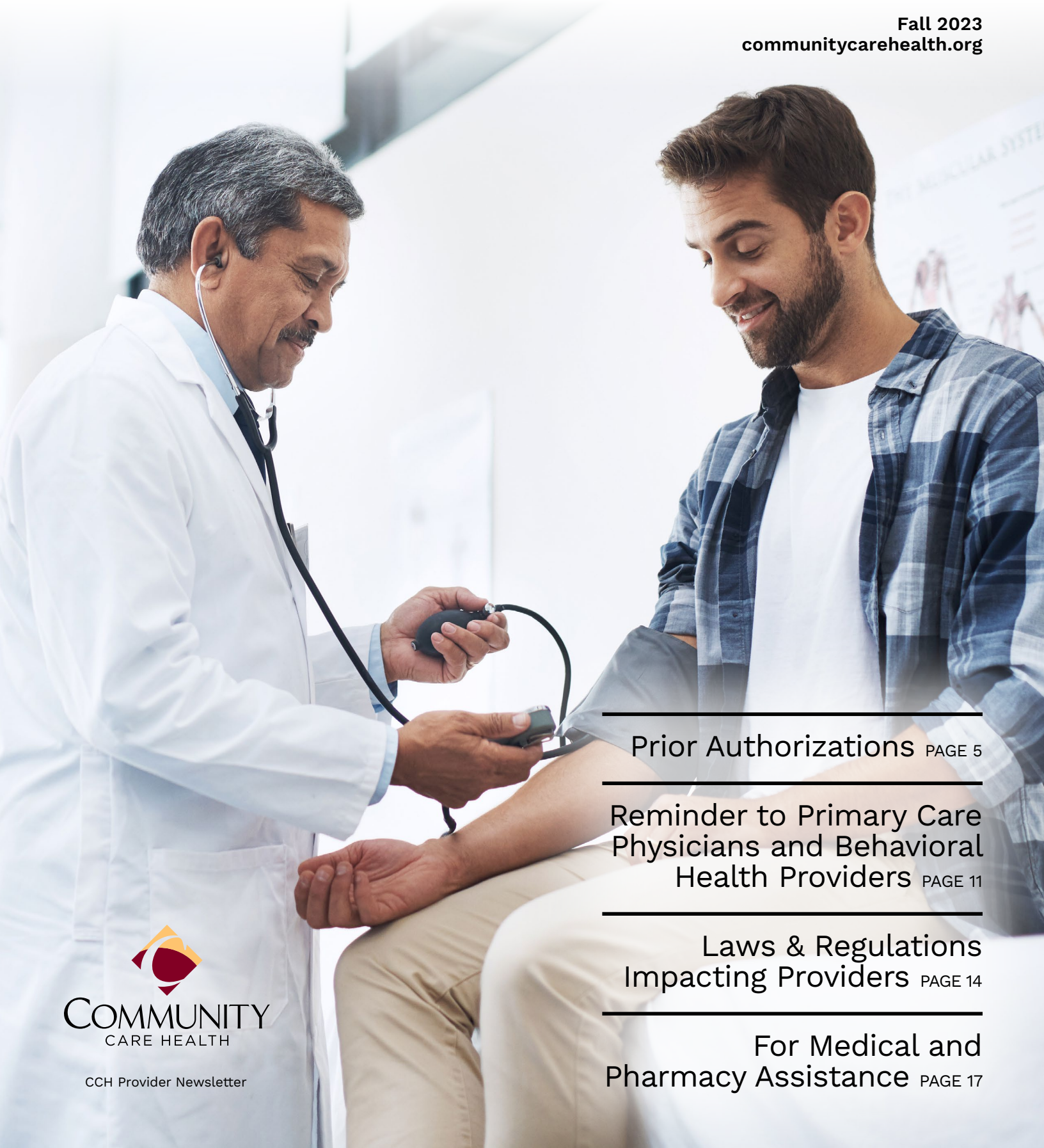
THE Check-In

Fall 2023
communitycarehealth.org



COMMUNITY CARE HEALTH

CCH Provider Newsletter

LETTER FROM THE CMO

Greetings! It is my pleasure to serve as CCH's Chief Medical Officer (CMO). I have large shoes to fill as we wish Dr. Anand Rajani, our former CMO, a fond farewell.

A few notes about me: I grew up in Southern California and attended Loyola Marymount University for undergrad and UCLA for medical school. I left Los Angeles and moved to Fresno for residency in Emergency Medicine. Since discovering the Central Valley, I have not left – spending the first half of my career in academic emergency medicine at the UCSF-Fresno training program. I have come to love the San Joaquin Valley as a place to live as well as the challenges and opportunities it presents in healthcare. In 2006, I joined Community Medical Centers as the Chief Quality Officer. This role has been an exciting journey in the effort to provide safe, reliable, efficient, and high quality health care to our patient population. Away from the office, my hobbies include aviation, hiking, golf, and skiing.

In my role as CCH CMO, my goal is work with our providers to provide high quality care to CCH members. In this endeavor, I hope to meet more of you in future. In the meantime, please feel free to reach out to me for any concerns.

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

CONTENT

Fall 2023

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

How You, Our Valued Partner, Can Help Ensure Members Avoid Out-Of-Pocket Costs

CCH wants to ensure that members minimize any out-of-pocket costs and utilize their CCH benefits to the best of their abilities.

Members may incur avoidable out-of-pocket 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.

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.

Laboratory services is the most-common example of CCH members being referred to non-participating providers. As a result, we request that providers refer to Quest Diagnostics - the only CCH participating laboratory. When members are directed to a non-participating laboratory, e.g., LabCorp, the member may be required to pay out-of-pocket. Please note that Quest Diagnostics does not provide genetic testing. In the event you need to refer a member for genetic testing, please reach out to CCH Customer Service for assistance at 1 (855) 343-2247.

You can locate participating providers on our CCH provider finder, www.communitycarehealth.org/find-a-provider, or you can call Customer Service at 1 (855) 343-2247.

Prior Authorization Approval

It is equally important that you do not provide a service that requires prior authorization until you receive CCH's approval. CCH will render its decision in a timely fashion appropriate to the nature of the member's condition, not to exceed five business days from our receipt of the information reasonably necessary and requested to make the determination. Pre-service urgent requests will be reviewed and decided within 72 hours.

For a list of services requiring prior authorization, please go to https://communitycarehealth.org/provider-resources/.

If you have questions regarding the prior authorization process, call Customer Service at 1 (855) 343-2247.

CCH participating providers are required to see members only at the location specified in their contract. If you have any questions or concerns regarding what locations are contracted, please reach out to ProviderRelations@communitycarehealth.org.

Prior Authorizations

Helping our network providers and their staff successfully execute their prior authorization requests is a top priority. The vast majority of prior authorizations are approved. There are, however, circumstances when an approval is not given (initially or subsequently).

Here are the top four reasons why a prior authorization may be denied, and ways you can prevent that from happening or subsequently get it approved.

1. Service was determined to not be medically necessary
Potential Solution: Please work to ensure the information submitted is detailed and clearly shows the medical necessity of the request (i.e., include all relevant medical records, clinical notes, past imaging, past treatment plans, labs, and X-rays, along with the patient's specific current medical condition).

2. Lack of documentation
Potential Solution: In order to avoid delays (including a denial), it is important that all pertinent medical information is submitted (as noted above). Delays can result from lack of medical records, past imaging, past treatment plans, labs or X-rays.

3. Service is not a covered benefit
Potential Solution: Avoid unnecessary paperwork. There is no medical review required – and you will not be paid by CCH – if the requested service is not a covered benefit. If you are not sure if a service is covered, reach out to CCH Customer Service at 1 (855) 343-2247.

4. Out-Of-Network (OON) provider request is not supported
Potential Solution: If you are requesting services from an out-of-network provider, then supporting medical documentation, availability constraints, and the reason for requesting an OON provider must be clearly explained and justified.

For a list of services requiring Prior Authorization, please go to https://communitycarehealth.org/provider-resources/.

If you have additional questions regarding the prior authorization process, please don't hesitate to reach out to CCH Customer Service at 1 (855) 343-2247.

View Online:
https://www.communitycarehealth.org/obtaining-prior-authorization/

Community Care Health Product Offerings

Community Care Health (CCH) is Fresno's only locally based, commercial health plan. CCH is pleased to offer both an HMO and EPO to both Large and Small Group employers.

The key difference between an EPO and HMO is that only the HMO requires members to 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 Required		X
Referral Required for Specialty Care		X
Access to Full CCH Network	X	X
All Emergency and Urgent Care Covered at In-Network Benefit Level	X	X
Access to Community Health System and Other Area Hospitals	X	X

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.

All 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. Speech and hearing impaired individuals 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.

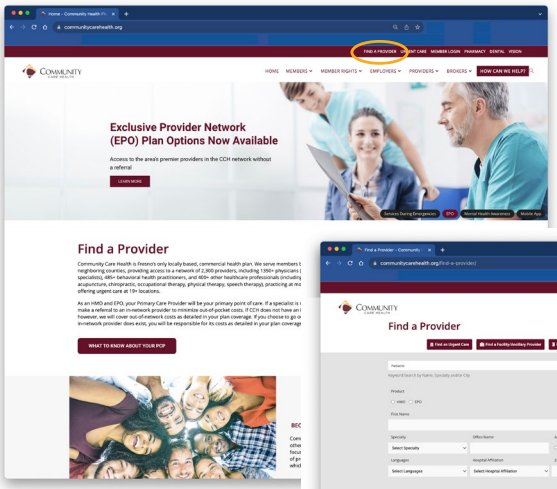
View Online:
https://www.communitycarehealth.org/language-assistance-program

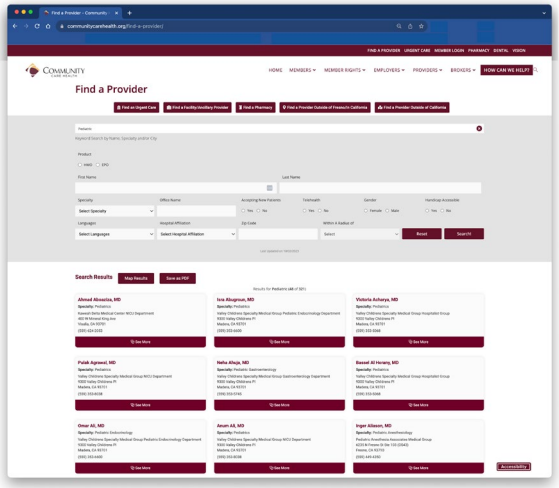
Provider Finder

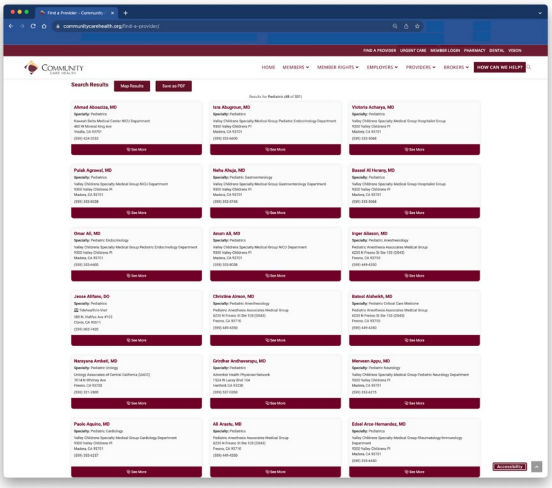
Designed for both members and providers alike, the Find a Provider tool allows you and your team to easily search for Providers, Urgent Care Centers, Pharmacies and Facilities.

Available now at both communitycarehealth.org and on our Mobile App, we invite you to use the Provider Directory Search Tool that includes the following:

- Ability to search by Product: HMO or EPO
- Ability to search by Keyword (name, specialty and/or city)
- Ability to search by Provider, Specialty, Location or Name
- Zip Code Search including Radius Search with mileage increments
- Target Searches by Languages Spoken, Provider Gender, Office Name and Hospital Privileges
- Map Results including additional practice locations (Google Maps integration)
- Detailed Data for each Provider, Facility and Practice, including contact information, National Provider Identifier (NPI) Number, CA License Number and more
- Ability to print or save results to a PDF







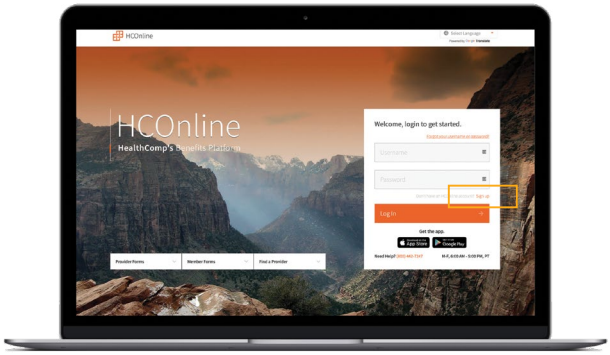
View Online:
http://www.communitycarehealth.org/find-a-provider

CCH Provider Portal

CCH's web-based Provider Portal provides a 24/7 centralized location to review eligibility and claims status.

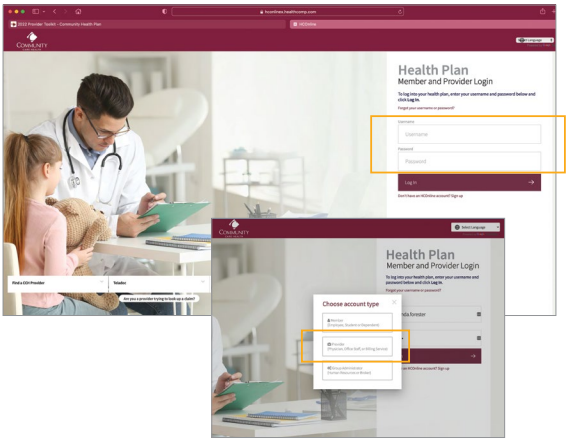
To verify eligibility

1. Visit https://hconline.healthcomp.com/CCH
2. Enter your Username and Password to Log In. If you do not have a HCOnline account, please see section titled "Register on HCOnline" below.
3. In the menu bar, click Verify Eligibility.
4. Enter the member's SSN or Subscriber ID in the textbox; select the corresponding radio button. Click Search.



Look up a claim

1. Navigate to: https://hconline.healthcomp.com/CCH
2. Click on "Are you a provider trying to look up a claim?" on the bottom.
3. In the bottom menu bar, click Claim Search.
4. Enter your search criteria and click Search.



Register on HCOnline

1. Navigate to: https://hconline.healthcomp.com/CCH
2. Click on "Don't have an HCOnline account? Sign Up.
3. In the upper-right corner, click Sign Up. From the dropdown menu, click Provider. This will open the New User Registration wizard.
4. Follow the step-by-step instructions to create your account.
5. To complete your registration, HCOnline will send a confirmation to your email address. Access your email and click the link within the email confirmation. This will complete the registration process.

For technical assistance, please contact us at: 1 (800) 442-7247.

Please check for updates to the Provider Portal as CCH continues to enhance the tool.

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 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
Access to 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
Access to Urgent Care services with a PCP that do not require prior authorization – includes appointment with a physician, nurse practitioner or physician's assistant in office	Appointment is offered within 48 hours from time of the request
Access to after-hours care with a PCP	Ability for Member to contact an on-call physician after hours; return call within 30 minutes PCP provides appropriate after-hours emergency instructions
Access to non-Urgent Care appointments with a Specialist	Appointment is offered within 15 business days from time of the request
Access to Urgent Care services that require prior authorization with a Specialist or other provider	Appointment is offered within 96 hours from time of the request
Telephone triage and screening	Provided within 30 minutes Available 24 hours per day, 7 days a week
Non-urgent appointments for ancillary services for the diagnosis or treatment of an injury, illness or other health condition	Appointment is offered within 15 business days from time of request
Non-urgent appointments with a mental health or substance use disorder provider (who is not a physician)	Appointment is offered within 10 business days from time of request
Non-urgent follow-up appointments with a non-physician mental health or substance use disorder provider for members undergoing a course of treatment for an ongoing mental health or substance use disorder condition	Appointment is offered within 10 business days of the prior appointment

Reminder to Primary Care Physicians and Behavioral Health Providers

Providers are to be available to Members for triage and screening twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year.

Members seeking triage and screening for mental health services can be directed to Halcyon Behavioral at 1 (855) 425-4800 where they will be connected to a licensed mental health professional.

View Online:
https://www.communitycarehealth.org/for-providers/#tcare

Continuity Of Care

Enrolling in Community Care Health gives members access to a large network of participating doctors and other providers. A member may be undergoing treatment by a provider outside the Community Care Health network at the time of enrollment and may qualify for Continuity of Care (also known as COC). An existing member may also qualify for continuity of care if they are receiving care from a provider who leaves the Community Care Health network. This means the member may be able to finish the treatment or have a few more visits before fully transitioning to a participating provider within the Community Care Health network. This is called “Completion of Covered Services.”

There are six conditions that may qualify for continuity of care:

An Acute Condition - A medical condition, including mental health, that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the acute condition.

A Serious Chronic Condition - A medical condition due to disease, illness, or other medical or mental health problem or medical or mental health disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a participating provider (a provider in the Community Care Health network), as determined by Community Care Health’s Chief Medical Officer or his or her designee in consultation with the member, and either (i) the terminated provider or (ii) the non-participating provider and, as applicable, the receiving participating provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed 12 months from the provider’s termination date or 12 months from the effective date of coverage for a newly enrolled member.

A Pregnancy - diagnosed and documented by (i) the terminated provider prior to termination of the provider agreement, or (ii) by the non-participating provider prior to the newly enrolled member’s effective date of coverage with Community Care Health. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period. In addition, for maternal mental health conditions diagnosed and documented by a terminating/non-participating provider, completion of covered services for the maternal health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

A Terminal Illness – An incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Services will be provided for the duration of the terminal illness, which may exceed 12 months from the provider contract termination date or 12 months from the effective date of coverage for a new enrollee.

Surgery or Other Procedure – Performance of a surgery or other procedure that has been authorized by Community Care Health or the member's assigned Participating Provider as part of a documented course of treatment and has been recommended and documented by the: (i) terminating provider to occur within 180 calendar days of the agreement's termination date, or (ii) Non-Participating Provider to occur within 180 calendar days of the newly enrolled member's effective date of coverage with Community Care Health.

Care for Child who is a Newborn to 36 Months of Age – Care for a child who is a newborn to 36 months of age, not to exceed 12 months from the member's effective date of coverage with Community Care Health for newly enrolled members, or twelve months from the agreement termination date for members receiving services from terminated providers.

Request Continuity of Care Benefits
You can read our Continuity of Care Policy by visiting our website at https://www.communitycarehealth.org/continuity-of-care-benefits and scrolling down to Request Continuity of Care Benefits. You can also call us at 1 (855) 343-2247 if you have any questions. If the member has one of the conditions that may qualify for Continuity of Care, direct them to complete the Continuity of Care Request Form. The member can send the completed form to us by U.S. mail, fax or email:

U.S. Mail: Community Care Health
Attention: Continuity of Care Department
P.O. Box 45026
Fresno, CA 93718

Phone: 1 (855) 343-2247
Fax: 1-559-599-0022
Email: COC@communitycarehealth.org

View Online:
https://www.communitycarehealth.org/continuity-of-care-for-cch-members/

Laws & Regulations Impacting 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 https://www. communitycarehealth.org/report-potential-directoryinaccuracies/ and email the form to CCHDataManagement@communitycarehealth.org.

Timely Access to Care

California's Timely Access to Non-Emergency Health Care Services Regulation (§1300.67.2.2, Title 28, California Code of Regulations) requires health plans to maintain an adequate provider network to ensure patients receive timely access to care appropriate for their condition.

Health plans are required to solicit their contracted providers' perspective and satisfaction with their patients' access to care within the timelines set forth under California law. CCH will once again be utilizing QMetrics to administer the annual Provider Satisfaction Survey. The survey will be fielded to a subset of our participating providers in October. In the event you receive the survey, we ask that you respond by the requested date so that CCH is able to demonstrate compliance with timely access standards and/or identify areas of opportunity within our network to improve member accessibility and ensure adequate coverage.

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: https://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 https://www.communitycarehealth.org/grievance-process/ and scroll down to the bottom of the page and click on "attached document."

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

Provider Resources

To support our ever-growing network of providers, CCH has created a number of resources:

- Quick Reference Guide – HMO
- Quick Reference Guide - EPO
- Provider Operations Manual
- Provider Referral Form – required for HMO Only
- Prior Authorization Form
- Prior Authorization List
- Quick Reference Guide – Pharmacy
- Provider Dispute Resolution Form

To access these resources, please go to the CCH website at https://www.communitycarehealth.org/provider-resources/

Our Provider Relations team is available to assist you with any questions. You can reach us at ProviderRelations@communitycarehealth.org.

For additional information on Provider Tools and Resources, please be on the lookout for our upcoming Provider Relations Webinar to be scheduled in November/December 2023.

View Online:
https://www.communitycarehealth.org/provider-resources/

For Medical and Pharmacy Assistance, Please Reach Out to Customer Service

CCH Customer Service

CCH Customer Service is available Monday through Friday, 8am-5pm at 1-855-343-2247 to verify eligibility and benefits, check status of prior authorization requests, and to view 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.

MedImpact Customer Service

CCH's pharmacy benefits manager (PBM), MedImpact, has a dedicated customer service line for CCH members and providers. They are available twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year 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.

AB 2352 requires all health plans to provide on-line access for critical prescription drug information. MedImpact is now offering MedPrescription Insight/Real Time Benefit Check. This tool will allow providers and members to:

- Verify the member's eligibility for the drug.
- Show the most current formulary applicable to the member.
- Provider Cost-sharing information for the drug and other formulary alternatives, if applicable, including any variance in cost-sharing based on the member's choice of pharmacy, whether retail or mail order, or the health care provider.
- Provider the applicable utilization management requirements for the drug and other formulary alternatives.

If you do not have access to an Electronic Medical Records (EMR) system, access to the Real Time Benefit Check is available twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year by contacting MedImpact at 1 (844) 348-8510.

Prescription Drug - Mail-Order Services

Are you aware that 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 https://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 (855) 873-8739.