THE Check-In

August 2024
communitycarehealth.org

COMMUNITY CARE HEALTH

CCH Provider Newsletter

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Referrals and Authorizations

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LETTER FROM THE CMO

I want to welcome you to another edition of the Community Care Health (CCH) Provider Newsletter, "The Check-In." We at CCH want to take this opportunity to provide you, our valued partners with information and tools to help guide you as you treat our members.

In this edition we want to highlight our Quality Management Program.

Who is responsible for Quality Management at CCH?

A committee of your peers serves this function appropriately named the QIOC– or Quality Improvement Oversight Committee. The ultimate responsibility for the Quality Management program of CCH ultimately lies with the CCH Board of Directors, who approves its activities and improvement measures for our plan. The Board delegates responsibility for the development, oversight, and reporting of this review function to the QIOC.

What is the role of the Quality Management program?

To provide the best care for our members, with the best providers. The QIOC is the primary vehicle for this, as it's utilized as a clearinghouse forum for data and performance improvement activity.

What is reported to QIOC?

A broad scope of key performance indicators relative to Quality Improvement activities, including the oversight and monitoring of our Delegates, Network Adequacy, Timeliness and Access to Care, Population Health indicators, and Policy introductions or revisions.

As a result of this oversight, CCH has seen key improvements as follows:

HEDIS

- Breast Cancer Screening: Improved 25%
- Controlling High Blood Pressure: Improved 30%

Timely Access/Satisfaction

- Met After-Hours & Appointment Access benchmarks
- Achieved 90% "Good" or better overall results in Member Satisfaction Survey
- Managed an industry-low average in grievances

CCH is committed to continual Quality Improvement with actionable strategies to accommodate our growing patient population and ever-changing regulatory environment. We are nimble, flexible, and able to execute quickly and efficiently with a highly experienced team.

Thomas Utecht, M.D.
Chief Medical Officer
Community Care Health

CONTENT

August 2024

This newsletter is brought to you from Community Care Health. Designed to keep physicians abreast of the latest information in healthcare, we hope you find this a valuable resource.

COMMUNITY CARE HEALTH

Member Grievances and Potential Quality Issues (PQIs) Involving a Provider

Member Grievances

An important feature of Community Care Health's (CCH) Quality Improvement Program is the investigation and resolution of member grievances. A grievance is a member's expression of dissatisfaction with any aspect of their health plan, including their health care and/or the delivery of care.

Grievance forms and a description of the grievance procedure must be readily available at each contracting provider's office or facility. Both can be found on CCH's website at the following link: www.communitycarehealth.org/grievance-form/

If a member grievance involves a provider, CCH may need information from the provider to help resolve the grievance. In those cases, CCH will send a letter to the provider requesting the information and asking the provider to respond within seven (7) business days. If the grievance involves a provider, in many cases it also involves a potential quality issue (PQI). CCH's process for addressing PQIs is described below.

Potential Quality Issues (PQIs)

A PQI is a suspected deviation from expected provider performance, clinical quality of care, or outcome of care which requires further investigation to determine if an actual quality of care concern or opportunity for improvement exists. While PQIs are identified through multiple sources, many are raised through member grievances.

Upon receipt of a PQI, the CCH Quality Department will send a letter to the provider containing a summary of the issue or allegation and asking the provider to respond within seven (7) business days. Medical records are requested if applicable to the member's issue. It is important for providers to respond promptly to such requests to ensure that grievances and PQIs are resolved within the timelines established by law.

When applicable, CCH uses responses from providers to identify opportunities to educate members. The responses also highlight opportunities for CCH to work more closely with providers on interactions that are perceived to be problematic by members and to improve CCH's processes. CCH views every grievance, PQIs and non-PQIs, as a chance to improve the member experience.

For additional information on Member Grievances and Potential Quality Issues (PQI) Policy, go to the CCH website at www.communitycarehealth.org/grievance-process/ and scroll to the bottom of the page and click on "attached document."

View Online:
www.communitycarehealth.org/grievance-process/

Laws & Regulations Impacting Providers

Gender Affirming Care – Provider Directories

Senate Bill 923 Transgender, gender diverse, and intersex (TGI) cultural competency, the Gender Affirming Care law becomes effective March 1, 2025 and requires a health plan to publish and maintain within its provider directory providers that have affirmed they provide gender-affirming services. Community Care Health (CCH) is awaiting guidance from the Department of Managed Health Care (DMHC) on what information will be required to be displayed in the directory. Once that guidance has been issued, CCH will reach out to our participating providers.

Health Care Coverage - Provider Directories

CCH places a high importance on regulatory and legal compliance, as well as ensuring our members can easily reach their providers when needed.

Health and Safety Code Section 1367.27 (SB 137) requires us at a minimum to annually verify the information contained in our provider directory. If you have received our correspondence and have returned the roster, CCH thanks you for ensuring CCH is displaying accurate practice information.

If at any time you notice any discrepancies or information that needs to be updated, call Customer Service at 1-855-343-2247, or complete the "Notice of Discrepancy" form found at www.communitycarehealth.org/report-potential-directoryinaccuracies/ and email the form to CCHDataManagement@communitycarehealth.org.

Notice of Language Assistance

CCH offers a no-cost telephonic interpreter service to members with limited English proficiency, both directly and through provider offices. To get an interpreter, or to ask about written information in a non-English language for a member, please call CCH Customer Service at 1-855-343-2247.

CCH members are entitled to full and equal access to covered services, including members with disabilities, as required under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. CCH' Customer Service Representatives are accessible by phone at 1-855-343-2247, and are available to assist the speech and hearing impaired. Speech and hearing impaired may use the California Relay Service's (CRS) toll-free telephone number 1-800-735-2929 or 1-888-877-5378 (TTY) and provide the CRS operator CCH's Customer Service number, 1-855-343-2247.

Timely Access to Care

Medical and Mental Health Appointments and Timely Access to Care Health Plans in California must ensure that members have timely access to their physicians and other providers when seeking care. This means that there are limits on how long members have to wait to get an appointment and telephone triage or screening. The wait times are shown in the chart below. Some exceptions to the wait times apply. If you or a Community Care Health (CCH) member are having difficulty in obtaining a timely referral to an appropriate provider, please call CCH Customer Service at 1-855-343-2247. Providers and members can also file a complaint with the Department of Managed Health Care at www.HealthHelp.ca.gov or by calling 1-888-466-2219.

Appointment Type	Standard
Emergency Care (life threatening)	Seek immediate care at the nearest hospital
Urgent Care (non-life threatening) – no prior authorization required	Appointment is offered within 48 hours from time of the request
Urgent Care (non-life threatening) – prior authorization required	Appointment is offered within 96 hours from time of the request
Non-urgent appointments with a primary care physician (PCP) for regular and routine primary care services	Appointment is offered within 10 business days from time of the request
Non-urgent care appointments with a specialist	Appointment is offered within 15 business days from time of the request
Non-urgent appointment with a mental health provider (who is not a physician)	Appointment is offered within 10 business days from time of request
Non-urgent appointments for ancillary services for the diagnosis or treatment of an injury, illness or other heath condition	Appointment is offered within 15 business days from time of request
Telephone triage and advice	No greater than 30 minutes

BEHAVIORAL HEALTH EMERGENT & NON-EMERGENT APPOINTMENT ACCESS STANDARDS

Appointment Type	Standard
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Urgent Care appointments	Must offer the appointment within 48 hours of request
Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for mental illness	Must Provide Both: • One follow-up encounter with a mental health provider within 7 calendar days after discharge **Plus** • One follow-up encounter with a mental health provider within 30 calendar days after discharge

Other Regulatory Requirements:

After Hours Care: You should be able to reach a recorded message or live voice response providing emergency instructions and for non-emergent (urgent) matters information when to expect to receive a call back.

Emergency Care: Providers should instruct their after-hours answering service staff that if the caller is experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the nearest emergency room. Answering machine instructions must also direct the member to call 911 or go the nearest emergency room if the caller is experiencing an emergency.

Pharmacy Coverage for CCH Members: Prior Authorization

Community Care Health (CCH) has partnered with MedImpact as our Pharmacy Benefit Manager to provide prescription drugs to our members. CCH offers both retail and mail-order services. CCH members are able to obtain a 90-day supply of ongoing medications through the mail-order program with Birdi. To submit a prescription on behalf of a CCH member please go to www.communitycarehealth.org/for-providers/#pharm and scroll down to complete a Birdi Enrollment/Medication Order Form and submit electronically via ePrescribing or fax to 855-873-8739.

CCH displays the Prescription Drug Formulary on our website. The formulary, which is updated monthly, provides a list of covered generic and brand name drugs selected by physician and pharmacist subject matter experts.

MedImpact has created a list of commonly prescribed medications, Preferred Drug List (PDL) within select classes to promote clinically appropriate utilization of medications in a cost-effective manner. The PDL can also be found on the CCH website.

CCH and MedImpact have established a Formulary Exception Request Process to obtain non-preferred drugs (Formulary Exception) for members. A physician must submit the request utilizing form 61-211, Prescription Drug Prior Authorization / Step Therapy Exception Request Form. The form is available on the CCH website.

Some covered drugs may have additional requirements or limits on coverage. These are denoted throughout the Formulary listing using the following symbols (refer to table below).

Symbol	Guidelines	Description
AGE	Age Edit	For certain drugs, the plan limits coverage of the drug within a determined age limit.
PA	Prior Authorization	The plan requires enrollees or their prescribing providers to obtain prior authorization for certain drugs. This means that the enrollee will need to obtain approval before the prescription will be covered.
QL	Quantity Limit	For certain drugs, the plan limits the amount of drug that is covered.
ST	Step Therapy	In some cases, the plan requires a trial of certain clinically appropriate alternative drug(s) before obtaining the prescribed drug.
SP	Specialty Drug	Coverage may require dispensing from a specialty pharmacy. Specialty copay/coinsurance may apply depending on benefit. Prior authorization may be required.
DD	Diabetes Drugs/Devices	Drugs or devices used to treat or manage diabetes
CT	Contraceptives	Drugs used to prevent pregnancy
OCH	Oral Cancer Drugs	Drugs taken by mouth to treat cancer

View Online:
www.communitycarehealth.org/pharmacy-coverage/

Pharmacy Coverage for CCH Members: Prior Authorization

Many drugs have multiple indications, so prior authorizations are placed on those drugs to make sure the drug is safe and appropriate for the member. Drugs that require prior authorization will show "PA" in the Coverage Requirements and Limits column of the Formulary document. Before these drugs are covered, the prescribing provider must show that the member has a medically necessary need for the drug.

Drugs requiring prior authorization have specific clinical criteria that the member must meet before the drug is covered. The prescribing provider should submit the form along with any supporting medical documentation to MedImpact by fax at 1-858-790-7100 or request by phone at 1-800-788-2949.

Upon receipt of all required supporting information, MedImpact will review the request and make a decision to approve or deny the request. **Failure to provide all required supporting documentation may result in the PA being denied.**

Decisions for routine requests are issued within 72 hours from the receipt of the complete information. If the member's provider believes the member's condition is life-threatening (exigent circumstance), the member's request will be expedited, and a decision will be issued within 24 hours from the receipt of the information. If a decision is not reached within these timeframes, the member's request is considered approved.

Weight Loss Drugs

There is a significant amount of confusion as to whether Community Care Health (CCH) covers weight loss medications. The answer is Yes and No.

CCH does not cover weight loss drugs used solely for weight loss management with the exception of morbid obesity, which is defined as a member having a BMI greater than 40.

CCH does cover weight loss drugs when prescribed for an underlying condition such as Type 2 Diabetes Mellitus, where approved medications include Mounjaro, Ozempic and Trulicity. Recently the FDA approved Wegovy for reducing the risk of major adverse cardiovascular events in adults with established cardiovascular disease and who are obese or overweight.

Referrals and Authorizations

Community Care Health (CCH) offers both an HMO and EPO to both Large and Small Group employers.

The main difference between an EPO and HMO is that only the HMO requires members select a Primary Care Physician (PCP) and obtain a referral for specialty care. Please see below for a comparison of EPO to HMO.

Comparison of EPO to HMO	EPO	HMO
PCP Selection/Assignment Required		x
PCP Referral Required for Specialty Care		x
Access to CCH Participating Providers	x	x
Authorized Care Outside of the Area	x	x
All Emergency and Urgent Care Covered at In-Network Benefit Level	x	x
Access to Community Health System and Other Participating Hospitals in the Area	x	x

There are some common misconceptions surrounding “referrals” and “authorizations.” Below is an overview of both and when a referral and authorization are to be utilized.

REFERRALS

HMO

A **referral** from a member’s Primary Care Physician (PCP) **is required** for all specialty services with the exception of Allergy, most Behavioral Health and Substance Abuse providers (SimpleBehavioral), Chiropractic, Dermatology, and Obstetrical and Gynecological services. In addition, members can self-refer for emergency and urgent care. The PCP can initiate the referral via phone, email or by completing a referral form. A copy of the CCH Referral Form can be found on the CCH website, www.communitycarehealth.org/for-providers. Any subsequent visits or additional specialized care, such .as certain lab tests, imaging services or therapy, might require a new referral or prior authorization. In some cases, the member’s condition will qualify for a standing referral to a specialist or specialty care center. Please note standing referrals require prior authorization from CCH.

EPO

Selection of a PCP is not required for EPO members. A **referral is not required** for specialty care to be provided to EPO members. Members may call specialty providers directly to schedule their appointment. If you have questions about the service requested being a covered benefit, please contact CCH Customer Service at 1-855-343-2247.

Referrals and Authorizations

PRIOR AUTHORIZATIONS

Medical Services

For HMO and EPO members, prior authorization is not required for initial office visits/consultations. However, subsequent specialty visits or additional specialized care, such as certain lab tests, imaging services or therapy, may require a new referral or prior authorization. Services must be performed at a contracted facility with appropriate authorization if required. The specialist is responsible for contacting CCH for necessary authorizations. The specialist is responsible for documentation of the services provided, including results of any diagnostic studies or procedures and recommendations for treatment or follow-up. The specialist is also responsible for sharing records with the HMO Member's PCP. A list of services for which Community Care Health requires Prior Authorization can be found at www.communitycarehealth.org/for-providers. If you have questions regarding the Prior Authorization process, or do not see a specific procedure or service on the list, please contact Customer Service at 855-343-2247.

Process to Submit a Prior Authorization

If a request for Prior Authorization is necessary, please see the following instructions:

Step 1: Complete form found at: www.communitycarehealth.org/PriorAuthRequest

Step 2: FAX completed form to: Primary: 559-243-7012 | Secondary: 559-499-1001

To help guide our providers through the process, CCH has developed a Provider Toolkit which contains key documents to help navigate providing care to CCH members. A Quick Reference Guide for HMO and EPO as well as the Provider Operations Manual can be found at www.communitycarehealth.org/provider-resources/.

Behavioral Health Services – Pre-Certification

CCH has partnered with SimpleBehavioral for both mental health and substance abuse disorders. Members have direct access to participating providers for behavioral health services without obtaining a PCP referral. Providers, or members, can call SimpleBehavioral at 1 (888) 425-4800 for pre-certification of services. The line is available 24/7/365.

Contractual Obligations to Treat CCH Members

Community Care Health (CCH) members who have secondary insurance (Medicare and/or Medi-Cal) are reporting in some instances they are being denied access to care. As a reminder of your contractual obligations under your CCH Participating Provider Agreement, Section 3.1 Health Service states:

"In accordance with generally accepted community standards, Provider agrees to render appropriate and Medically Necessary Health Services to any CCH Member who is covered under a Health Benefit Plan. This provision does not affect any right which Provider may otherwise have to elect not to provide treatment to any patient."

Should you have any questions or concerns please reach out to CCH Customer Service at 1-855-343-2247.

Ensuring Members Do Not Incur Out-Of-Pocket Costs

Community Care Health (CCH) has a wide array of providers serving our members and strive to minimize members' out-of-pocket costs.

Members may incur costs when they receive care from a non-participating provider, whether through self-referral or referral by a CCH participating provider, or when a participating provider fails to obtain prior approval of a service that's on CCH's prior authorization list.

As a reminder you can obtain a list of services requiring prior authorization by going to www.communitycarehealth.org/provider-resources/ or by calling CCH Customer Service at 1-855-343-2247.

We want to remind you that referring members to a non-participating provider, without CCH's authorization, is in violation of your participating provider agreement and may result in the member filing a grievance.

Laboratory services is the most common example where CCH members are referred to a non-participating provider. CCH's preferred laboratory provider is Quest Diagnostics and we request that providers only refer members to Quest Diagnostics.

When members are directed to a non-participating laboratory such as LabCorp, the member may be required to pay out-of-pocket. If there is a service that Quest Diagnostics does not provide, such as genetic testing, we ask that you reach out to CCH Customer Service at 1-855-343-2247 for assistance.

To locate CCH participating providers, pleaseuse the Find a Provider tool at www.communitycarehealth.org/find-a-provider or call CCH Customer Service at 1-855-343-2247.

Medical and Pharmacy Assistance

Community Care Health (CCH) Customer Service

CCH Customer Service is available Monday through Friday, 8am-5pm at 1-855-343-2247 to verify eligibility, benefits, check status of prior authorization and to review claims. Participating providers can also access vital information 24 hours a day / 7 days a week by logging into the Provider Portal. Once registered, the portal offers providers convenient access to verify eligibility, review benefits and view claims.

If you have a question regarding your provider contract or are not yet a participating provider but are interested in becoming one, please email, providerrelations@communitycarehealth.org and a representative will contact you within two business days.

Pharmacy Customer Service

MedImpact, CCH's Pharmacy Benefit Management partner, has a dedicated customer service line for CCH members and providers. They are available Monday through Friday, 8am-5pm at 1-844-348-8510. Participating providers can verify eligibility, obtain information on what is included in the formulary, check status of prior authorizations, and obtain the location of the nearest pharmacy.

CCH members are able to obtain a 90-day supply of ongoing medications through mail-order with Birdi. With mail-order, members can have their prescriptions delivered right to their home.

To submit a prescription on behalf of a CCH member please go to the CCH website at www.communitycarehealth.org/for-providers, Pharmacy Coverage for CCH Members and click on the link to complete a Birdi Enrollment/Medication Order Form and submit electronically via ePrescribing or fax to 1-855-873-8739.

Reporting a Provider Directory Discrepancy

Community Care Health (CCH) strives to accurately display you and your practice in both our online and print directories. To that end, we make available on our website the ability to Report a Discrepancy. Please go to www.communitycarehealth.org/report-potential-directory-inaccuracies/, complete and submit the form.

Thank you for ensuring CCH maintains the most current and accurate information for both Members and Providers.

Department of Managed Healthcare (DMHC) Annual Provider Surveys

Provider Appointment Availability Survey ("PAAS") Starts August 26th!

On behalf of Community Care Health (CCH), QMetrics will once again administer the PAAS survey. MY2024 survey fielding is expected to begin on or after August 26th.

The PAAS will be fielded via fax or email. We encourage you to complete the survey within five (5) business days from receipt. Providers that do not respond by the deadline will be contacted by phone to complete the survey telephonically. We strongly encourage you to respond to the fax or email to avoid receiving a telephone call as this will reduce the burden on your office staff.

Keep an Eye Out for...

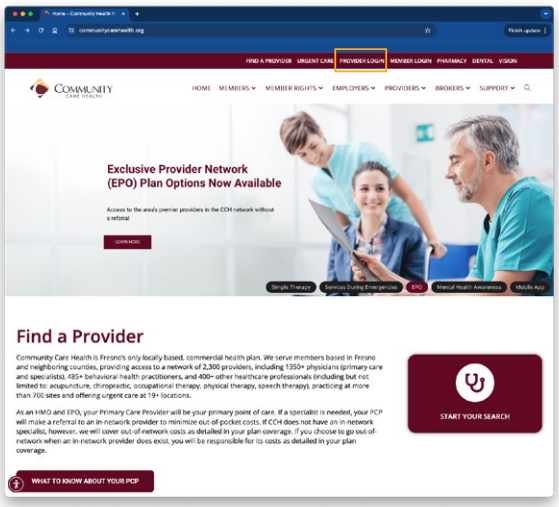
- **Emails will come from QMetrics Surveys** <invites@mailer.surveygizmo.com> with the Subject Line: "**A Short DMHC Required Survey.**"
  Each survey will have a unique link to a provider specific survey to be completed online.
- **Faxes will come from 877-399-3439** and completed surveys should be returned to this same fax number.

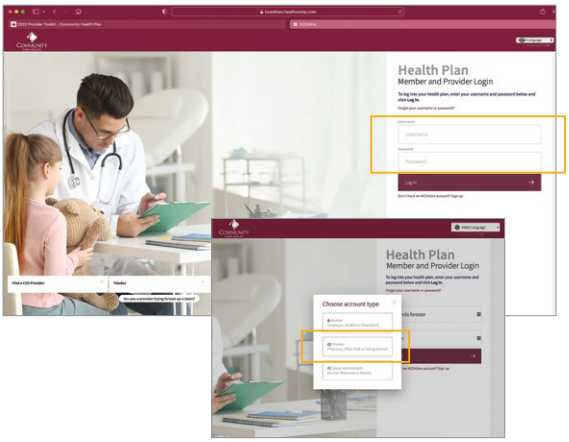
In late October, QMetrics will begin the administration of the Annual Provider Satisfaction Survey ("PSS") and the After Hours ("AH") surveys.

Thank you for taking the time to participate in these important surveys to measure how easily members are able to access CCH's network.

Community Care Health Website

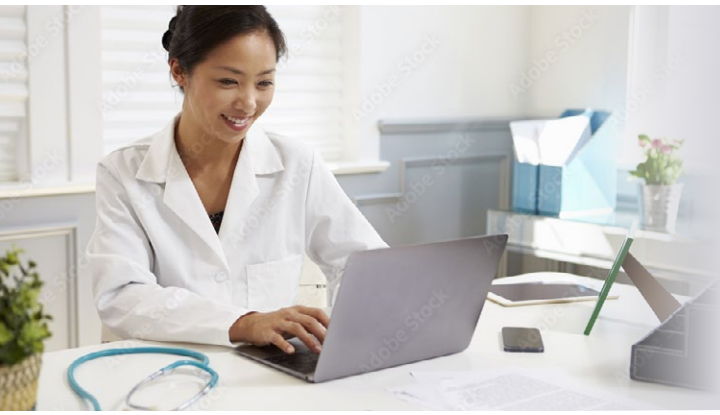
The Community Care Health (CCH) website located at www.communitycarehealth.org offers a wide variety of information for our providers on both the HMO and EPO products. An invaluable tool for members, brokers, employers – as well as for you, our provider community. In addition to timely and topical content, the site has a dedicated Providers section built specifically with you in mind, providing one-click access to a variety of information and tools.





Please note the “Provider Resources” icon which houses key materials such as the Provider Operations Manual, Prior Authorization List, Quick Reference Guide for HMO, EPO & Pharmacy, among other provider focused materials.

We welcome input from you and your staff on other documents that you feel would be beneficial to your treating CCH members.



Upcoming changes to the site include, launching a new Provider Portal on January 1, 2025. We will provide more detailed information on the relaunch later this year.