

Standards:

1. The Level I Appeal is not a legal hearing, and the procedural rights associated with formal peer review hearings do not apply. At a Level I Appeal, practitioners may not be represented by a licensed attorney.
2. 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, required medical staff privileges, 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, business, or directive guidelines, or a change in CCHP's business needs
3. To provide a mechanism for peer review of CCHP providers and a mechanism for appropriate action such as a process for the practitioner to request a review of negative peer review recommendations, decisions, and actions for any reason related to quality-of-care issues, non-quality of care issues, professional conduct, and credentialing requirements as requested by CCHP's Quality Improvement Committee or CCHP's Chief Medical Officer regarding practitioner status including but not limited to:
    I. Denial
    II. Reduction
    III. Suspension
    IV. Termination

4. All credentialing, appeal, and proceeding records shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law

Procedure:
Explicit time frames for each step from initiation to resolution are defined as follows:

- Practitioner must request appeal within 30 business days of notice
- CCHP to schedule appeal within 30 business days of request
- Decision to be communicated within 10 business days of the appeal

If an appeal is submitted in a timely manner, CCHP arranges for a review to be conducted at the next scheduled meeting of CCHP's Quality Improvement Committee which is on a quarterly basis. CCHP will send a written notice to the practitioner via electronic or certified mail informing the practitioner of the date, time, and place of the meeting within thirty (30) business days of receipt of the appeal. CCHP will also require that the provider acknowledges that the electronic or certified mail has been received.

The practitioner's written response to the notice of action or proposed action shall be summarized in or attached to a report to CCHP's Quality Improvement Committee which shall be written by CCHP's Chief Medical Officer.

CCHP's Quality Improvement Committee shall have the discretion to prescribe such additional procedural elements as it deems appropriate to the circumstances.

Rights:

A summary of the practitioner's rights will be provided at the appeal, and it will be held before CCHP's Quality Improvement Committee. This will list:

i. The right to present any additional written material to CCHP's Quality Improvement Committee
ii. The right to present any information in person to CCHP's Quality Improvement Committee
iii. The right to be represented by a non-attorney representative of their choice

Evaluation:

When CCHP's Quality Improvement Committee completes its evaluation and renders a decision to uphold or overturn the denial, the practitioner is notified in writing of the appeal determination within ten (10) business days of the decision.

Upheld Decision

In cases where the decision by CCHP's Quality Improvement Committee for the Level I

Appeal results in the denial, suspension, reduction, or termination of the practitioner's network participation or status with CCHP, the written notice will include the following:

a. The Level I Appeal decision, including a brief description of the proposed recommendation, decision, or action
b. The reasons for the Level I Appeal decision, including explanation and reference to evidence or documentation
c. The action, if implemented, must be reported to the MBOC, OMBC, CBO, or NPDB, under California Business and Professions Code, Section 805, as applicable, or under any other applicable federal or state law
    I. Actions that are reported include decisions to restrict, reject, or terminate a practitioner's application or participation for staff privileges, membership for a medical discipline, or employment
d. The practitioner will be notified of the reports and their contents sent to the MBOC, OMBC, CBO, or NPDB, under California Business and Professions Code, Section 805, as applicable, or under any other applicable federal or state law
e. That the practitioner may request a Level II Appeal hearing in person
f. That a Level II Appeal hearing must be requested in writing, within thirty (30) business days of receipt of the notice by the practitioner and that it must be submitted in writing, directed to CCHP's Chief Executive Officer or Chief Medical Officer
g. A brief summary of the practitioner's rights with respect to the Level II Appeal hearing including:
        I. Representation by legal counsel if a majority of the Board of Trustees members, in their discretion, permit both sides to be represented. Practitioners are required to notify CCHP if they intend to be represented by legal counsel. CCHP may not be represented by an attorney if the practitioner is not as well. Both parties shall have the right to the assistance of an attorney in the preparation of the hearing. If attorneys are not allowed in the hearing, the practitioner and CCHP may be represented at the hearing by a licensed practitioner who is not an attorney.
h. The Level II Appeal proceeding shall take place before a Hearing Officer, selected by CCHP's Chief Medical Officer and will be considered as a legal hearing
i. A statement that the practitioner is required to utilize the Level II Appeal hearing prior to seeking judicial review of the recommendations, decisions, or actions of CCHP's Quality Improvement Committee
j. Practitioners who do not request a Level II Appeal within the required timeframe and meet requirements shall be deemed to have accepted the recommendation, decision, or action involved, and shall be deemed to have waived all further appeal rights, and the recommendation, decision, or action may be adopted by CCHP's Quality Improvement Committee as CCHP's final action
k. The practitioner may re-apply after one (1) year of termination or denial

Section 6.4 Level II Appeal

Scope:

The following applies to all practitioners participating or requesting participation as a provider for CCHP, including but not limited to 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), Speech/Language Therapists (S/LT), 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.

Standards:

1. The Level II Appeal is a legal hearing, and the procedural rights associated with formal peer review hearings apply
2. The hearing panel will include an actively-practicing clinical peer of the practitioner who is not involved in network management
3. 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, required medical staff privileges, 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, business, or directive guidelines, or a change in CCHP's business needs
4. To provide a mechanism for peer review of CCHP providers following a Level I Appeal and a mechanism for appropriate final action such as a process for the practitioner to request a review of negative peer review recommendations, decisions, and actions for any reason related to quality-of-care issues, non-quality of care issues, professional conduct, and credentialing requirements as requested by CCHP's Quality Improvement Committee or CCHP's Chief Medical Officer regarding practitioner status including but not limited to:
    I. Denial
    II. Reduction
    III. Suspension
    IV. Termination
5. All credentialing, appeal, and proceeding records shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law
6. All activities conducted pursuant to the 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)

7. 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 judged unconstitutional or invalid, such unconstitutionality or invalidity shall affect only that part, sentence, paragraph, section, or clause of this document, person, or entity; and shall not affect or impair any of the remaining provisions, parts, sentences, paragraphs, sections, clauses of this document, or its application to other persons or entities.
8. This policy shall be applicable to all Level II Appeals and shall be controlling

Procedure:

Explicit time frames for each step from initiation to resolution are defined as follows:

- Practitioner must request Level II Appeal within 30 business days of Level I Appeal decision
- Level II Appeal to be scheduled within 60 calendar days of request
- Final decision to be communicated within 60 calendar days after hearing closure

As a health care service plan, CCHP is defined as a peer review body under applicable law. Certain peer review functions are the responsibility of CCHP's Quality Improvement Committee. The hearing of a Level II Appeal is to be delegated to the Board of Trustees following the completion of a Level I Appeal.

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 written notice via electronic or certified mail of the time, place, and date of the hearing at least sixty (60) calendar days prior to the date of the hearing. This notice will include:

- An explanation of the reasons for the proposed adverse action
- Reference to the evidence or documentation for the propose adverse action
- A description of practitioner's right to be represented by legal counsel

The time frames set forth herein may be shortened or extended for a reasonable time by mutual written agreement of the parties if the Hearing Officer has not been appointed yet.

The peer review process shall be completed within a reasonable time after the practitioner has received notice of the final proposed action, an immediate suspension, or restriction of clinical privileges or consented to the delay in the proceedings.

Hearing Officer

CCHP shall appoint a Hearing Officer to preside over the hearing. The Hearing Officer shall be an attorney at law who has been admitted to practice before the courts of California for at least five (5) years prior to appointment and is qualified by knowledge and experience to preside over a quasi-judicial 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, an advocate for CCHP, 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 a legal advisor to it, but they shall not be entitled to vote. The Hearing Officer will be sent a letter of appointment by CCHP's Quality Improvement Committee.

The duties of the Hearing Officer shall be:

a. To preside over the hearing, including any pre-hearing and/or post-hearing procedural matters
b. To rule on the challenges to the impartiality of Board of Trustee members and/or the Hearing Officer
c. To rule on requests for access to information and/or relevancy
d. To rule on requests for continuances
e. To rule on evidentiary and burden of proof issues
f. To prepare the written report and recommendation to the Board of Trustees
g. To perform other necessary or appropriate functions to facilitate completion of a fair hearing process as expeditiously as possible

Discovery

Rights of Discovery and Copying

The practitioner may inspect and copy at their own expense any documents relevant to the charges that CCHP's Quality Improvement Committee possesses or controls after the practitioner's request for a Level II Appeal. CCHP's Quality Improvement Committee shall have the right to inspect and copy at its own expense any documents relevant to the charges that the practitioner has in their possession or control after the practitioner receives a request from CCHP's Quality Improvement Committee for such documents.

The right of discovery and copying does not require documents to be modified or created to satisfy the request for information. The right to inspect and copy by either party does not extend to confidential information that identifies providers other than the practitioner for review. Failure to comply with reasonable discovery requests at least ten (10) business days prior to the Level II Appeal hearing shall be a good cause for a continuance of the Level II Appeal hearing.

Limits on Discovery

The Hearing Officer, upon the request of either side, may impose safeguards including but not 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 consider:

a. Whether the information sought may be introduced to support or defend the charges

b. 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
c. The burden on the party of producing the requested information
d. Other discovery requests the party has previously made or has previously resisted

Pre-Hearing Witness List and Document Exchange

At least (10) business days prior to the 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.

Representation

Practitioners are required to notify CCHP if they intend to be represented by legal counsel. CCHP may not be represented by an attorney if the practitioner is not as well. Both parties shall have the right to the assistance of an attorney in the preparation of the hearing. If attorneys are not allowed in the hearing, the practitioner and CCHP may be represented at the hearing by a licensed practitioner who is not an attorney.

Failure to Appear

Failure, without good cause, of the practitioner to appear at the Level II Appeal shall be deemed to constitute voluntary acceptance of the recommendation or action decided by CCHP’s Quality Improvement Committee and it shall thereby be considered as the final decision.

Postponements and Extensions

Postponements and extensions of time beyond the times expressly permitted in this Level II Appeal process may be affected upon written agreement of the parties or granted by the Hearing Officer. Reasons would include a showing of good cause and are subject to the Hearing Officer’s discretion to assure that the hearing proceeds and is completed in a reasonably expeditious manner under the circumstances.

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 their 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.

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
e. To submit a written statement at the close of the hearing

The practitioner may be called by CCHP'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.

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 the conduct of serious affairs. A practitioner shall not be permitted to introduce information that has not been requested by 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 provided previously as reasonable.

Basis of Recommended Decision

The recommended decision of the Board of Trustees shall be based on, and may not be limited to, the evidence produced at the hearing and any written statements submitted to the Board of Trustees.

Burden of Going Forward and Burden of Proof

In all Level II Appeals, CCHP shall have the burden of initially presenting evidence to support its recommendation, decision, or action.

a. If CCHP's Quality Improvement Committee recommends denying initial CCHP affiliation, the practitioner shall bear the burden of persuading the

Board of Trustees that they are qualified to have affiliation in accordance with the professional standards of CCHP. This burden requires the production of information that allows for evaluation and resolution of reasonable doubts concerning the practitioner's qualifications, subject to CCHP's right to object to the production of certain evidence as provided herein. A practitioner shall not be permitted to introduce information not requested by the peer review body during the application process, unless the initial applicant establishes that the information could not have been provided previously as reasonable.

b. If CCHP's Quality Improvement Committee's action involves the termination, suspension, reduction, or limitation of privileges to perform patient care services for existing participation, CCHP 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" is defined to be 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.

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 CCHP's Chief Medical Officer, the practitioner involved, and CCHP's Chief Executive Officer.

Final action shall be taken by CCHP's Quality Improvement Committee. There shall be no right of further appeal to the CCHP Quality Improvement Committee following a formal Level II Appeal. The practitioner shall receive a written decision from the Quality Improvement Committee, including a statement of the basis for the decision, which shall be sent via electronic or certified mail within sixty (60) calendar days of the completion of the hearing closure.

Upheld Decision

If the decision by CCHP's Quality Improvement Committee for the Level II Appeal results in the denial, suspension, reduction, or termination of the practitioner's network participation or status with CCHP, the written notice will include the following:

a. The notice shall contain a statement that there is no right to appeal the final decision of the Level II Appeal of CCHP's Quality Improvement Committee
b. The Level II Appeal decision, including a brief description of the proposed recommendation, decision, or action

c. The reasons for the Level II Appeal decision, including explanation and reference to evidence or documentation
d. The action, if implemented, must be reported to the MBOC, OMBC, CBO, or NPDB, under California Business and Professions Code, Section 805, as applicable, or under any other applicable federal or state law
    I. Actions that are reported include decisions to restrict, reject, or terminate a practitioner's application or participation for staff privileges, membership for a medical discipline, or employment
e. The practitioner will be notified of the reports and their contents sent to the MBOC, OMBC, CBO, or NPDB, under California Business and Professions Code, Section 805, as applicable, or under any other applicable federal or state law
f. The practitioner may re-apply to CCHP's network after one (1) year of termination or denial

Costs of Hearing

The costs associated only with the conduct of the Level II Appeal hearing 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.

The costs to be divided between the practitioner and 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 the Board of Trustees, which shall be borne by CCHP, each party shall bear their own costs for these items individually.

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).

Timely access involves physicians 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 30 minutes. Please review "Section 7.4 Appointment and Availability Standards" below 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 handled by Carenet Health 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.

Section 7.3 After Hours Instructions

CCHP 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 are dealing with a life-threatening situation, 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 30 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	96 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. DMHC approved vendor QMetrics verifies that primary care providers meet Advanced Access Verification requirements by conducting phone calls to confirm same day or next business day appointment availability from the time an appointment is requested. An advanced access provider is required to give written notice to the plan no more than 30 calendar days after provider stops offering advanced access appointments.
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

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 (TTY 1-877-681-8898).
October 1 - March 31: 7 days a week from 8:00 a.m. to 8:00 p.m.
April 1 - September 30: Mondays – Fridays 8:00 a.m. to 8:00 p.m.

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 healthcare coverage. To request a free translation, please call 1-888-775-7888 (TTY 1-877-681-8898).
October 1 - March 31: 7 days a week from 8:00 a.m. to 8:00 p.m.
April 1 - September 30: Mondays – Fridays 8:00 a.m. to 8:00 p.m.

If unable to reach us, please contact the Department of Managed Health Care's Help Center at 1-888-466-2219 (TTY 1-877-688-9891). 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.

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 1-888-775-7888 right away.

重要通知：您是否能夠閱讀此文件？如果您無法閱讀，我們有專員為您提供協助。此外，我們也可以將此 文件翻譯成您使用的語言。 如需要免費服務，請立即致電 1-888-775-7888。

IMPORTANTE: ¿Puede leer este documento? Si no es así, podemos ayudarle a leerla. También es posible que usted pueda recibir este documento en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-888-775-7888.

語言服務的重要資訊

口譯服務

如果您需要協助與醫生溝通或安排醫療服務，我們可提供免費口譯服務。如要安排口譯服務，請致電 1-888-775-7888，聽力殘障人士 TTY 1-877-681-8898。熱線時間：10 月 1 日至 3 月 31 日，每週 7 天，上午 8 時至晚上 8 時；4 月 1 日至 9 月 30 日，星期一至五，上午 8 時至晚上 8 時。

會員書面資訊翻譯服務

在本計劃的成員中，中文是最常被使用的語言。本計劃可根據您的要求提供涉及您承保範圍的書面資訊翻譯服務。如需免費翻譯服務，請致電 1-888-775-7888，聽力殘障人士 TTY 1-877-681-8898。熱線時間：10 月 1 日至 3 月 31 日，每週 7 天，上午 8 時至晚上 8 時；4 月 1 日至 9 月 30 日，星期一至五，上午 8 時至晚上 8 時。

如果您無法與我們聯繫，請致電加州醫療護理管理部 1-888-466-2219（聽力殘障人士 TTY 1-877-688-9891）。 該部門提供超過 100 種語言的電話翻譯服務，同時也提供西班牙語及中文的獨立醫療審查及投訴的書面翻譯服務。

Información importante sobre servicios de asistencia con el lenguaje

Servicios de interpretación

Usted puede conseguir un intérprete sin costo alguno si 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 (TTY 1-877-681-8898)
1 de octubre - 31 de marzo: 7 días a la semana de 8:00a.m. a 8:00p.m.
1 de abril - 30 de septiembre: lunes a viernes de 8:00a.m. a 8:00p.m.

Traducción de información escrita para miembros del plan

El idioma que se habla con más frecuencia entre los miembros de CCHP es el 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 (TTY 1-877-681-8898) 1 de octubre - 31 de marzo: 7 días a la semana de 8:00a.m. a 8:00p.m. 1 de abril - 30 de septiembre: lunes a viernes de 8:00 a. m. a 8:00 p. m.

Si no puede comunicarse con nosotros, por favor póngase en contacto con el Departamento de Centro de Ayuda de Atención Médica Administrada llamando al 1-888-466-2219 o TTY 1-877-688-9891. 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 8:00a.m. a 6:00p.m. para responder preguntas.

SECTION 8
UTILIZATION 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 along with ancillary clinical guidelines for conditions not addressed by InterQual® (see Section 8.4 Determination of Medical Necessity below). 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.

Please Note: 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 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 Delegated UM Services

A. Hill Physicians Medical Group (HPMG)

UM Processes related to members whose PCP is within the HPMG contracted network will follow HPMG guidelines.

- HPMG has the following delegated CCHP membership:
    - CCHP Commercial members (both on and off the Covered California Marketplace) who elect an HPMG provider as their PCP, or
    - CCHP Medicare members who elect an HPMG provider as their PCP

Please contact HPMG's Utilization Management Department at **800-445-5747** for more information on their UM processes.

B. Jade Medical Group (Jade)

UM Processes related to members whose PCP is within the Jade contracted network will follow Astrana's guidelines.

- Jade has the following delegated CCHP membership:

- CCHP Medicare members who elect a Jade provider as their PCP

Please contact Astrana's Utilization Management Department at **626-282-0288** for more information on their UM processes.

Section 8.3 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 8.4 Determination of Medical Necessity

CCHP has explicit criteria for evaluating medical necessity that are based on current medical or scientific evidence as well as widely accepted, consensus-driven standards of clinical practice. Criteria used for determining medical necessity are drawn from many sources including (but not limited to):

- State and Federal (CMS) Mandates and Guidelines
- Member Benefits
- InterQual®
- CCHP medical policy for CCHP member authorization requests
- Health Plan medical policies and benefits for which CCHP is the TPA
- Hayes Medical Technology Directory
- National standards reflecting best practice
- Other sources as appropriate and available
- Mental Health/Substance User Disorder services: CCHP uses the non-profit professional associations in accordance with SB 855:
  - ASAM (current version) guideline developed by American Society of Addiction Medicine (ASAM) for Substance Use Disorder (SUD) for any age
  - Level of Care Utilization System (LOCUS) (current version) developed by American Association of Community Psychiatrists (AACP) for Mental Health Disorders for patients 18 and older
  - Child and Adolescent Level of Care Utilization System (CALOCUS-CASII) (current version) developed by American Association of Community Psychiatrists (AACP) and American Academy of Child & Adolescent Psychiatry (AACAP) for Mental Health Disorders for patients 6 to 17 years of age
  - Early Childhood Service Intensity Instrument (ESCII) (current version) developed by AACAP for Mental Health Disorders for patients 0 to 5 years of age
  - WPATH Standards of Care (current version) developed by World Professional Association for Transgender Health (WPATH) for patients with Gender Dysphoria

Sufficient member specific medical information is required to determine 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 8.5 Primary Care Physician Referral Process

Members of CCHP are required to select a primary care physician (PCP) from the CCHP Provider Directory. The directory can be found at:

CCHP:

https://cchphealthplan.com/provider-search/#search_by_doctor_name

Balance (By CCHP):

https://balancebycchp.com/provider-search/

Family members may select different primary care physicians. CCHP delegates the responsibility for providing general medical care for Members to Primary Care Physicians (PCPs). 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 within their network using the Service Authorization Form (SAF) and process.

In the event 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.

PROCEDURES:

1. Referrals to specialists, second opinions, elective hospital admissions, or any service which require prior authorization are initiated by PCPs or specialists using a SAF. 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. Service authorization timelines:
    a. Urgent & Concurrent decisions:
        - Commercial and Exchange – the initial determination will be rendered within 24 hours of the request.
        - Medicare and Medi-Cal– the initial determination will be rendered within 72 hours of the request
    b. Ongoing concurrent decisions:
        - All Product Lines – Following the initial review, ongoing concurrent reviews are determined by the member's acuity level, individual circumstances, and InterQual® criteria.
    c. Urgent Pre-Service Decisions
        - All Product Lines – a determination is rendered within 72 hours of the request.
    d. Non-Urgent Pre-Service Decisions
        - All Product Lines – a determination is rendered 14 calendar days of the request.
    e. Post-Service decisions
        - All Product Lines – a determination is rendered within 30 calendar days of the request

3. 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.
4. 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.
5. 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.
6. CCHP maintains denial logs and letters for in-network and out-of-network denials and modifications and reviews them monthly 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.

7. CCHP reserves the right to perform site audits or to verify accuracy of information on referral logs by examining source information.
8. Referrals for mental health and substance use disorder services for Members are initiated by the PCP through CCHP as outlined in CCHP Policy.

Section 8.6 Referral from PCP to Participating Specialists

A Service Authorization Form is used by the physician when referring a member to another provider. The primary care physician (PCP) determines the medical necessity and appropriateness for the referral and controls all referrals to specialists, both contracted and non-contracted physicians. The PCP refers members to non-contracted physicians when providers in the medical group cannot provide the service. CCHP will ensure that members have access to covered services that are not available from plan providers. Referrals to non-contracted providers require health plan authorization.

In Network Women's health services (access to OB/GYN providers) do not require a referral for routine or preventive health services including mammography from a participating gynecologist or other qualified health care provider.

Section 8.7 Referral from PCP to Mental Health Specialists, Substance Abuse Specialists or Detoxification or Mental Health Facilities

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 performed outside POS 11 require prior authorization. Prior authorization is also required for non- emergency admissions to detoxification or mental health facilities.

Section 8.8 Mental Health Coordination of Care

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. This 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 8.9 Documentation Requirements and Communication Methods

All communication between the primary care physician and the mental health specialist must be documented when providing care for CCHP patients. Methods of written communication may include a letter, documentation in a shared electronic health record, as well as sharing 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 8.10 Review Procedures - Standing Referral/Extended Access to Specialty Care

A. established procedures for Primary Care Physicians (PCPs) to request a standing referral to a specialist for members with ongoing ambulatory care needs including:
   - continuing specialty care over a prolonged period, or
   - extended access to a specialist due to 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), may 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:

CCHP:
https://cchphealthplan.com/provider-search/#search_by_doctor_name

Balance By CCHP:
https://balancebycchp.com/provider-search/

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

PROCEDURES:

1. 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. If a member requests 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 a Service Request Form (SAF). Appropriate medical records shall be attached to the request. CCHP's Medical Director (or designee) will render a determination on the request within 3 calendar days of urgent requests, and within 14 calendar days of standard requests.
2. After approval of the standing specialty or extended access to specialty care with or without a treatment plan, CCHP will notify the PCP, specialist, and member in writing of the specifics of the determination within two (2) business days of the determination.
3. All delegate 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.
4. CCHP can require specialists to provide to the PCP and CCHP written reports of care provided under a standing referral.
5. Members can be referred to out-of-network practitioners when appropriate specialty care is not available within the network.
6. All services for out-of-network providers shall be coordinated adequately and timely.
7. 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.

A. 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. Rehabilitation 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;
i. Members with a combination of conditions that require complex including but not limited for example to diabetes mellitus, COPD and congestive heart failure.

B. 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.

C. 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.

e. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:
    i. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
    ii. The nurse practitioner or physician assistant meets the qualifications specified in this policy; and
    iii. The nurse practitioner or physician assistant and the supervising HIV/AIDS specialist have the capacity to see an additional patient.
f. 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.

Section 8.11 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 CCHP. Prior Authorization is to be obtained by the process outlined below.

Section 8.12 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 8.13 Services Requiring Prior Authorization

The following contains a summary of services requiring prior authorization**.** Please refer to the Covered Services and Exclusions section of a member's Evidence of Coverage for more information on services that require 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.

Services (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 Services from Non-Preferred Providers (as indicated on the Outpatient Services List in this Section)
- Physical Therapy after initial consultation and 6 follow-up sessions
- Radiology Scans: CT, MRI, PET
- Skilled Nursing Facility (SNF)
- Speech Therapy
- Transportation (Non-emergency medically necessary ambulance, wheelchair, medi-van, air ambulance)

Section 8.14 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 8.15 Emergency Services

Prior authorization is not required for the 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,
        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.

    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 the Hospital and Delegate, claims can be submitted to CCHP for final adjudication.

PROCEDURES:

1. Final determination of whether 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 consider 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 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 8.16 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
    - Fax- Provider completes the CCHP Service Authorization Form (SAF) with clinical information and faxes to the UM Department at **1-415-398-3669**;
    - Mail- Provider completes the CCHP Service Authorization Form (SAF) with clinical information and mails to the UM Department:

      445 Grant Avenue
      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, a 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 to 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 8.17 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. CCHP is responsible for meeting the same timeframe and notification requirements for EIODs, regardless of whether additional clinical information is requested.
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,
    a. Explain that the request will be processed using the timeframe for standard determinations;
    b. 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;
    c. 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
    d. Provide instructions about the expedited grievance process and its timeframes.
9. If the request is approved for an EIOD, the determination shall be made in accordance with the following requirements:
10. 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.
11. 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.

12. 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.
13. 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:
    a. The specific reason for the denial that takes into account the Member's presenting medical condition, disabilities, and if any, special language requirements;
    b. The determination is based upon NCD, LCD, Medicare Coverage Guidelines, InterQual criteria, and/or national and or community standards reflecting best practice;
    c. 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;
    d. 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
    e. The Member's right to submit additional evidence in writing or in person.
14. An extension of no more than fourteen (14) calendar days may be allowed to perform the review under the following circumstances:
    a. 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.
    b. The practitioner requests an extension of time to provide CCHP with additional information.
    c. 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.
15. Extensions shall not be used to pend organization determinations while waiting for medical records from contracted Providers.
16. 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 8.18 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 1-628-228-3297.

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 CCHP Medical Director may be reached at 414-412-0777. The attending physician should then submit a timely SAF to the Utilization Management Department the next business day.

Section 8.19 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.

Behavioral and Non-Behavioral Healthcare Authorization Process

A. Utilization decisions are made in a timely manner in accordance with regulatory requirements and depending on the urgency of the request. The UM Department maintains a tracking system for identifying the status of all authorization requests.

B. Utilization decisions follow regulatory times for Commercial, Exchange, Medicare, and Medi-Cal products.

Urgent Reviews

A. Commercial and Exchange urgent concurrent decisions.
The UM Nurse will render a decision (approve, modify, defer/pend, deny) regarding the initial review of medical necessity for the hospital admission or ongoing treatment within 24 hours of the request. Ongoing concurrent reviews are based on the member's acuity level, individual circumstances, and InterQual® criteria.

B. Medicare and Medi-Cal urgent concurrent decisions.
The UM Nurse will render a decision (approve, modify, defer/pend, deny) regarding the initial review of medical necessity for the hospital admission or ongoing treatment within 72 hours of the request.

C. All Product Lines – ongoing concurrent decisions.
Following the initial review, ongoing concurrent reviews are determined by the member's acuity level, individual circumstances, and InterQual criteria. CCHP gives the requesting provider/facility written or electronic notification within one working day of the decision with copies of the determination sent to the primary care

physician and the member.

D. All Product Lines – urgent preservice decisions.
CCHP gives electronic or written notification of the decision to members, the requesting provider, and the member's PCP within 72 hours of the request.

Non-Urgent Pre-Service Decisions

A. All Product Lines.
The UM Nurse will render a decision (approve, modify, defer/pend, deny) and provide electronic or written notification of the decision to members, the requesting provider, and the member's PCP within 14 calendar days of the request.

Post-Service Decisions

A. All Product Lines.
The UM Nurse will render a decision (approve, modify, defer/pend, deny) and provide electronic or written notification of the decision to members, the requesting provider, and the member's PCP within 30 calendar days of the request

Section 8.20 UM Decision Delays

It is CCHP's policy to make authorization decisions based upon complete information. Decisions may be delayed only in the following circumstances:

- All information reasonably necessary and requested has not been received
- Consultation is required by an expert reviewer
- Additional examinations or tests need to be performed upon the member.

Decision-Delay Timelines:

Urgent Requests:	• Pend letters must be sent within 24 hours of an urgent request. • CCHP allows 48 hours for the provider to submit additional information. • CCHP will render a decision within 48 hours of receipt of the additional information, complete or not. • If no additional information is received, CCHP will render a decision within 48 hours from expiration of deadline to receive.
Non-Urgent Requests:	• Pend letters must be sent within 5 business days from the date of receipt of the request for authorization. • CCHP allows 45 calendar days for the provider to submit additional information • If additional information is received within the 45-calendar day window, a decision will be made within 5 calendar days from receipt of the additional information. • If no additional information is received within 45 calendar days of the request, CCHP will render a decision based on available information within 5 days of the expiration of the 45-day window.

Post-Service Requests:	• Pend letters must be sent within 30 calendar days of receipt of request. • CCHP allows 45 calendar days for the provider to submit additional information • If additional information is received within the 45-calendar day window, a decision will be made within 15 calendar days from receipt of the additional information, whether it is complete or not. • If no additional information is received within 45 calendars of the request, CCHP will render a decision based on available information within 15 calendar days of the expiration of the 45-day window.

Section 8.21 Denial Process

CCHP ensures that any service request that is denied has clear documentation for the reason(s) for denial. Members and practitioners are given the rationale behind and criteria for the denial decision, as well as information on how to appeal a denial decision. Any modification of services that is not agreed to by the requesting provider and member is treated as a denial and follows CCHP's denial 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 behavioral 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 is available to the practitioner and member on request. An alternative treatment plan is identified when medically indicated.

If a request is out of the realm of the CMO's expertise, a board-certified specialist in that field will be consulted before a decision is made. MCMC, a vendor who specializes in independent medical review, may also be utilized to render decisions out of the realm of the CMO's expertise.

Section 8.22 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 provider 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.

Section 8.23 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 8.24 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 facility is responsible for notifying members who are under Observation Status for more than 24 hours must be informed that they are outpatients receiving observation services and not inpatients using the Medicare Outpatient Observation Notice (MOON).

C. 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.

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

E. 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.

F. 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 8.25 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 8.26 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 8.27 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 8.28 Conflict of Interest

No person may participate in the review, evaluation or final disposition of any case in which they have 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 8.29 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 8.30 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 8.31 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: Office Ally. The CCHP 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
Post Office Box 1599
San Leandro, CA 94577

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
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.

Upon reviewing claims in the Provider Portal, if you still have questions or require additional information regarding denial reasons, payment amounts, or EOP requests, please reach out to us at providerinquiry@cchphealthplan.com.

Inquiries will be acknowledged within 5 business days, triaged, and sent to the appropriate CCHP team for review. Status updates will be provided for managed inquiries.

Section 9.9 Refunds

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

Refund requests should be sent to:

CCHP - Claims Refunds
445 Grant Ave
San Francisco, CA 94108

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 statuses can be viewed online anytime, 24 hours a day, in the Provider Portal located: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx

If you have additional questions regarding your claims, please contact our claims team. Contacts can be found on Section 1.7 How to Contact Us – Helpful Resources. CCHP maintains claims processing, tracking, and payment systems to comply with applicable state and federal law, regulations, and contract requirements.

Section 9.12 Website Instructions for Checking the Status of Claims

Contracted providers with internet access can use the Provider Portal to check the status of any claims. To check claims statuses:

1. Go to the Provider Portal at: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Enter your username and password and click on “Logon”
3. Select “Provider’s Claims” on the left side tab (naming may be different per account type)
4. Claims may be searched by Date, Claim Number, or Patient Account Number

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:

        CCHP:
        https://cchphealthplan.com/provider-resources/#claims

        Balance By CCHP:
        https://balancebycchp.com/providers/provider-resources/#

    Contact the Provider Dispute team per the contacts listed in Section 1.7 for additional questions.

2. Disputes may be mailed to:
    CCHP Provider Disputes
    445 Grant Avenue
    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. Interest Calculations
    a. When applicable, interest is calculated following HICE guidelines.

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 from October 1 - March 31; 8:00 a.m. to 8:00 p.m., Mondays - Fridays from April 1 - September 30. 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/provider/#Provider_Resources.

The formulary is based on a multiple tier incentive design. The formulary lists preferred generic drugs, which have a first-tier copayment, generic drugs with second-tier copayment, preferred brand name drugs with a third-tier copayment, and non-preferred drugs with a fourth-tier copayment. Depending on their pharmacy benefit, some members also have a fifth-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:

MedImpact Healthcare Systems at 1-800-788- 2949, 24 hours a day, seven days a week

- If you need further assistance, please call CCHP Member Services at 1-888-775-7888, 8:00 a.m. to 8:00 p.m., seven days a week from October 1 - March 31; 8:00 a.m. to 8:00 p.m., Mondays - Fridays from April 1 - September 30.

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 the request (for approval decisions). Document date and time of oral notifications.	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.

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, CVS, Safeway, and Costco. 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 MedImpact Direct. 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 CCHP's Member Services Department at 415-834-2118.

SECTION 11
QUALITY IMPROVEMENT PROGRAM

Section 11.1 Quality Improvement Program

CCHP has established a Quality Improvement (QI) Programs to provide for the delivery of high-quality care and services to all of 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.

Objectives

The objectives of the QI Program are aligned with the quadruple aim:

- To demonstrate improvement in the care and services provided to all members.
- To improve member satisfaction.
- To improve provider satisfaction.
- To reduce cost

Scope

The scope of the QI program includes but is not to be limited to:

- Establishing safe clinical practices throughout providers.
- Collaboration between Quality Improvement, Care Coordination and Risk Adjustment Programs.
- Maintaining compliance with accreditation standards.
- HEDIS compliance audit and performance measures.
- Managing any quality of care and quality of service complaints.
- Managing Grievances and Appeals.
- Establishment of a Population Health Management Program in 2024.

Goals of the Population Health Program:

2024 Population Health Management Goals:

A. Improve Blood pressure control by 19% by December of 2024 for members with hypertension through the Hypertension Management Program.
    a. Baseline of CBP from 2022 MY from 61.078%
B. Implement a Scientific program to identify the following:
    a. Prevalence of stroke and myocardial infarction in 2023 on Members participating in Hypertension Management Program
    b. Prevalence of stroke and myocardial infarction in 2024 on Members participating in Hypertension Management Program
    c. Prevalence of stroke and myocardial infarction in 2023 on Members not participating in Hypertension Management Program
    d. Prevalence of stroke and myocardial infarction in 2024 on Members not participating in Hypertension Management Program
C. In collaboration with Care Coordination and other clinical departments, identify high risk population and coordinate visit with Primary care provider at least once a year

Functions of the Quality Improvement Program:

Implementation of a multi-dimensional and multi-disciplinary Quality Improvement Program (QIP) that effectively and systematically monitors and evaluates the quality and safety of clinical care and quality of services rendered to its members. Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.

- Improve health outcomes for all members by incorporating health preventive programs and preventive medicine services into all primary care delivery sites.
- Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the QIP.
- Ensure effective continuous quality improvement activities across the health plan.
- Improve performance measures relevant to accreditation including Access to Care, Complaints and Member Satisfaction

Objectives

A. Achieve a centralized, ongoing, and effective program that involves all providers in action plans to improve care and service to our members.
B. Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.
C. Continuously measure, assess and improve processes and outcomes of care and service by designing new systems and processes; improving the functioning of existing systems and processes; and maintaining the stability of existing systems and processes that are functioning well.
D. Coordinate quality assessment activities with other performance monitoring and management activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.
E. Coordinate the collection of objective, measurable data, based on current knowledge and clinical experience to monitor and evaluate each important aspect of care.
F. Identify and monitor important aspects of care and services, quality indicators, problems, and concerns about health care services provided to members.
G. Ensure that appropriate care is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan, its providers, and others.
H. Provide effective monitoring and evaluation of patient care and services to ensure that care provided by health plan practitioners/providers meets the requirements of sound medical practice and is positively perceived by health plan members and health care professionals.
I. Provide data for practitioner re-credentialing used in performance appraisal process for identification of trends/patterns regarding the quality of care and service.
J. Survey health-plan members and practitioners' satisfaction with the quality of care and services provided.
K. Ensure that members' cultural and linguistic needs are being addressed as described in cultural competency policies by reducing health care disparities in clinical areas, improve cultural competency in material and communications, improve network

adequacy to meet the needs of underserved groups, and to improve other areas of needs as the organization deems appropriate.

L. Comply with the requirements of all federal, local, and state regulatory requirements and accreditation standards.
M. Review and approve all medical policies.

Health Plan Committees (Organization Structure)
The oversight of the quality improvement program is to provide through a committee structure, which allows the flow of information to and from the Board of Trustees.

A. Board of Trustees

The Board of Trustees is the governing body of the organization. The Board of Trustees functions as they relate to the QI Program include:

- Reviews and approves the following annual documents:
  - QI and Utilization Management Program Descriptions
  - QI and Utilization Management Work Plans
  - QI and Utilization Management Evaluations
  - Credentialing plan
  - Population Health Program Description and Evaluation

- Provides feedback and recommendations to the Quality Improvement Committee related to summary reports, documents and any issues of concerns.

B. Quality Improvement Committee

The Board of Trustees has delegated responsibility for the oversight of the plan's QI activities to the Quality Improvement Committee (QIC). The QIC is the decision-making body that is ultimately responsible for the implementation, coordination, and integration of all QI activities for the health plan.

The QIC is chaired by the Chief Medical Officer (CMO), a member of senior management with the authority and responsibility for the overall operation of the quality management program, at least one participating provider or a mechanism to receive input from participating providers. The Chief Medical Officer is the designated physician to support the QIC outlined in this program and provides oversight and management of quality improvement. A minimum of 51% of committee membership constitutes a quorum. All members are voting members. The QIC meets at least quarterly and reports to the Board of Trustees.

The Chief Medical Officer delegates the day-to-day direction, management, and implementation of the program of to the Quality Improvement Director who is responsible for the following functions:

- Implementation oversight of the Quality Improvement Work Plan
- Quality performance through analytics and training for members in all lines of business.

- The scope of quality includes NCQA and URAC, CAHPS, HEDIS reporting and interventions, STAR ratings, PSIs, HOS reporting, Pay for Performance, clinical gaps and adherence.
- Shares responsibilities for reporting of clinical quality initiatives and quality improvement programs with contracted provider network and facilities, and oversight and accountability for grievance and appeals, and credentialing.
- Maintains performance standards that are in compliance with state, federal and other regulatory bodies by developing, implementing, and effectively managing and evaluating departmental personnel, work processes, performance standards and quality improvement initiatives.

The QIC utilizes a contracted network doctoral-level psychologist as the designated behavior health practitioner for the QIC. The designated behavior health practitioner advises the QIC to ensure the goals, objectives, and scope of the QIP are interrelated in the processing of monitoring the quality of behavior health care, safety, and services to our members. The behavioral healthcare practitioner must be a medical doctor or have a clinical Ph.D. or PsyD and may be a medical director, clinical director, and a participating practitioner from the organization or behavioral healthcare delegate.

The responsibilities of the QIC are:

- Receives recommendations from the CCHP's Quality Improvement Committee on a quarterly basis or more frequently as necessary.
- The implementation, annual review and update of the written description of the QI Program, and the annual QI Work Plan goals for submission to the Board of Trustees for approval.
- Assess the overall effectiveness of the program by reviewing the progress in meeting quality improvement goals through periodic reports on provider and member satisfactions surveys, analyses of member's grievances and appeals.
- Approval of the CCHP's mechanism to respond on an urgent basis to situations that poses an immediate threat to the health and safety of consumers
- Provide program direction and continuous oversight of QI activities in the areas of clinical care, service, patient safety, administrative processes, compliance and credentialing and re-credentialing.
- Recommends policy decisions based on this evaluation.
- Monitor and evaluate improvement plans for access and availability of network practitioners by analysis of access to services, analysis of satisfaction and CCHP's performance with respect to its standards to assure that members have access to services.
- Ensure compliance with regulatory requirements and accrediting organizations such as URAC (Utilization Review Accreditation Commission) Standards.
- Developing, communicating and implementing clinical practice guidelines based on current medical standards of care to promote appropriate and standardized quality of care; monitors clinical quality indicators such as Healthcare Effectiveness Data and Information Set (HEDIS), adverse events, sentinel events, peer review outcomes,

quality of care tracking, etc. to identify deviation from standards of medical management; and assists in formulation of corrective action, as appropriate. These guidelines include, but are not limited to standards instituted and approved by:

- American Academy of Family Physicians
- American College of Physicians
- American College of Obstetrics and Gynecology
- American College of Surgeons
- Agency for Healthcare Research and Quality
- American Psychological Association

C. Credentialing Committee

All participating practitioners, hospitals and ancillary providers undergo a careful review, and in some cases primary source verification of their qualifications, including education and training, board certification status, license status, hospital privileges, and malpractice and sanction history. All practitioners undergoing initial credentialing and triennial re-credentialing are reviewed and approved by the Chinese Community Health Plan Provider Relations Department.

Practitioners, hospitals and ancillary providers are required to adhere to CCHP Provider Manual.

D. Medical Technology Assessment Committee (MTAC)

The Medical Technology Assessment Committee (MTAC) is responsible for the development and management of:

- Evidence-based position statements on selected medical technologies
- Assessments of the evidence supporting new and emerging technologies
- Maintenance of externally licensed guidelines
- The consideration and incorporation of nationally accepted consensus statements, clinical guidelines, and expert opinions into the establishment of the standards for The Plan.
- Ensuring that clinical decisions about the safety and efficacy of medical care are consistent across all products and businesses.

The membership of the MTAC includes:

- Chief Medical Officer (Committee Chair)
- Health Plan and other physicians with diverse specialty backgrounds
- Quality Improvement Director
- Guest Physician Specialist as needed

The Committee meets at least one time per year and as needed.

E. Committee Minutes

Minutes are recorded at all quality committee meetings using a standardized format including topic, discussion, recommendations, and follow-up. The meeting scribe will be assigned by the chairperson. Follow-up items will become topics for the next committee meeting and will be recorded on the Next-Steps Grid. All minutes are maintained in a confidential manner. The appropriate chairperson reviews the minutes for accuracy and completeness. The chairperson and scribe signs and dates the minutes. The minutes of all committees may be shared with staff members.

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 Encounter Data Processing System (EDPS) 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.

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 Advance Directive

The Patient Self-Determination Act required many hospitals, nursing homes, home health agencies, hospice providers, health maintenance organizations (HMOs), and other health care institutions to provide information about advance health care directives to adult patients upon their admission to the healthcare facility.

The requirements of the PSDA are as follows:

Patients are given written notice upon admission to the health care facility of their decision-making rights, and policies regarding advance health care directives in their state and in the institution to which they have been admitted. Patient rights include:

1. The right to facilitate their own health care decisions
2. The right to accept or refuse medical treatment
3. The right to make an advance health care directive
    - Facilities must inquire as to whether the patient already has an advance health care directive and make note of this in their medical records.
    - Facilities must provide education to their staff and affiliates about advance health care directives.
    - Health care providers are not allowed to discriminately admit or treat patients based on whether or not they have an advanced health care directive.

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 aged 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 participating physicians should 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

1. Included in this Section is a booklet entitled "Your Right to Make Decisions about Medical Treatment" and an Advance Directive Form for patient distribution.
2. For additional information about advance directives, including information in Chinese and Spanish, go to **http://www.coalitionccc.org**
3. Advance Care Planning: Advance Directives for Health Care | National Institute on Aging (nih.gov)

SECTION 12
PROVIDER PAYMENT

Providers are paid based on the member's Line of Business and enrollment rules.

Section 12.1 Jade and Access Medical Group

12.1 a

Medicare membership is capitated by CCHP for services performed. Remuneration for providers is per their agreement with their Medical Group.
Providers have the opportunity to earn a bonus based upon certain quality-related metrics that are adjusted annually. Historically, metrics have been selected from the HEDIS set and the count of Annual Wellness Visits has also been utilized. For 2025, metrics to be used include: Diabetes Control, Blood Pressure Control, Breast Cancer Screening rates and Annual Wellness Visit completion rates. The 4 Star cut points are to be used as the goal for the HEDIS metrics.

12.1 b

Commercial and ACA membership (Applies to Jade Medical Group only) Providers are paid based on FFS calculation.

Section 12.2 Hill Physicians Medical Group (HPMG)

Providers capitated for Services provided to CCHP membership, actual remuneration is determined per contract between providers and HPMG.

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.

Section 13.2 Member Rights & Responsibilities

As a CCHP-contracted provider, it is essential to understand and support the full list of member rights and responsibilities outlined in this section.

All CCHP members have the right to:

A. Courteous and considerate treatment; to be treated with respect and recognition of their dignity and right to privacy.
B. Receive information about CCHP, its services, its practitioners/providers, and members' rights and responsibilities.
C. Make recommendations regarding CCHP's member rights and responsibilities policy.
D. Be informed about their available health plan benefits, including a clear explanation about how to obtain services.
E. Receive appropriate preventive health services as indicated in their Evidence of Coverage (EOC).

F. Receive upon request, names, specialties, and titles of the professionals responsible for their care.
G. Amend their own health care information that CCHP has when they consider it is incorrect or incomplete.
H. Participate with practitioners in the decision-making regarding their health care.
I. Inspect and copy their own medical information used to make decisions about their health care.
J. 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.
K. 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.
L. 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).
M. Be represented by parents, guardians, family members, or other conservators for those who are unable to fully participate in their treatment decisions.
N. Be fully informed of CCHP's grievance procedure and how to use it without fear of prejudicial treatment from their health care provider.
O. Voice complaints or appeals about CCHP or the care provided.
P. A timely response to requests for services, complaints, and inquiries regarding their health benefits and services.
Q. Request a copy of CCHP's Notice of Privacy Practices.

CCHP Members are responsible for:

A. Knowing and understanding their health benefits and services and how to obtain them.
B. Contacting their physician or CCHP coordinator with any questions or concerns regarding health benefits or services.
C. Providing, to the best extent possible, information that CCHP and its practitioners/providers need in order to care for them.
D. Understanding their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
E. Cooperating with those providing health care services; however, they have the right to refuse medical treatment.
F. Following the plans and instructions for care that they have agreed upon with their practitioners.
G. Providing CCHP with information when another source responsible to pay for health care is involved, such as liability insurance after an 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.

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 Grievances and Appeals 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 D-SNP including a downloadable, bilingual complaint form and the ability to submit a complaint online at:

CCHP:
https://cchphealthplan.com/grievances-and-appeals-medicare/

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:

Balance By CCHP
https://balancebycchp.com/grievances-and-appeals/

Section 14.4 How to File a Complaint – Appeal or Grievance

Contact the 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:	888-775-7888 or (TTY) 1-877-681-8888
By Fax:	415-397-2129
In Person:	Member Services 445 Grant Ave San Francisco, CA 94108
By Mail:	Member Services 445 Grant Ave San Francisco, CA 94108
Online:	**CCHP:** https://cchphealthplan.com/grievances-and-appeals-medicare/ **Balance By CCHP:** https://balancebycchp.com/grievances-and-appeals/

SECTION 15
PROVIDER RIGHTS AND RESPONSIBILITIES

The following applies to all CCHP Plan Providers.

1. All network providers, including those contracted directly with CCHP or through affiliated medical groups, are obligated to participate in and work with CCHP programs, services, standards, and processes
2. CCHP recognizes that providers have the right to:
    - Access information about CCHP including available programs, services, staff, staff qualifications, and operational requirements
    - Access information about how CCHP coordinates treatment plans for patients
    - Receive support from CCHP regarding decision making for patient health care
    - Receive contact information for staff that manage and communicate with the provider's patients
    - Access clinical and member experience data
    - Receive professional and courteous conduct from CCHP staff
    - File grievances with CCHP for topics including but not limited to staff, policies, and processes
3. Providers directly contracted with CCHP have the following credentialing rights:
    - To review information used in credentialing applications
    - To correct inaccurate information used in the credentialing process
    - To know the status of their credentialing application
4. Providers are responsible for:
    - Being familiar with and complying with all CCHP policies and procedures
    - Complying with all regulations and medical standards from appropriate regulatory agencies
5. Providers are notified of their rights and responsibilities as follows:
    - Provider's rights and responsibilities are communicated in the provider's contractual agreement with CCHP and/or other provider entities within the CCHP network
    - New providers receive a digital copy of CCHP's Provider Manual or physical copy upon request
    - Providers can access the CCHP Health Plan (www.cchphealthplan.com) or Balance By CCHP (www.balancebycchp.com) websites for updates to existing policies and procedures
    - Providers receive monthly Provider Newsletters that communicate new programs, benefits, policies, regulations, and changes to existing processes
    - Applicable new and updated policies and programs may also be received through written correspondence, such as by letter or memo
6. Providers can contact the Provider Relations team regarding complaints, inquiries, or concerns in relation to the above rights and responsibilities at:

Telephone Number: (628) 228-3485
Email: Provider.relations@cchphealthplan.com

7. By receiving CCHP's Provider Manual and upon no further inquiries, providers acknowledge that they are informed of their rights and responsibilities, the consequences of non-compliance, and their contractual agreements.

SECTION 16
COMPLIANCE PROGRAM

Section 16.1 Overview of the CCHP Compliance Program and General Compliance and Fraud, Waste, and Abuse (FWA) Training Required for Providers and Office Staff

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 the CCHP Compliance Program.

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 16.2 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, San Francisco, CA 94108
    (2) By E-mail to: CCHPComplianceDept@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 16.3 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, San Francisco, CA 94108
Fax: (415) 955-8818
E-mail: CCHPComplianceDept@cchphealthplan.com

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

6. In accordance with the 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

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


CCHP
Health Plan


Balance
by CCHP