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 Health 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 policies 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) October 1 – March 31: 7 days a week from 8 a.m. – 8 p.m. April 1 – September 30: Monday-Friday, 8 a.m. – 8 p.m.
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@cchph	

	ealthplan.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	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.**	
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	CCHP Pharmacy Department	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 I **www.balancebycchp.com**

Balance by CCHP offers a variety of commercial products for employers of 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, San Mateo and Alameda Counties. Understanding today's distributed nature of workforces around the Bay Area, we extend the coverage area to Contra Costa and Marin counties for employees who reside there. Our plans for individuals are available in San Francisco and San Mateo counties.

- **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.
- For details go to: Employer Group Plans - Balance by CCHP or Individual & Family Plans - Balance by CCHP

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. These plans include a Medicare Part D drug benefit, vision, hearing and preventive dental benefits. They also offer an optional comprehensive dental rider. These plans are available in San Francisco, San Mateo and Alameda counties.
- **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, hearing and vision benefits, and a dental allowance. This plan is available only for San Francisco residents.
- For details go to: https://cchphealthplan.com/plan-documents/

Section 2.2 Service Area

CCHP's Service Area includes the 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 urgent and 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) with the exception of behavioral health.

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 in which they enroll. For enrolled 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 Provider Services team at 1-628-228-3485.

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		

Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
Diet, Mental Counseling by PCP to Promote a Healthy Diet[18]	B	x	x		
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		

Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
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.

Create a Provider Portal Account:

https://portal.cchphealthplan.com/iTransact/Logon/CreateAccounts.aspx

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:

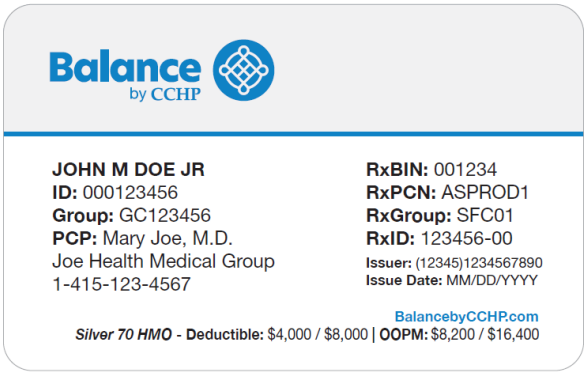
1. Go to https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Enter your username and password and click on “Logon”.
3. For CCHP Member Eligibility Search, select the “**Check Eligibility**” option on the left side bar.
4. You can search by CCHP Member ID, Policy #, Last Name, First Name, 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

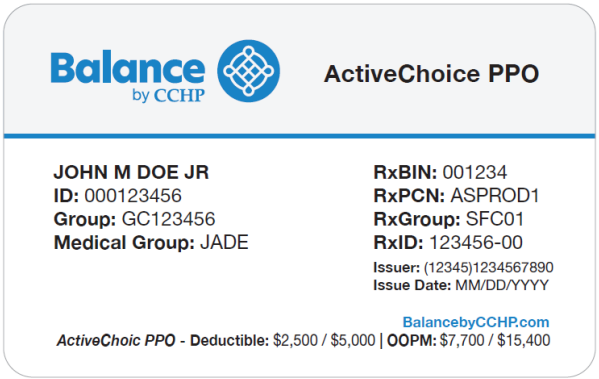
Please ask patients to present their CCHP ID Card each time they present for services. The ID Card is not proof of eligibility. It is for identification purposes only; however it contains information to assist you in verifying eligibility on our website. If a member does not have an ID Card, you can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

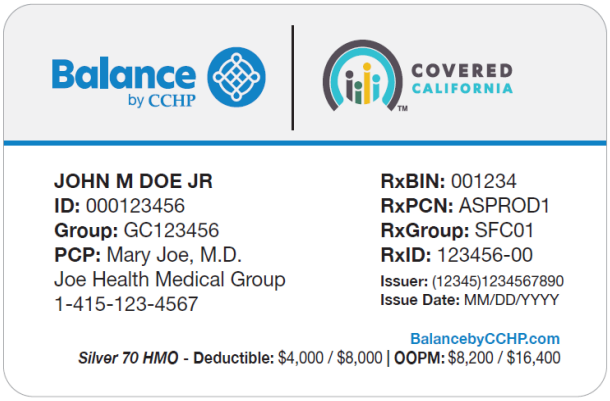
Balance by CCHP Commercial (HMO) Program ID Card
(Employer Group and Individual/Family Plan)



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

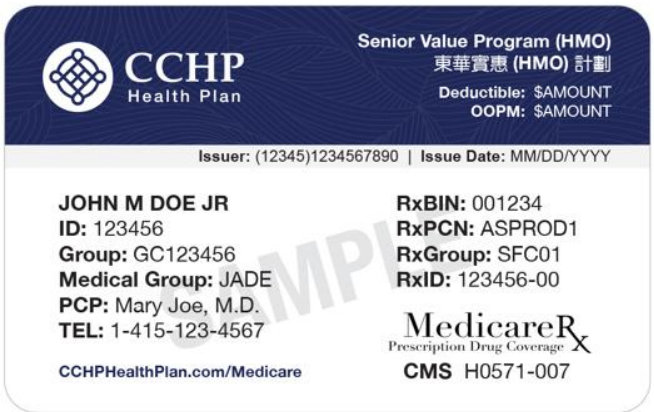


CCHP Covered California (HMO) Program ID Card
(Covered California)



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)	
Jade Health Care Medical Group	San Francisco, San Mateo
Hill Physicians Medical Group	San Francisco, San Mateo
Balance Commercial HMO (Small Group, Large Group)	
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)	
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)	
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
- Gender
- Accreditation Status
- Quality Data

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)
    - Sutter Delta Medical Center
    - 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
    - Lucile Packard Children's Hospital
    - Washington Hospital

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 & CLINICS

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
Distinct-Part Skilled Nursing Facility (D/P SNF)	• 23-bed unit certified by CMS & CDPH
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 (Limited on-call Schedule)	• 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
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
Urology	• General Urology surgery • Lithotripsy
GYN	• General GYN
Dialysis	• Inpatient only

UNAVAILABLE SERVICES

- Burn
- Cardiac Cath
- Cardiovascular Surgery
- CRRT
- Dermatology
- Electrophysiology
- IVC Filter Placement
- Interventional Cardiology
- Neuro surgery
- Neuro-interventional
- NICU
- OB
- Pediatrics
- Psychiatry (Tele-service only, no 5150 holds)
- Radiation Therapy
- Rheumatology
- Transplant
- Trauma Surgery
- 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 10/14/2025: *** 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	San Francisco
Behavioral Health	**Advanced Psychiatry Associates#**	(877) 272-5818	Telehealth Only	All Counties
	Beyou Behavior Therapy#	(877) 296-8222	Home-Based and Telehealth Services	All Counties
	Brain Health USA Inc#	(877) 515-8113	Telehealth Only	All Counties
	Comprehensive Psychiatric Services#	(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
Behavioral Health	**Cyti Psychological#**	(866) 478-3978	Telehealth Only	All Counties
	David Lai, PHD (Psychologist)	(415) 608-7092	2485 Clay Street, #103 San Francisco, CA 94115	San Francisco
	Diana Wong, PsyD, LMFT#	(415) 942-9287	Telehealth Only	All Counties
	Fairmont Hospital (Outpatient Psychiatric)	(510) 895-4200	15400 Foothill Blvd, San Leandro, CA 94578	Alameda
	Kadiant	(866) 523-4268	Home-Based Services	All Counties
	Kavoos Bassiri, LMFT#	(614) 412-1582	Telehealth Only	All Counties
	Lighthouse Counseling Solutions#	(213) 505-6771	Telehealth Only	All Counties
	Ling Orgel, PHD#	(415) 775-5998	Telehealth Only	All Counties
	Minjun Wang, LPCC#	(628) 227-6412	1777 Borel Pl, Ste 400, San Mateo, CA 94402	San Mateo
	Pacific Health Group#	(877) 811-1217	Telehealth Only	All Counties
	Scott Stutz MFT#	(916) 532-6397	Telehealth Only	All Counties
	Sutter Health (Psychiatrist - Sutter Pacific Medical Group) #	(415) 600-5959	601 Duboce Ave, Ste 250 San Francisco, CA 94107	San Francisco
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	All Counties
Diabetic Supplies	Byram Healthcare	(877) 902-9726	—	All Counties
	CHME	(800) 906-0626	—	
	Sincere Care Management	(415) 752-3288	—	
Dialysis	Alameda County Dialysis	(510) 568-5849	10700 Macarthur Blvd, Bldg 7, Oakland, CA 94605	Alameda
	Antioch Dialysis Center	(925) 753-5000	3100 Delta Fair Blvd, Antioch, CA 94509	Contra Costa
	Castro Valley Dialysis	(510) 889-9973	20359 Lake Chabot Rd, Castro Valley, CA 94546	Alameda
	Colma Dialysis	(628) 529-1031	1055 El Camino Real, Colma, CA 94014	San Mateo
	Daly City Dialysis	(650) 755-4751	1498 Southgate Ave, #101, Daly City, CA 94015	San Mateo
	Mission District Dialysis	(628) 600-8705	2765 16th St, South Tower 2nd Floor, San Francisco, CA 94103	San Francisco
	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

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Dialysis	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
	East Bay Peritoneal Dialysis Center	(510) 614-1380	13939 E 14th St, Ste 110, San Leandro, CA 94578	Alameda
	Fremont At Home PD	(510) 494-1348	39355 California St, #101, Fremont, CA 94538	Alameda
	Fremont Dialysis	(510) 796-4385	2599 Stevenson Blvd, Fremont, CA 94538	Alameda
	Hayward Dialysis Center	(510) 780-9094	21615 Hesperian Blvd, Ste F, Hayward, CA 94541	Alameda
	Oakland Peritoneal Dialysis Center	(510) 597-0398	5352 Claremont Ave, Oakland, CA 94618	Alameda
	Pleasanton Dialysis Center	(925) 737-0120	5720 Stoneridge Mall Rd, #160, Pleasanton, CA 94588	Alameda
	Pleasanton Santa Rita	(925) 474-4051	4270 Rosewood Dr, Ste E, Pleasanton, CA 94588	Alameda
	Redwood City Dialysis	(650) 365-0129	1000 Marshall St, Redwood City, CA 94063	San Mateo
	San Bruno Dialysis	(650) 794-1138	841 San Bruno Ave W, San Bruno, CA 94066	San Mateo
	San Francisco Home Training (PD)	(415) 346-3382	1493 Webster St, San Francisco, CA 94115	San Francisco
	San Pablo Dialysis	(341) 300-1577	13352 San Pablo Ave, San Pablo, CA 94806	Contra Costa
	South Hayward Dialysis Center	(510) 583-1255	254 Jackson St, Hayward, CA 94544	Alameda
	Union City Dialysis Center	(510) 489-6996	32930 Alvarado-Niles Rd, #300, Union City, CA 94587	Alameda
	Walnut Creek Dialysis Center	(925) 937-0203	404 N Wiget Ln, Walnut Creek, CA 94598	Contra Costa
	Westlake Daly City Dialysis Center	(650) 755-9480	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 94080	San Mateo
	Satellite Healthcare San Leandro	(510) 352-4011	801 Davis Street, San Leandro, CA 94577	Alameda
	Satellite Healthcare West San Leandro	(510) 746-3900	2401 Merced Street, Ste 110, San Leandro, CA 94577	Alameda
	Satellite WellBound of Fremont	(510) 953-7800	39510 Paseo Padre Parkway, Ste 100, Fremont, CA 94538	Alameda
	Satellite Healthcare Daly City	(650) 746-3140	2001 Junipero Serra Blvd, Ste 100, Daly City, CA 94014	San Mateo
	WellBound Daly City	(650) 550-3600	2001 Junipero Serra Blvd	San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
			#535, Daly City, CA 94014	
	WellBound San Leandro	(510) 383-9602	1040 Davis St, #101 San Leandro, CA 94577	Alameda
	WellBound of San Mateo	(650) 377-0882	2000 South El Camino Real, 2nd Floor, San Mateo, CA 94403	San Mateo
Dietitians and Nutritionists	Harmony Home Health Services	(415) 829-9008	295 89th St, #307, Daly City, CA 94015	San Mateo
	Chinese Hospital	(415) 982-2400	845 Jackson St, San Francisco, CA 94133	San Francisco
	Sunset Health Services	(415) 677-2388	1800 31st Ave, San Francisco, CA 94122	San Francisco
	Excelsior Health Services	(415) 677-2488	888 Paris Street, Suite 202, San Francisco, CA 94112	San Francisco
	Gellert Health Services	(650) 761-3500	386 Gellert Boulevard, Daly City, CA 94015	San Mateo
Durable Medical Equipment	Enes, Inc. dba Late Bloomers	(650) 343-7000	50 Ben Franklin CT, San Mateo, CA 94401	San Mateo
	Cranial Technologies Inc	**Oakland:** (510) 646-4066 **San Francisco:** (415) 960-6800	**Alameda County** 3300 Webster St, Ste 1109, Oakland, CA 94609 **San Francisco County** 1100 Van Ness Ave, Ste 1000, San Francisco, CA 94109	Alameda and San Francisco
	CHME*	(800) 906-0626	—	All Counties
	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	—	
Emergency Care	CEP America	(800) 498-7157		All Counties
Emergency Medical Transportation (EMT)	Royal Ambulance	(877) 995-6161	—	San Francisco and San Mateo
Gastroenterology	UNIO Specialty Care	**San Francisco County:** (628) 358-9813 **San Mateo County:** (650) 667-2036	2186 Geary Blvd, Ste 320 San Francisco, CA 94115 1860 El Camino Real, #101 Burlingame, CA 94010	San Francisco and San Mateo
Hearing Aids	NationsHearing	(877) 439-2665	—	San Francisco and San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Home Health Services	21st Century Home Health Services	(415) 801-2651	1633 Old Bayshore Hwy, #216 Burlingame, CA 94010	San Mateo
	ABL Health Care	(650) 257-0559	1601 Bayshore Hwy, #258, 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) 344-6505	7027 Dublin Blvd, Suite 100 Dublin CA 94568	Alameda
	Carelink Home Health	(650) 375-8223	851 Burlway Rd, #502 Burlingame, CA 94010	San Mateo
	Crossroads Home Health Care & Hospice	(415) 682-2111	1109 Vicente Street, Ste 101 San Francisco, CA 94116	San Francisco
		(510) 638-8033	333 Hegenberger Road, Suite 710, Oakland, CA 94621	Alameda
	Golden Pacific	(510) 373-2799	1151 Harbor Bay Pkwy #201, Alameda, 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	Alameda, San Francisco, and San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Home Health Services	Self-Help for the Elderly		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	
	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	Sutter Infusion & Pharmacy Service (SIPS)	(888) 395-2200	1105 Atlantic Ave, Suite 102, Alameda, CA 94501	Alameda
	AmeriPharma	(877) 778-0318	—	All Counties
	Option Care Health	**Alameda County** Hayward: (510) 264-5454 **San Francisco County** San Francisco: (800) 824-8400 **San Mateo County** Redwood City:	**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	Alameda, San Francisco, and San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
		(510) 264-1237	Redwood City, CA 94061	
	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
	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	San Francisco
	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	(510) 655-4000	350 Hawthorne Ave Oakland, CA 94609	Alameda
	Alta Bates Summit Medical Center - Summit Campus	(510) 204-4444	3100 Summit Street, Oakland, CA 94609	Alameda

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Hospital	California Pacific Medical Center – Davies Campus	(415) 600-6000	601 Duboce Avenue, San Francisco, CA 94117	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
	John George Psychiatric Hospital	(510) 346-1300	2060 Fairmont Drive San Leandro, CA 94578	Alameda
	Lucile Packard Children's Hospital Stanford	(650) 497-8000	725 Welch Rd, Palo Alto, CA 94304	Santa Clara
	Mills Health Center	(650) 696-5400	100 S San Mateo Dr, San Mateo, CA 94401	San Mateo
	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
	UCSF Health Saint Francis Hospital	(415) 353-6000	900 Hyde Street San Francisco, CA 94109	San Francisco
	UCSF Health St. Mary's Hospital	(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
	Stanford Medical Center	(650) 723-4000	300 Pasteur Drive Palo Alto, CA 94305	Santa Clara
	Sutter Delta Medical Center	(925) 779-7200	3901 Lone Tree Way, Antioch, CA 94509	Contra Costa
	UCSF Benioff Children's Hospital San Francisco	(415) 476-1000	1975 4th Street San Francisco, CA 94158	San Francisco
	UCSF Medical Center at Mission Bay	(415) 353-3000	1975 4th Street San Francisco, CA 94158	San Francisco
	UCSF Medical Center at Mt. Zion	(415) 567-6600	1600 Divisadero Street San Francisco, CA 94115	San Francisco
	UCSF Medical Center at Parnassus	(415) 476-1000	505 Parnassus Ave San Francisco, CA 94143	San Francisco
	Washington Hospital	(510) 797-1111	2000 Mowry Ave, Fremont, CA 94538	Alameda
Hyperbaric	Holistic Hyperbarics	(510) 648-9496	5900 Hollis St, Suite J, Emeryville, CA 94608	Alameda
Labs and Imaging	**Chinese Hospital***	(415) 677-2328	845 Jackson Street, Floor B2, 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

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Labs and Imaging	Bioreference Laboratories	**Alameda County** Fremont: (510) 792-2505 **San Francisco County** 950 Stockton Street: (415) 402-0650 2320 Sutter Street: (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	All Counties
	Quest Diagnostics	(866) 697-8378	https://www.questdiagnostics.com/locations/search	All Counties
	Radnet Imaging Center	**Alameda County** Fremont: (510) 713-1236 Pleasanton: (925) 463-0554 San Leandro: (510) 351-7742 Oakland: (510) 663-1951 **Contra Costa County** Concord: (925) 825-7777 Walnut Creek: (925) 937-6100 **San Francisco County** San Francisco: (415) 922-6767	**Alameda County** 2201 Walnut Ave., Ste. 150, Fremont, CA 94538 5924 Stoneridge Dr., Ste. 105 & 106, Pleasanton, CA 94588 2450 Washington Ave., Ste. 120, San Leandro, CA 94577 3200 Telegraph Ave., Oakland, CA 94609 **Contra Costa County** 2300 Clayton Rd., Ste. 160, Concord, CA 94520 114 La Casa Via, Ste. 100 & 200, Walnut Creek, CA 94598 **San Francisco County** 3440 California St., San Francisco, CA 94118	Alameda, Contra Costa, and San Francisco
	SimonMed Imaging	**Alameda County** Castro Valley: (510) 856-4800 **San Francisco County** Sacramento Street: (415) 321-4674 Post Street: (415) 248-3700 Van Ness Avenue: (415) 229-7825 **San Mateo County** Daly City: (650) 757-2030	**Alameda County** 21030 Redwood Rd, Ste B, Castro Valley, CA 94546 **San Francisco County** 325 Sacramento St, San Francisco, CA 94111 1180 Post St, San Francisco, CA 94103 1005 Van Ness Ave, San Francisco, CA 94109 **San Mateo County** 455 Hickey Blvd, Ste 200, Daly City, CA 94015 345 Convention Way, Ste 1-D,	Alameda, San Francisco, and San Mateo

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
		Redwood City: (650) 306-3900 San Mateo: (650) 343-1655	Redwood City, CA 94063 101 S. San Mateo Drive, Suite 201, San Mateo, CA 94401	
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	—	—	All Counties
	Totah Enterprises LLC dba Valiant Medical Transportation	(415) 910-3500		All Counties
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
	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	All Counties
Orthotics and Prosthetics	**Hanger Prosthetics & Orthotics West***	(877) 442-6437	—	All Counties
	Sincere Care Management	(415) 752-3288	—	All Counties
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
	Select Physical Therapy*	**Alameda County** Emeryville: (510) 529-7550 Berkeley: (510) 644-3031 Hayward: (510) 732-7881 Fremont: (510) 608-3730 Pleasanton: (925)	**Alameda County** 5901 Christie Ave, Suite 305, Emeryville, CA 94608 2000 Center Street, Suite 300, Berkeley, CA 94704 22533 Foothill Blvd, Hayward, CA 94541 3905 Beacon Ave, Fremont, CA 94538 5980 Stoneridge Drive, Suite	All Counties

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Physical Therapy		847-8833 Livermore: (925) 373-9394 **San Francisco County** Vicente: (415) 661-1057 Dewey: (415) 242-2444 Geary: (415) 831-4658 1700 California: (415) 921-1758 230 California: (415) 989-0955 **San Mateo County** Burlingame: (650) 259-8009 Belmont: (650) 363-5668 Redwood Shores, Redwood City: (650) 591-9581 Veterans Blvd, Redwood City: (650) 701-0390 Menlo Park: (650) 561-9589 **Marin County** San Rafael: (415) 532-8335 **Contra Costa County** Walnut Creek: (925) 939-8710 Concord: (925) 326-2211	100, Pleasanton, CA 94588 87 Fenton Street, Suite 106, Livermore, CA 94550 **San Francisco County** 3129 Vicente Street, San Francisco, CA 94116 402 Dewey Boulevard, San Francisco, CA 94116 3222 Geary Blvd, San Francisco, CA 94118 1700 California Street, Suite 530, San Francisco, CA 94109 230 California Street, Suite 400, San Francisco, CA 94111 **San Mateo County** 1860 El Camino Real, Suite 201, Burlingame, CA 94010 540 Ralston Avenue, Suite B, Belmont, CA 94002 268 Redwood Shores Parkway, Redwood City, CA 94065 900 Veterans Blvd, Suite 230, Redwood City, CA 94063 3532 Alameda De Las Pulgas, Menlo Park, CA 94025 **Marin County** 1099 D Street, Suite 105, San Rafael, CA 94901 **Contra Costa County** 120 La Casa Via, Suite 212, Walnut Creek, CA 94598 1470 Civic Court, Suite 320, Concord, CA 94520	
	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	—	All Counties

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Rx - Preferred Pharmacy	**Chinese Hospital Pharmacy***	(415) 677-2430	845 Jackson Street 1/F San Francisco, CA 94133	San Francisco
	Chinese Hospital Pharmacy (386 Gellert Blvd)*	(650) 761-3560	386 Gellert Boulevard Daly City, CA 94015	San Mateo
	Costco Pharmacy #1042	(650) 568-4049	2300 Middlefield Rd, Redwood City, CA 94063	San Mateo
	Costco Pharmacy #144	(415) 626-4341	450 10th St, San Francisco, CA 94103	San Francisco
	Costco Pharmacy #147	(650) 286-0759	1001 Metro Ctr Blvd, Foster City, CA 94404	San Mateo
	Costco Pharmacy #422	(650) 872-0637	451 S Airport Blvd, S San Francisco, CA 94080	San Mateo
	Costco Pharmacy #475	(650) 757-3002	1600 El Camino Real, S San Francisco, CA 94080	San Mateo
Skilled Nursing Facility	Alameda Hospital - (SNF Unit)	(510) 522-3700	2070 Clinton Ave, Alameda, CA 94501	Alameda
	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
	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	Santa Clara
	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	Santa Clara
	Marina Garden Nursing Center	(510) 523-2363	3201 Fernside Blvd Alameda, CA 94501	Alameda
	Park Bridge Rehabilitation and Wellness Center	(510) 522-1084	2401 Blanding Ave, Alameda, CA 94501	Alameda
	Palo Alto Sub-Acute and Rehabilitation Center	(650) 327-0511	911 Bryant Street Palo Alto, CA 94301	Santa Clara

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
	San Francisco Health Care & Rehab	(415) 563-0565	1477 Grove Street San Francisco, CA 94117	San Francisco
	South Shore Rehabilitation and Wellness	(510) 523-3772	625 Willow Street, Alameda, CA 94501	Alameda
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
	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	Santa Clara
Speech Therapy	Sensational Kidz Speech Therapy	(415) 699-4128	1948 California St, San Francisco, CA 94109	San Francisco
	Seven Bridges Speech Pathology	(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
			295 89th St, Suite 305, Daly City, CA 94015	
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 **Marin County** Corte Madera: (415) 980-5483 Novato: (415) 449-4127 **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, #B, Alameda, CA 94501 2671 Blanding Ave, #A & B, Alameda, CA 94501 1080 Monroe St, #120, Albany, CA 94706 2920 Telegraph Ave, #100, Berkeley, CA 94705 411 Grand Ave, Oakland, CA 94610 **Contra Costa County** 5829 Lone Tree Way, #D110, Antioch, CA 94531 5434 Ygnacio Valley Rd, #250, Concord, CA 94521 1125 Arnold Dr, Martinez, CA 94553 **Marin County** 303 Corte Madera Town Center, Corte Madera, CA 94925 132 Vintage Way, #F5, Novato, CA 94945 **San Francisco County** 1390 Market St, #109, San Francisco, CA 94102 1998 Market St, San Francisco, CA 94102 2131 Irving St, San Francisco, CA 94122 3251 20th Ave, #320, San Francisco, CA 94132 **San Mateo County** 46 Hillsdale Mall, San Mateo, CA 94403	All Counties

TYPE OF SERVICE	CCHP CONTRACTED ANCILLARY PROVIDERS & FACILITIES	PHONE	LOCATION	SERVICE COUNTY
Urgent Care	GoHealth Urgent Care GoHealth Urgent Care	**Alameda County** Oakland: (415) 432-7899 **Marin County** **Mill Valley:** (415) 384-4778 **San Francisco County** 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	**Alameda County** Oakland: 3900 Piedmont Ave, Oakland, CA 94611 **Marin County** Mill Valley: 750 Redwood Hwy, Suite 1204, Mill Valley, CA 94941 **San Francisco County** 2288 Market St, San Francisco, CA 94114 930 Cole Street, Ste 102, San Francisco, CA 94117 2895 Diamond St, San Francisco, CA 94131 2395 Lombard St, San Francisco, CA 94123 170 Columbus Ave, Ste 110, 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, Ste I-J, San Bruno, CA 94066	Alameda, Marin, 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

Objectives:

The Chinese Community Health Plan (CCHP) has developed and adopted a Credentialing Program.

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.

The Credentialing Program ensures patient safety by having all physicians and other health practitioners who provide direct patient care to be credentialed when initially joining the association and every three years (Credentialing and recredentialing providers) 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.

Any adverse matters discovered during the business of any program relating to quality of care or utilization are referred to the Quality Improvement (QI) Committee for investigation. The CCHP Quality Improvement Committee facilitates the Credentialing Committee.

Evaluation:

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.

In the event that modifications to initial credentialing or recredentialing information are identified as non-compliant with organizational policies or procedures, the Credentialing Program shall initiate a quarterly monitoring process. This process will include a review of both initial and recredentialed provider files to assess whether established policies are being met. Quarterly monitoring will continue until at least one identified finding demonstrates sustained improvement over three consecutive quarters.

Governing Body:

The Board of Trustees has the ultimate responsibility for performance of credentialing and membership activities by establishing and supporting the Credentialing and Recredentialing Program.

1. 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.
2. The Board of Trustees has the ultimate responsibility for determining provider membership.
3. The implementation and monitoring of the Credentialing Program is delegated to the CCHP Administrative and Medical Departments.

The CCHP Chief Medical Officer, a senior physician, who has an unrestricted license in the State of California and has substantial managed care experience, has the responsibility for the implementation of the Credentialing Program, reporting activities to the Board of Trustees and

providing feedback, as necessary.

Credentialing Committee:

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 (i.e. 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 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.

Committee Authorities:

Chief Medical Officer

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 if applicable, including but not limited to:

- A current, valid license to practice medicine in California
- An active DEA certificate
- Verification of medical school completion, residency training and fellowship
- Verification of board certification
- 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 Office 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.

Chief Executive Officer

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

Credentialing Chair

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.

Committee Members

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

Credentialing File Preparation:

Primary Care, Specialty Care, and Behavioral Health Providers

The Credentialing Program includes primary care, specialty care, and behavioral health providers within credentialing and recredentialing processes. CCHP has a designated process to credential or recredential these providers per Provider Network Management procedures. For some of these providers, credentialing and recredentialing processes may be delegated to the contracted organization.

Facilities

CCHP credentials and recredentials facilities which include, but are not limited to hospitals, home health agencies, skilled nursing facilities, ambulatory surgical centers, inpatient behavioral health care facilities, residential behavioral health care facilities, and ambulatory behavioral health care facilities. CCHP has a designated process to credential or recredential these groups per Provider Network Management procedures. For some of these facilities, credentialing and recredentialing processes may be delegated to the contracted organization.

Primary Source Verification

Data Collection

1. CCHP delegates primary source verification of credentialing and recredentialing elements to the Council for Affordable Quality Healthcare, Inc (CAQH), a credential

verification organization that is certified by NCQA. Elements that are verified by CAQH include (if applicable), but are not limited to:

a. Board Certification including issue and expiration dates
b. State License including limitations as well as issue and expiration dates
c. Verification of DEA or CDS certification
d. The provider's education as well as the graduation year
e. The work history for the provider as well as gap times
f. Malpractice insurance amounts including effective and expiration dates
g. Malpractice History and dates of cases
h. Disciplinary Sanctions and dates of cases
i. Medicare Sanctions and dates of cases
j. Medicaid Sanctions and dates of cases
k. Confirmation of listings on OIG or SAM
l. Confirmation of Medicare Opt-Out statuses
m. Disclosures for ongoing investigations
n. Disclosures for Criminal/Civil History
o. An attestation by the provider that the information provided is accurate

2. The contractor will maintain a file that contains all of the required elements.
3. If a provider/facility is found to not be accredited, CCHP will conduct an onsite quality assessment through its Quality Improvement Committee.
4. CCHP may periodically reach out to providers/facilities during the data collection process to confirm that the information received is accurate or to request supporting documentation. The situation in which this process may be applicable would be when information obtained during the organization's credentialing process varies substantially from the information provided to CCHP.

File Management

Initial credentialing and recredentialing information will be received and monitored by the Provider Network Management Department at CCHP. The Provider Network Management Department also manages a Master Credentialing List that includes all credentialing and recredentialing records.

Dates

CCHP tracks the date of:

1. The initial credentialing/recredentialing request
2. CCHP's notification to the provider that the credentialing/recredentialing process has begun
3. The PSV Verification
4. The Credentialing Committee
5. The Credentialing Committee decision
6. The final credentialing/recredentialing decision
7. The notification to the provider of the final credentialing/recredentialing decision

Storage

CCHP will maintain a file on each provider/facility. If applicable, 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. The file for each provider will be maintained and tracked by the Provider Network Management Department.

Staff

Staff who are authorized to review, track, and maintain credentialing/recredentialing information will be Provider Relations Specialists as well as the Provider Relations and Network Manager from the Provider Network Management Department. Security controls to ensure only CCHP Provider Network Management staff may modify provider/facility profiles include shared drive edit access for the Provider Network Management Department to be limited to only staff members.

Compliance

CCHP monitors its compliance with the aforementioned file management areas through its quarterly credentialing/recredentialing processes which involves the review, tracking, and maintenance of provider/facility profiles. Upon discovery of process issues, staff will notify the Credentialing Committee during the quarterly credentialing/recredentialing review.

Submission to Credentialing Committee

The Provider Network Management Department will submit all practitioner files to the Credentialing Committee for review including clean credentialing and recredentialing files. Clean credentialing and recredentialing files are up to date on all primary source verification documents as well as on any data collected during the data collection process.

<u>Credentialing Committee Meeting</u>

Responsibilities

1. Review credentialing files for all practitioners whom CCHP has direct contracts with and who fall within the scope of CCHP's authority and action
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, specialty care, behavioral providers, and others.
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 authority to:
    a. Approve or disapprove applications by providers for organization participation status
    b. 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
14. Credentialing Committee members may deny credentialing or recredentialing status to a provider/facility when instances of poor quality are identified.
15. Reviews quarterly credentialing reports by delegated medical groups/independent physician associations

Decision

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 recredentialed 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.

Credentialing Committee Decision Provider 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.

Final Decision

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.

Final Credentialing Decision Provider Notification

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).

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.

Credentialing Rejection Process and Provider Directory

Any providers/facilities that have been denied credentialing or recredentialing will follow the procedure outlined in CCHP's Practitioner Termination Appeal Rights and Fair Hearing policy *(12-PNM 12-004 Policy – Practitioner Termination Appeal Rights and Fair Hearing)*.

All of CCHP's providers listed in the CCHP Provider Directory must be credentialed. In the situation that a provider or organization is not approved during the credentialing or recredentialing 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.

Operations

Schedule

1. Quarterly or more frequently, if necessary. Conference calls are permitted. The minutes of all meetings, including real-time virtual meetings (i.e. 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.

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.
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.

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.

Conflict of Interest

No program members 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 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.

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 the meeting may continue to do business until adjournment, notwithstanding the withdrawal of enough members to leave less than a quorum.

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.

Reporting

Credentialing Program activities will be reported to the CCHP 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.

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.

Provider Rights

Discrimination

CCHP does not discriminate during its credentialing or recredentialing process in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of their license. Decisions regarding credentialing and recredentialing are not made solely on the basis of an applicant's race, ethnicity or national identity, gender, age, sexual orientation, or the specific procedures or patient populations in which the practitioner specializes.

CCHP will review any complaints about possible discrimination on a quarterly basis within its Credentialing Committee, which is facilitated by the Quality Improvement Committee.

Provider Notices

Upon an organization's initial submission of a request to credential or recredential a provider/facility, CCHP will notify the respective organization by writing in the same format as the request (i.e. if the original request was made through email, the notification would be through email as well) about:

1. Their right to review information submitted to support their credentialing application
2. Their right to correct erroneous information
3. Their right to receive the status of their credentialing or recredentialing application upon request

Confidentiality

Credentialing Program 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.

4. Members may not discuss confidential aspects of Program proceedings with physicians or other individuals whose professional activities are subject to review by the Program.
5. The Program may also discuss aspects of the case with others whose expertise is required.

Section 6.2 Practitioner Termination, Appeal Rights, and Fair Hearing

Objectives & Review:

To ensure that providers are entitled to an appeal and fair hearing when reduction, suspension, or termination of a provider's affiliation with Chinese Community Health Plan (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 behavioral health professionals licensed to provide behavioral 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:

a. Denial
b. Reduction
c. Suspension
d. 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:

a. The right to present any additional written material to CCHP's Quality Improvement Committee
b. The right to present any information in person to CCHP's Quality Improvement Committee
c. 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 behavioral health professionals licensed to provide behavioral 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:
    a. Denial
    b. Reduction
    c. Suspension
    d. 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
    a. 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 Sutherland 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 English followed by 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 preservice, concurrent and retrospective reviews of inpatient and outpatient care and services.

Chinese Community Health Plan (CCHP) uses InterQual criteria, Level of Care Utilization System (LOCUS), MCMC Board-Certified Physician Reviewers and internally developed policies for UM decision-making (see Utilization Management (UM) decision-making is based on medical necessity, the individual's unique care needs 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 below). InterQual criteria provide health care professionals with evidence-based clinical guidelines at the point of care. InterQual criteria 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, the individual's unique care needs 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 American Society of Addiction Medicine (ASAM) 4th edition, which are part of InterQual's database in accordance with SB 855:
    - (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
    - WPATH Standards of Care (current version) developed by World Professional Association for Transgender Health (WPATH) for patients with Gender Dysphoria

Member specific, contemporaneous medical information is required to determine medical necessity; if sufficient information is not provided, the UM review nurse may pend the request until additional information is received.

“Urgent” Pre-Service Service Authorization Requests
The UM Department follows all regulatory guidelines for making decisions, that is 5 days for commercial members and 14 days for seniors. Most UM decisions are made well in advance of those requirements so please consider carefully before labelling a UM request as “urgent”. If your request is for care or service that is needed in 24 to 48 hours, you can mark the request as medically urgent. Requests for care and service that are not necessary within 24-48 hours are routine requests.

Through CCHP’s agreement with MCMC, https://www.mcmcllc.com/, Board- certified physicians from specialty areas of medicine and surgery, are available to review cases pertaining to their specialty. Annual interrater reliability testing for UM review nurses and UM medical director assures the consistent application of 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 (Medicare enrollees):

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 medically necessary referrals to specialists and other plan providers,
3. Providing 24-hour coverage for advice and access to care, and
4. Encouraging shared medical decision-making

When a member’s care needs are outside the scope of the PCP, 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, attending physician or CCHP specialist must request prior authorization from the Utilization Management Department before referring to a non-contracted, out-of-network, or non-preferred 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. Verification of the place of service, referred to practitioner, or specialist is within the CCHP network; and
    c. Assessment and declaration of the medical necessity and appropriateness of level of care with determination of approval or denial for the proposed service or referral.

2. Please see the 2024 decision-making timeliness requirements for commercial, Medicare and Medi-Cal at the end of this chapter.

3. Referrals to specialists, out-of-network (OON), non-preferred practitioners for care or services require prior authorization, documentation of medical necessity, your rationale for using an OON or non-preferred provider for the requested referral. Once prior authorization is obtained, the PCP continues to assess the member's progress
4. Members requiring special tests/procedures obtain prior authorization.
    a. Each specialist is encouraged to provide their consultation to the referring PCP.
    b. The PCP evaluates the report information, initials and dates the report.
5. A written notice of authorization or denial is provided to the PCP and the member. Denial notices include information on the appeal and grievance process.
6. ~~6.~~ CCHP maintains a log and letters for in-network and out-of-network denials and modifications
7. CCHP reserves the right to perform site audits or to verify accuracy of information on referral logs by examining source information

No prior authorization is needed for mental health and substance use disorder for members to receive care from CCHP behavioral health providers. Prior authorization by CCHP is required for referral to an OON, not contracted or non-preferred provider.

Section 8.6 Referral from PCP to Participating Specialists

A Service Authorization Form, located at the end of this chapter, 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 or non-preferred physicians only 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.

Women's health services offered by CCHP OB/GYN providers do not require a referral for routine or preventive health services including mammography.

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 for behavioral health care, psychological or psychiatric treatment or behavioral health or substance use disorder (SUD) assessments, interventions or treatments performed by a CCHP behavioral health or SUD specialist do not require prior authorization. Prior authorization is required for non-emergency admissions for medical detoxification or behavioral health facilities.

Section 8.8 Mental Health Coordination of Care

CCHP strongly encourages the coordination of care between behavioral health specialists and the primary care physicians to achieve optimal health for each member. By sharing members' behavioral health information, including the diagnosis, progress and current medications, the PCP and behavioral health specialist can effectively and confidentially coordinate care with appropriate treatment for individuals that have coexisting medical and behavioral diagnoses, reduce complications or adverse outcomes from medication interactions, duplicate medications and tests resulting from the lack of communication.

Section 8.9 Documentation Requirements and Communication Methods

All communication between the primary care physician and the behavioral health specialist must be documented. For urgent matters, telephone communication is often appropriate. Telephone conversations should be documented in the member's health record.

Section 8.10 Review Procedures - Standing Referral/Extended Access to Specialty Care

A. Primary Care Physicians (PCPs) may 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. Contact CCHP at (415) 955-8800 or for TTY (877) 681-8898 or search CCHP's online provider directory for a list of specialists.
CCHP (Medicare enrollees):
https://cchphealthplan.com/provider-search/#search_by_doctor_name

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

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.
2. A member may request a standing referral. If the PCP agrees with the member's request, he/she submits a standing referral request to CCHP UM. CCHP can require specialists to provide the PCP and CCHP written reports of care provided under a standing referral.
3. Members can be referred to out-of-network or non-preferred practitioners only when appropriate specialty care is not available within the network.

Section 8.11 Referral to Non-Participating Specialists

Prior Authorization is required to refer members to non-participating or non-preferred specialists

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

Please refer to CCHP 41-UM AUTH 600 Service Auth Request at the end of this chapter

Section 8.14 Outpatient Services

Outpatient services, diagnostic studies and specialty referrals are authorized based upon medical necessity by the UM Department. If the medical group cannot provide a medically necessary service, a prior authorization request is submitted to CCHP UM for approval.

Section 8.15 Emergency Services

Prior authorization is not required for emergency services, including EMS system emergency ambulance.

Section 8.16 How to Request Prior Authorization

A. PCPs are responsible for providing general medical care for members and for requesting specialty care, diagnostic tests, and other medically necessary services either through CCHP's consultation referral or CCHP's prior authorization processes.

B. Any referral or prior authorization requests from an affiliated mid- level practitioner, i.e. Nurse Practitioner (NP) or Physician Assistant (PA), is reviewed by the supervising physician prior to the submission of the referral.

C. CCHP has processes in place to deny or modify (authorize an amount, duration, or scope that is less than requested). Decisions are made by a qualified health care professionals with appropriate clinical expertise in the condition and disease.

PROCEDURES:

1. Providers 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.

Section 8.17 Expedited Initial Organization Determinations (EIOD)

See 41-UM DEN 200 at the end of this chapter.

Section 8.18 Urgent Authorizations

Urgent requests receive special attention. The UM Department makes every effort to

return authorization determinations in a timely manner and within regulatory timeliness requirements. Urgent or emergent care should never be delayed while awaiting prior authorization.

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, contact the UM department at 1-877-208-4959 or 415-955-8835 **Weekends, After Hours, Holidays**

On weekends, after hours or holidays, the primary physician or the CCHP Medical Director has the authority to authorize treatment for services that the physician considers urgent/emergent. The attending physician should then submit a timely SAF to the Utilization Management Department the next business day.

Section 8.19 Utilization Management Timeliness Standards

Please refer to the DMHC commercial, Medicare and Medi-Cal timeliness standards for UM decisions at the end of this chapter.

Section 8.20 Denial Process

CCHP includes the decision criteria and appeal instructions with any denied service request medical necessity.

Medical appropriateness reviews are conducted and documented by physician reviewers from the relevant specialty. Behavioral health denials based on medical necessity are reviewed by a psychiatrist, doctoral-level psychologist or an addiction medicine specialist. The denial rationale is clearly documented and made available to providers and members upon request. When clinically appropriate, an alternative treatment plan is provided.

Requests for care or service outside the scope of the Chief Medical Officer's (CMO) expertise will be reviewed by a board-certified specialist in the relevant field. MCMC, CCHP's contracted vendor, is used for this purpose.

Section 8.21 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 8.22 Inpatient/Outpatient Case Management

CCHP’s Care Coordination team includes Registered Nurses, Medical Social Workers and administrative coordinators that offer comprehensive assessment, individual care planning, and facilitates medically appropriate, quality care in the most appropriate setting. CCHP’s delegated medical groups offer case management services to their members. Members, families and providers can call CCHP’s Care Coordination team by calling CCHP Member Services at **415-834-2118.**

Section 8.23 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.

Additional Instructions for Medicare Advantage Patients:

See 41 UM DEN 200 at the end of this chapter.

Section 8.24 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 8.25 Retrospective Review

When inpatient services have been provided without prior authorization, medical necessity and length of stay are determined using the medical records from the hospitalization. The determinations are made within 30 days of receipt of all information.

Section 8.26 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 8.27 Conflict of Interest

Individuals may not participate in the review or disposition of any case where they are professionally involved or where impartiality could be compromised. If necessary, external physician reviewers will be engaged to ensure an objective determination.

Section 8.28 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.

Section 8.29 Second Opinions

CCHP members have the right to a second opinion regarding treatment choices, side effects, cost, and treatment time even if those choices are not a covered benefit. A medical or surgical second opinion is provided when a treating physician, or if the CCHP Medical Director feels this would be helpful in determining a diagnosis or course of treatment.

Reasons a member is entitled to a second opinion include:

- Reasonableness or necessity of recommended surgical procedures.
- Questions regarding the 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.
- When the reason for treatment is not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.
- When the treatment plan in progress is not improving the medical condition within an appropriate period given the diagnosis and plan of care.

A. Members are encouraged to discuss their treatment options with their Primary Care Physicians (PCPs), and Specialists.

B. Every member has the right to have a second opinion from a CCHP physician or physicians outside of CCHP.

C. Requests for second opinions are processed according to regulatory time frames.

D. Members are responsible only for the costs of applicable copayments

E. Second opinions are provided by appropriately qualified physicians in the same or equivalent specialty.

PROCEDURES:

See 41-UM-AUTH 602 Second Opinions at the end of this chapter.

Section 8.30 Retroactive Authorizations

See 41 UM DEN 200 at the end of this chapter.

POLICY NUMBER	41-UM-DEN 200
POLICY TITLE	Issuance of Notices of Non-Coverage
INITIAL EFFECTIVE DATE	10/99
REVIEW / REVISION DATE (S)	4/00, 8/00, 4/01, 10/01, 9/02, 10/03, 1/04, 8/04, 5/05, 8/07, 7/09, 5/13.1/15, 1/16, 2/18, 4/19, 7/20, 2/21, 2/22, 2/23, 5/24, 5/25, 12/25
DEPARTMENT	Utilization Management
ORGANIZATION (S)	CCHP
LINES OF BUSINESS	Medicare, Commercial, Exchange

Purpose

To outline the process of issuing notices of non-coverage in accordance with regulatory requirements.

Definitions

Concurrent Review
An assessment that determines medical necessity or appropriateness of services as they are being rendered, e.g. continued inpatient care

Delay or Pend
When there is not enough information available to make a medical necessity decision within required timeframes.

Denial
Non-authorization of care or services.

Discontinue
Determination that inpatient continued or skilled level care is no longer medically necessary e.g. discharges from an acute care hospital or SNF.

Modify
Any change made to a request for authorization of medically necessary services.

Pre-Certification/Prior Authorization/Prospective Review
Prior assessment that proposed services, such as hospitalization, are appropriate for a particular member and will be covered by the Plan.

Retrospective review
Assessments of the appropriateness of medical services after the services have been provided

Policy

CCHP issues notices of non-coverage in accordance with regulatory guidelines including member

and provider right to file an expediated and routine appeal.

Procedure

Based on the individual circumstances one of the following notices are provided to members and providers.

Commercial/MediCal
- Carve Out
- Pre-Service Denial Notice
- Pre-Service Extension
- Termination of Services
- Refusal to Transfer
- SNF Continued Stay Denial
- SNF Exhaustion of Benefits
- Reinstatement Notice for Skilled Nursing Facility – Continued Stay
- Home Health

Senior
- Carve Out Situations: Use when CCHP is not responsible for payment or authorization of services
- Extension Needed for Additional Information: Use when more than 14 days will be needed to make a decision.
- Services Requested Do Not Meet Expedited Criteria
- Pre-Service Denial
- Inpatient Psychiatric Facility Exhaustion of Benefits
- Detailed Notice of Discharge (DND)
- Refusal to Transfer
- SNF Pre-Service Denial
- Notice of Medicare Non-Coverage
- Detailed Explanation of Non-Coverage
- SNF Exhaustion of Benefits
- Reinstatement Notice for Skilled Nursing Facility – Continued Stay

The reason for the denial shall be included in the letter with an easily understandable summary.

Denials for medical necessity include the criteria used in making the determination, a description of the criteria and a statement of how the member's condition does not meet the criteria.

All notices of denial or non-coverage include member and provider information for filing an appeal.

Denial notices are faxed to the physician.

Detailed Notice of Discharge (DND) are faxed to members via the acute hospital case if the member disagrees with the discharge.

A Notice of Medicare Non-Coverage (NMNC) is given to the member 48 hours prior to the discharge date from home health, SNF or CORF. Hospital staff are responsible for obtaining the signature of the patient or family member. To assure that the member receives his/her appeal rights the UM Nurse Reviewer may contact a family member by telephone, give the information verbally and so document. The NMNC is sent by certified mail to the family member who was informed.

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 your Provider Portal (https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx)

or by calling the phone number listed in Section 1.7 How to Contact Us – Helpful Resources. Resubmissions of a claim should be no earlier than 60 days following the original claims.

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 30 calendar 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.

Use of Performance Data
CCHP requires all providers and practitioners to cooperate with all quality activities. We also require practitioners and providers to allow CCHP to use their performance data to ensure success of the QAPI Program.

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 as described in Section 13.2 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:

- Choose a Health Care Provider in their Plan's network and change to another doctor in their Plan's network if they are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in their Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of their Plan's network when their Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for their disability, including:

    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if they need it.
    - Taking their service animal into exam rooms with them.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Courteous and considerate treatment; to be treated with respect and recognition of their dignity and right to privacy.
- Receive information about CCHP, its services, its practitioners/providers, and members' rights and responsibilities.
- Make recommendations regarding CCHP's member rights and responsibilities policy.
- Be informed about their available health plan benefits, including a clear explanation about how to obtain services.
- Receive appropriate preventive health services as indicated in their Evidence of Coverage (EOC).
- Receive upon request, names, specialties, and titles of the professionals responsible for their care.
- Amend their own health care information that CCHP has when they consider it is incorrect or incomplete.
- Participate with practitioners in the decision-making regarding their health care.
- Inspect and copy their own medical information used to make decisions about their health care.
- 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.
- Receive reasonable information regarding the risk of a given treatment, the length of disability, and the qualifications of the care provider prior to giving consent for any procedure.
- Additional medical or surgical opinions from out–of–network providers, in situations when their treating physician or the Plan feels this would be helpful in determining a diagnosis or course of treatment (with an approved referral).
- Receive health care coverage even if they have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on their Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from their Plan a second opinion by an Appropriately Qualified Health Care Provider
- Expect their Plan to keep their personal health information private by following its privacy policies and state and federal laws.

- Ask most Health Care Providers for information regarding who has received their personal health information.
- Ask their Plan or their doctor to contact them only in certain ways or at certain locations.
- Have their medical information related to sensitive services protected.
- They may ask their doctor or health plan to change information about them in their medical records if it is not correct or complete. Their doctor or health plan may deny their request. If this happens, they may add a statement to their file explaining the information.
- Have an interpreter who speaks their language at all points of contact when they receive health care services.
- Have an interpreter provided at no cost for them.
- Receive written materials in their preferred language where required by law.
- Have health information provided in a usable format if they are blind, deaf, or have low vision.
- Request continuity of care if their Health Care Provider or medical group leaves their Plan or they are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about their Plan's grievances procedure and understand how to use it without fear of interruption to their health care.
- File a complaint, grievance, or appeal in their preferred language about:
    - Their Plan or Health Care Provider.
    - Any care they receive, or access to care they seek.
    - Any covered service or benefit decision that their Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination based on gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
- Not meeting their language needs.
- Knowing why their Plan denies a service or treatment.
- Contacting the Department of Managed Health Care if they are having difficulty accessing health care services or have questions about their Plan.
- To ask for an Independent Medical Review if their Plan denied, modified, or delayed a health care service.
- Be represented by parents, guardians, family members, or other conservators for those who are unable to fully participate in their treatment decisions.
- Be fully informed of CCHP's grievance procedure and how to use it without fear of prejudicial treatment from their health care provider.
- Voice complaints or appeals about CCHP or the care provided.
- A timely response to requests for services, complaints, and inquiries regarding their health benefits and services.
- Request a copy of CCHP's Notice of Privacy Practices.

CCHP Members are responsible for:

- Treating all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Sharing the information needed with their Plan and Health Care Providers, to the extent possible, to help them get appropriate care.
- To the extent possible, keep all scheduled appointments, and call their Health Care Provider if they may be late or need to cancel.
- Knowing and understanding their health benefits and services and how to obtain them.
- Contacting their physician or CCHP coordinator with any questions or concerns regarding health benefits or services.
- Providing, to the best extent possible, information that CCHP and its practitioners/providers need to care for them.
- Understanding their health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible.
- Cooperating with those providing health care services; however, they have the right to refuse medical treatment.
- Following the plans and instructions for care that they have agreed upon with their practitioners.
- Providing CCHP with information about which another source responsible for paying 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.
- Refrain from submitting false, fraudulent, or misleading claims or information to Plan or Health Care Providers.
- Notify their Plan if they have any changes to their name, address, or family members covered under their Plan.
- Timely pay any premiums, copayments, and charges for non-covered services.
- Notify their Plan as soon as reasonably possible if they are billed inappropriately.

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 regard 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 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