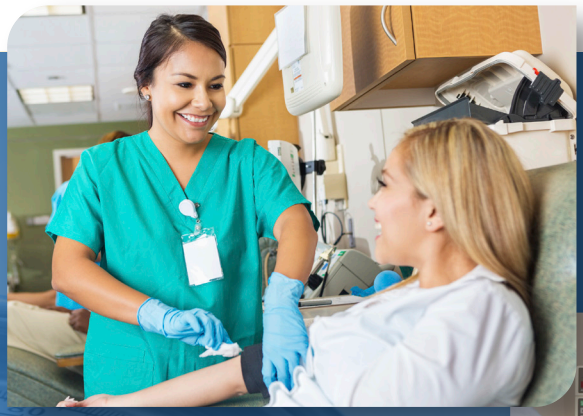
To Improve the Health of Our Members Through the Provision of High Quality Care and Services

Gold Coast Health Plan℠
A Public Entity



2018/19
PROVIDER MANUAL

For Questions and Gold Coast Health Plan Information, Please Call 1-888-301-1228
www.goldcoasthealthplan.org

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Table of Contents

SECTION 1: INTRODUCTION

Gold Coast Health Plan Mission Statement

"To improve the health of our members through the provision of high quality care and services."

Welcome to Gold Coast Health Plan

Gold Coast Health Plan (GCHP) is a County Organized Health System (COHS) that administers the Medi-Cal program in Ventura County. The COHS is governed by the Ventura County Medi-Cal Managed Care Commission (VCMMCC). The commission is comprised of 11 members representing providers, clinics, hospitals, service agencies, elected officials and the public. There are two collaborative groups that report to the commission: the Provider Advisory Committee (PAC) and the Consumer Advisory Committee (CAC). The commission meets monthly to review local concerns about health care issues, receive advisory input, and revise GCHP policies, as appropriate. GCHP's policies are responsive to local input due to the Plan's local governance and operations.

Organization of the Provider Manual

This Provider Manual describes the operational policies and procedures of GCHP. The covered topics are included in the Table of Contents at the beginning of the Provider Manual and in the Index of Topics at the end. You also may access this Provider Manual online by visiting GCHP's **website**. For your convenience, a list of forms you may need can be found in Section 19 of this manual (they are also available on the Plan's website). The manual will be updated and revised periodically as needed to reflect the Provider Operations Bulletin (POB), which is released quarterly. Revisions and updates will be incorporated into the online version of the manual.

Provider Web Portal

Registered providers may access the GCHP Provider Web Portal to verify the eligibility of GCHP members, check the status of a claim and query, and submit prior authorizations. Providers must register using their GCHP Provider Identification Number (PIN) to access the portal. To start using these services, go to the **Provider Web Portal** and complete the registration process. For assistance, please contact the Plan's Customer Service Department at 1-888-301-1228 or e-mail **ProviderRelations@goldchp.org**.

Other Resources on GCHP's Website

Visit GCHP's **website** to access resources and tools, such as:

- **Provider Directories:** The Primary Care Provider (PCP) Directory and the Specialist Physicians and other Non-PCP Directory are available in PDF format to download and print at your convenience.
- **Drug Formulary:** GCHP's List of Covered Drugs is available along with other pharmacy information.
- **Forms and Documents:** GCHP's various forms are available.

If you have ideas or suggestions for ways GCHP can improve its service to providers or members, please email them to **ProviderRelations@goldchp.org**.

SECTION 2: GLOSSARY OF TERMS

Administrative Day: Any day in an acute care facility for which inpatient care is not required due to medical necessity or the physical condition of the member and the member is awaiting placement in a nursing home or other subacute or post-acute care as approved by GCHP.

Administrative Members: The following are considered Administrative Members:

- Share of Cost (SOC): A member who has Medi-Cal with an SOC requirement, which is the amount they must pay for health care before Medi-Cal starts to pay. SOC is a set amount based on how much money a member makes. Members only need to meet the SOC in the months health care services are received.
- Long-Term Care (LTC): A member who is residing in a skilled- or intermediate-care nursing facility and has been assigned an LTC aid code.
- Out of Area: A member who lives outside of GCHP's service area but whose Medi-Cal case remains in Ventura County.
- Other Health Coverage: A member who has other health insurance that is primary to their Medi-Cal coverage. This includes members with both Medi-Cal and Medicare, as well as members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore, GCHP members with other health coverage must access care through their primary insurance.
- Members who are enrolled under special aid categories, such as the Breast and Cervical Cancer Treatment Program (BCCTP).
- Hospice: A member who has been assigned a Medi-Cal Hospice Restricted Services Code.

Administrative members are not required to select a PCP. The GCHP member identification (ID) card will indicate if the member is Administrative. These members can see any PCP that is contracted with GCHP.

Adverse Benefit Determination: The denial, deferral or limited authorization of a requested covered service, including: determinations on the level of service / care; denials of medical necessity; reduction, suspension, or termination of a previously authorized service; the denial, in whole or part, of payment for a service; failure to provide timely services, as defined by the state, for a resident in a rural area; the denial of a member's ability to exercise the right to obtain services out of GCHP's network; and the denial of a member's request to dispute a financial liability, including cost sharing, deductibles, and other financial liabilities.

Aid Code: A classification to identify the types of services for which a Medi-Cal member is eligible.

Appeal: A review by GCHP of an Adverse Benefit Determination.

Assigned Members: Medi-Cal members who have been assigned to, or who have chosen, a PCP or clinic for their medical care.

Attending Physician: a) Any physician who is acting in the provision of emergency services to meet the medical needs of the Medi-Cal member, b) Any physician who is, through referral from the member's PCP, actively engaged in the treatment or evaluation of a Medi-Cal member's condition, and c) Any physician designated by the medical director, or designee, to provide services for Plan members.

Auto Assignment: This is the process used by the Plan for assigning members automatically to a particular PCP (physician or clinic) by a pre-determined process. It only occurs when the member has been unable to complete the selection process within the 30 days allowed upon initial enrollment. The auto assignment is based on the zip code of the member's residence, location of PCP office, past history with a specific PCP, mother-child and family link, available capacity in the provider's practice to accept new Plan members, preferred language, and other factors. If the member is not satisfied with the auto

assignment, the member can contact GCHP and select a new PCP. The new selection is effective on the first of the month following the date of the selection. If the member completes the PCP selection in a timely manner, there will be no auto assignment.

California Children's Services (CCS): A public health program that ensures the delivery of specialized diagnostic, treatment, and therapy services to financially- and medically-eligible children under the age of 21 who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Section 41800.

Capitation Payment: The prepaid monthly amount that the Plan pays to PCPs (or a group of PCPs) based on assigned membership and treatment of capitated primary care services for the scope of services incorporated into the PCP Medical Services Agreement (as defined in Attachment C).

Care Management: A collaborative process that assesses, develops, plans, implements, coordinates, monitors, and evaluates the options and services needed to meet a member's health and human service needs and is characterized by advocacy, communication, and resource management. Care Management includes:

- Care Coordination: Short-term interventions for members with potential risks due to barriers or gaps in services, poor transitional care, and/or co-morbid medical issues that require brief care management interventions. Care Coordination is focused on improving the link between members and providers to reduce inefficiencies that present as risks for higher utilization.
- Complex Case Management: A collaborative process that provides intensive, personalized case management services and goal setting for members who have complex medical needs and require a wide variety of resources to manage their health and improve their quality of life.
- Disease Management / Population Health: A collaborative process focused on self-management that involves short-term interventions, as well as intense personalized wellness coaching that is designed to address a member's needs.

Case Rate: An all-inclusive payment paid by the Plan to a participating provider for a defined set of covered services that are delivered to a member for medical or surgical management of the case in question (e.g., heart transplant cases).

Chief Medical Officer (CMO): The medical director of the Plan or their designee; a physician licensed to practice medicine in the state who is employed by the Plan to monitor quality improvement and to implement the quality improvement activities of the Plan.

Child Health and Disability Prevention Services (CHDP): California's version of the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, which provides for health care preventive services and immunizations for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et. seq., and Title 17, CCR, Sections 6842 through 6852.

Claim Form: Form UB-04 is used by participating hospitals, Federally Qualified Health Centers (FQHC) and other facilities to report to the Plan the provision of covered services to Medi-Cal members, to request payment for services or to report encounter data. Claim form CMS-1500 is primarily used by participating physicians to report to the Plan the provision of covered services to Medi-Cal members, to request payment for services or to report encounter data.

Clean Claim: A claim in which all information necessary to determine payer liability for the adjudicating of the claim is present (Health and Safety Code Section 1371).

Community Based Adult Services (CBAS): An outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family / caregiver training and support, meals, and transportation to eligible Medi-Cal beneficiaries.

Comprehensive Perinatal Services Program (CPSP): A program that provides a wide range of services to pregnant women, from conception through 60 days postpartum. In addition to standard obstetrical services, women receive enhanced services in the areas of nutrition, psychosocial behavior and health education. This approach is shown to reduce both low birth weight rates and overall health care costs in women and infants. The program is funded by Title V (Maternal and Child Health) and Title XIX (Medicaid) and other state and federal funds.

Concurrent Review: A part of a utilization management program in which health care is reviewed by the Plan as it is provided. Reviewers are usually nurses and monitor the appropriateness of care, the care setting and the progress of the discharge plan. The ongoing review is directed by the Plan to ensure the member receives the appropriate level of care at the right time and at a reasonable cost while maintaining the effectiveness and quality of care. Concurrent Review may be done on-site at a hospital's facilities, by phone, by fax or via secured e-mail. The Plan also conducts Concurrent Review in accordance with evidence-based criteria to determine if the services provided by a hospital are in accordance with the Member Handbook.

Contract Year: The 12-month period following the effective date of the service agreement between a specific participating provider and the Plan.

Contracting Providers: A medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges for or provides health care services for GCHP members under a contract, but does not include an individual or a plan.

Council for Affordable Quality Healthcare (CAQH): A nationally-recognized central repository for provider credentialing information storage and retrieval. If providers are affiliated with CAQH and their information is current and complete, they do not have to file a new credentialing application with GCHP.

County Organized Health System (COHS): A managed care health plan serving Medi-Cal members in a designated county. The COHS known as Gold Coast Health Plan (GCHP) only serves Ventura County.

Covered Billed Charges: The amount charged by a provider for services that are covered Medi-Cal benefits. This amount may be different from the total billed charges, as some of the billed charges may be for non-covered services. GCHP will deduct the total amount of charges for non-covered services from the total billed amount to determine the Covered Billed Charges.

Covered Services: All medically-necessary services to which members are entitled from the Plan, as set forth in the Member Handbook, including primary care, referral specialist, medical, hospital, preventive, ancillary, emergency and health education services.

Crossover Claim: A claim for a member who is eligible for both traditional Medicare and Medi-Cal, where traditional Medicare pays a portion of the claim and Medi-Cal is billed for any remaining deductible and/or coinsurance. These members are often referred to as "Medi-Medi" or dually eligible members. These members are classified as Administrative members. California law limits Medi-Cal reimbursement for a crossover claim to an amount that when combined with the Medicare payment should not exceed the maximum allowed under the Plan's contract with the provider. (Refer to *Welfare and Institutions Code*, Section 14109.5.)

Cultural and Linguistic Services: GCHP is committed to delivering culturally- and linguistically-appropriate health care services to its diverse membership. The goal of Cultural and Linguistic Services is to ensure that all GCHP members – regardless of race, gender, sexual identity, sexual orientation, color, physical or mental disability, religion, national origin or language ability – have equal access to quality health care.

Department of Health Care Services (DHCS): A state regulatory organization that finances and administers a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal). Its mission is to protect and promote the health status of Californians through the financing and delivery of individual health care services.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program: Provides routine physicals and well-child exams, including developmental screenings for Medi-Cal eligible children at specified ages. It is considered preventive care. Children are checked for medical / behavioral health problems early. Specific screenings are recommended as children grow older.

Eligible Beneficiary: Any Medi-Cal beneficiary assigned to GCHP who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal agreement. The member must be certified as eligible for Medi-Cal by the county agency responsible for determining the initial and continuing eligibility of persons for the Plan's service area.

Emergency Medical Condition: A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; b) Serious impairment to bodily functions; or c) Serious dysfunction of any bodily organ or part.

Emergency Services: Those health services needed to evaluate or stabilize an emergency medical or psychiatric condition.

Encounter Data: Captures the interaction between a patient and a provider who delivers services to the patient. It includes detailed information about the individual services rendered by a provider contracted with a managed care entity.

Enrollment: The process by which the Ventura County Human Services Agency (HSA) determines the Medi-Cal benefit eligibility of an individual. The agency then communicates the eligibility status to GCHP.

Excluded Services: Services that are non-covered or carved-out for which the Plan is not responsible and for which it does not receive a capitation payment from DHCS.

Expedited Review: A case that may involve an imminent and serious threat to the health of a member, including, but not limited to, severe pain or potential loss of life, limb or major bodily function, to be resolved within 72 hours from the time of receipt of the request. If this is an Expedited Grievance, it might not involve the appeal of an Adverse Benefit Determination; however, it can be urgent or expedited in nature.

Fee-For-Service Payment (FFS): The lowest allowable Medi-Cal payment that is permitted by DHCS. This rate is the lower of the following rates applicable at the time the services were rendered by the provider: a) The usual charge made to the general public by the provider; b) The maximum FFS rate determined by DHCS for the service under the Medi-Cal Program; or c) The rate agreed to by the provider. All covered services that are authorized and compensated by the Plan pursuant to its written service agreement will

be compensated by the Plan at the lowest allowable FFS rate unless otherwise identified in a special attachment to the signed agreement.

Fiscal Year of Plan: The 12 calendar months for which the Plan prepares and submits its financial reports. GCHP's fiscal year starts July 1 and ends June 30.

Formulary: The list of pharmaceuticals that have been approved for prescribing by Plan providers and use by enrolled members. Any prescriptions for drugs or other items that are not on the formulary will require prior authorization by the Plan in accordance with the procedures outlined in this manual.

GCHP Managed Member: An eligible Medi-Cal beneficiary who is enrolled with GCHP and is not required to select a PCP (e.g., certain foster care children).

Gemini Diversified Services (GDS): The Credentials Verification Organization (CVO) that has contracted with GCHP to verify primary source documentation of credentials for all provider applicants wanting to join the Plan's network to serve Medi-Cal beneficiaries in Ventura County.

Gold Coast Direct Members: An eligible Medi-Cal beneficiary who is enrolled with GCHP and is assigned to a PCP. These members will have an aid code of L1, M1 or 7U.

Governmental Agencies: The state Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Justice (DOJ), and California Attorney General and/or any other agency that has jurisdiction over the Plan or Medi-Cal (Medicaid).

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, interpersonal relationships such as rudeness of a provider or employee, and the member's right to dispute an extension of time proposed by GCHP to make an authorization decision.

Health Information Form (HIF) / Member Evaluation Tool (MET): A screening tool sent to newly-enrolled GCHP members to identify those who may need expedited services.

Health Insurance Portability and Accountability Act (HIPAA): HIPAA was enacted in 1996 by Congress to protect health insurance coverage for workers and their families under certain conditions related to employment. This law also covers issues of privacy over the collection, use, handling and disclosure of confidential patient records called Private Health Information (PHI).

Hospital: Any acute general care facility.

Hospital Observation Services: Hospital Observation Services shall be approved without an authorization for the first 24-hour period. For observation services in excess of the initial 24-hour period, the hospital shall notify GCHP to request the Plan's review of medical necessity to extend observation services and the Plan's authorization to extend observation services. Any extension of observation services in excess of an initial 24-hour period shall be limited to one additional 24-hour period only (i.e., the total period for observation services shall not exceed 48 hours). The Plan will conduct subsequent review of medical necessity for such extended observation services by no later than the end of the next business day. Should the hospital fail to notify GCHP to request the Plan's review of medical necessity to extend observation services and the Plan's authorization for an extended period of observation services for a member, payment for any claims submitted by the hospital for such additional observation services are subject to the Plan's review and determination that such additional observation services were medically necessary. Accordingly, the Plan shall not be responsible for payment of any observation services that the

Plan determines are not medically necessary. In no event shall the Plan be responsible for payment for observation services in excess of 48-hours (i.e., two 24-hour periods or two calendar days).

Identification Card (ID Card): The card that is prepared and issued by GCHP which bears the Plan's logo and contains the member's: a) Name, b) ID number, c) PCP or Clinic (if assigned / regular member) and d) Other identifying information. NOTE: The card is not proof of the member's Medi-Cal or GCHP eligibility.

Language Access: All Limited English Proficiency (LEP) members and seniors and persons with disabilities (SPD) are entitled to free interpreter and translation services when accessing medically-necessary covered services.

Limited Service Hospital: Any hospital which is under contract with the Plan, but not as a primary hospital since it is located outside of Ventura County. (See: Primary Hospital definition).

Long-Term Care (LTC): The care of patients in long-term care who are in need of nursing care and assistance with activities of daily living.

Medical Home Case Management: The responsibility for primary and preventive care, and for the referral, consultation, and ordering of therapy, admission to hospitals, provision of Medi-Cal covered health education and preventive services, follow-up care, coordinated hospital discharge planning that includes necessary post-discharge care, and maintenance of a medical record with documentation of referred and follow-up services.

Medically Necessary: Reasonable and necessary services to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. These services will be in accordance with professionally-recognized standards of medical practice and not primarily for the convenience of the member or the participating provider. When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21, medical necessity is expanded to include the services that are necessary to correct or ameliorate the defects and physical and mental illnesses and conditions discovered by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening services.

Medi-Cal Managed Care Program: The program under which GCHP operates in accordance with its Medi-Cal agreement with the Department of Health Care Services (DHCS) for the service area.

Medi-Cal Provider Manual: The state Department of Health Care Services' (DHCS) provider manual, issued by the DHCS Fiscal Intermediary for the state.

Member (Regular): An eligible Medi-Cal beneficiary who is enrolled in GCHP and is required to select a PCP. Enrolled members will have the name of their PCP listed on their GCHP ID cards.

Member Handbook: The GCHP Medi-Cal Combined Evidence of Coverage and Disclosure Form that sets forth the benefits to which a Medi-Cal member is entitled under the Medi-Cal Managed Care Program operated by GCHP, the limitations and exclusions to which the Medi-Cal member is subject, and the terms of the relationship and agreement between GCHP and the Medi-Cal member.

Non-Emergency Medical Transportation (NEMT): Transportation services required to access medical appointments and to obtain other medically-necessary covered services by members who have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323. Transportation is provided by Ventura Transit System (VTS) via non-emergency ambulances, gurney vans, or wheelchair vans.

Non-Medical (NMT) Transportation: Transportation services to and from a medical appointment for treatment or screening when an ambulance, litter van or wheelchair van is not medically needed. NMT is provided by Ventura Transit System (VTS) using passenger vehicles.

Non-Physician Medical Practitioner: A physician assistant, nurse practitioner, registered nurse or certified midwife authorized to provide primary care services under physician supervision.

Notice of Action (NOA): A formal letter informing a member and/or provider of a benefit determination.

Notice of Appeal Resolution (NAR): A formal letter informing a member that an Adverse Benefit Determination has been overturned or upheld.

Observation Service: Covered Services furnished to a member by a hospital on the hospital's premises, including the use of a bed and physician periodic monitoring and active monitoring by the hospital's nursing or other ancillary staff. Observation Services is for patient care, which is considered reasonable and necessary as ordered by a physician to evaluate a patient's condition on an outpatient basis or to determine the need for an inpatient admission.

Out-of-Area: The geographic area outside of Ventura County.

Out-of-Plan: Non-contracted providers located inside or outside of Ventura County, also referred to as "non-par" providers, indicating that they are not participating providers in the Plan's network.

Outpatient Services: Medical procedures or tests that can be done in a medical facility without requiring an overnight stay. Outpatient services include:

- Wellness and prevention, such as counseling and weight loss programs.
- Diagnosis, such as lab tests and MRI scans.
- Treatment, such as some surgeries and chemotherapy.
- Rehabilitation, such as physical therapy.

Participating Hospital: A facility licensed by the state as an acute care hospital or other licensed facility that provides covered services - or for any out-of-area / out-of-plan services as authorized by the Plan - to Medi-Cal members through a written agreement between the participating hospital and the Plan.

Participating Provider: A health professional, facility or vendor typically licensed by the state and credentialed to provide covered services to members and that has executed an agreement with GCHP to participate in the Plan's network of contracted providers.

Per Diem Payment: The all-inclusive, fixed amount of payment for a hospital day, unless exceptions (carve-outs) are listed. The applicable per diem payment is described in the hospital service agreement.

Physician: A person who holds a degree of Doctor of Medicine (MD) or Osteopathy (DO) from an accredited university.

Plan: The Medi-Cal Managed Care Program governed by the Ventura County Medi-Cal Managed Care Commission (VCMMCC), doing business as Gold Coast Health Plan (GCHP), serving Ventura County's Medi-Cal eligible beneficiaries.

Plan Partner: A health care service plan, subject to regulation by the Department of Managed Health Care (DMHC), which contracts directly with GCHP and:

- Is responsible for providing health care services for GCHP members.

- Receives compensation for those services on any capitated or fixed periodic payment basis.
- Is responsible for the processing and payment of claims made by providers for services rendered on behalf of the Plan partner that are covered under the capitation or fixed periodic payment made by GCHP to the Plan partner.

Primary Care Provider (PCP): A clinic, physician(s) or mid-level licensed professional practicing under physician supervision who has an agreement with the Plan to provide primary care services. The individual must be licensed by the appropriate professional state board and enrolled in the state's Medi-Cal program. The PCP is responsible for supervising, coordinating, and providing primary care services to members, initiating referrals, and maintaining the continuity of care for the members who select or are assigned to the PCP. PCPs include general and family practitioners, internists, pediatricians, and other mid-level professionals, such as nurse practitioners, physician assistants, etc.

Primary Care Provider (PCP) Directory: The listing of all PCPs and clinics that is periodically updated and published by the Plan. It is provided to members to help them in their selection of a PCP for each member of their family (members of the same family do not have to select the same PCP). Members are able to change their selection. (See: Auto Assignment)

Primary Care Services: Those services defined in Attachment C of the PCP Medical Services Agreement and are provided to members by a PCP. These services constitute a basic level of health care usually rendered in ambulatory settings and focus on general health needs. (See: Capitation Payment)

Primary Hospital: Any hospital affiliated with participating PCPs that has a written agreement with GCHP to provide covered services to members.

Provider Advisory Committee: A committee composed of 10 voting members. Each seat represents a constituency served by the Plan and serves as a platform to exchange ideas and present peer / community interests to the Plan regarding health care matters at the national, regional, state and local levels.

These issues may include, but are not limited to:

- Improvement of health care and clinical quality.
- Improvement of communications, relations and cooperation between physicians and the Plan.
- Matters of a clinical or administrative nature that affect the interaction between physicians and the Plan.

Provider Manual: The manual of operational policies and procedures for the Plan.

Quality Improvement Program (QIP): Systematic activities to monitor and evaluate the clinical and non-clinical services provided to members according to the standards set forth in statute, regulations, and the Plan's agreement with DHCS. The QIP consists of processes that measure the effectiveness of care, identify problems, and implement improvement on a continuing basis towards an identified target outcome measurement. The Plan's QIP is overseen by the Quality Improvement Committee (QIC).

Referral Physician (also referred to as a Participating Provider): Any qualified physician, duly licensed in California, who meets the general credentialing requirements of the Plan and has signed an agreement with the Plan. The provider, to whom a PCP may refer any member for consultation and treatment, has an executed agreement with the Plan.

Referral Services: Covered services, which are not primary care services, provided by specialist physicians on referral from a PCP.

Service Agreement: An agreement entered into between a licensed physician, hospital, allied health care professional (non-physician, non-hospital), or other such health care providers and the Ventura County Medi-Cal Managed Care Commission (VCMMCC), doing business as Gold Coast Health Plan (GCHP).

Service Area: GCHP's service area in Ventura County and the zip codes located therein.

Urgent Care Services: Services furnished to an individual who requires services within 12 hours to avoid the likely onset of an emergency medical condition.

Vision Care: Pursuant to the policies and limitations of the Medi-Cal schedule of covered vision benefits, the eye examination, eyeglasses prescription and basic low-cost frames will be provided by the Plan's contracted optometrist, VSP. Lenses must be provided by the Prison Industries Authority (PIA) under contract with DHCS.

Section 3: Provider Application, Credentialing and Contracting

Initial Application Process and Re-credentialing

Providers or health care professionals who are interested in partnering with Gold Coast Health Plan (GCHP) to be a contracted provider or health care professional should contact the Provider Relations Department at **ProviderRelations@goldchp.org** or Customer Service at 1-888-301-1228.

To participate in the GCHP network, all providers must have their credentials approved by the Plan's Credentials / Peer Review Committee and sign a service agreement with the Plan. Providers are re-credentialed within 36 months of the initial credentialing date or last re-credentialing approval date.

Pursuant to the Provider Services Agreement, all new providers and those eligible for re-credentialing must return a signed credentialing application form to GCHP, along with all other required attachments including, but not limited to, copies of the following:

- A current and valid professional license to practice in California.
- A current and valid federal DEA Certificate for practitioners with the authority to write prescriptions, as applicable, for practice.
- Board certification or eligibility is a requirement for GCHP Physicians requesting network participation after May 8, 2015. The practitioner must have relevant education (residency) in their practicing specialty. New graduates must become board certified within two years of first eligibility. Board certification requirements may be waived upon review by the Credentials / Peer Review Committee if the practitioner has five years of verified relevant work history and/or has unrestricted, current active privileges in the specialty area.
- Documentation showing that the provider is currently participating in Medi-Cal.
- Documentation for National Provider Identifier (NPI) and Taxonomy Code.
- Professional Liability Insurance (malpractice) face sheet (Required limits are $1 million per occurrence / $3 million annual aggregate).
- Signed Taxpayer Identification Form (W-9).
- Signed current Attestation Form declaring the accuracy of all information submitted.

Additional Requirements for Child Health and Disability Prevention Program (CHDP), Comprehensive Perinatal Services Program (CPSP), HIV/AIDS

For some physician specialties, there are additional credentialing pre-requisites. For example, pediatricians and family practice specialists who care for children should also be paneled by the Child Health and Disability Prevention Program (CHDP) to participate in GCHP's network. Neonatologists should be certified by California Children's Services (CCS). Obstetricians should be paneled by the Comprehensive Perinatal Services Program (CPSP). HIV/AIDS specialists must document that they meet certain additional education and training requirements. For more information on these requirements, please contact GCHP's Provider Relations Department at **ProviderRelations@goldchp.org**.

Council for Affordable Quality Healthcare (CAQH) and Gemini Diversified Services (GDS)

The Council for Affordable Quality Healthcare (CAQH) is a nationally-recognized, centralized repository or warehouse for provider credentialing information. If the physician applicant is a participant with CAQH and has all active credentialing information on file and up-to-date, then the provider does not need to submit a completed credentialing application to GCHP. The provider merely has to authorize access for GCHP to obtain primary source documentation from the CAQH repository and confirm that all information is accurate and up to date. If this is not the case, the provider will either have to file with CAQH or complete the credentials application provided by Gemini Diversified Services (GDS). GDS is a Credentialing Verification Organization (CVO) that has contracted with GCHP to verify primary source documentation for

all GCHP providers. Neither CAQH nor GDS make any recommendations to approve or deny admission to GCHP's network. All initial credentialing and re-credentialing decisions are the sole responsibility of the GCHP Credentials / Peer Review Committee.

Credentialing for Organizational Providers

GCHP conducts initial assessments and re-assessments of organizational providers to evaluate and confirm that the organizational provider has met all regulatory and quality requirements as set forth by the Plan's policies and procedures, the Department of Health Care Services (DHCS), National Committee for Quality Assurance (NCQA) standards, and any other applicable regulatory entities. Organizational providers will be re-assessed within three years of the last assessment date.

GCHP will credential and re-credential:

- Hospitals.
- Skilled Nursing Facilities / Long-term Care Facilities.
- Freestanding Surgical Centers.
- Home Health Agencies / Hospice Providers.
- Freestanding Acute Rehabilitation Facilities.
- Freestanding Birthing Centers.

Each organizational provider must meet minimum standards for participation in GCHP. These guidelines are intended to comply with regulatory and accreditation standards established by DHCS or its designee, NCQA, GCHP, and state laws. The GCHP standards for participation include:

- A copy of the current and valid state license.
- A copy of the current General and Professional Liability Insurance Coverage face sheet (Required limits are $1 million per occurrence / $3 million annual aggregate).
- A copy of the documentation of accreditation status.
- Verification of current Medi-Cal license number.
- Verification of the provider being in good standing with state and federal regulatory bodies and complying with all federal, state, local, city and county laws and regulations currently in effect or later enacted by these agencies as they relate to services rendered to members.

The requirements for the types of organizational providers are:

Hospitals:

- All hospitals must be accredited by an acceptable organization.
- A copy of current accreditation by an acceptable organization is required. Acceptable accrediting organizations for hospitals are The Joint Commission (TJC) and Det Norske Veritas Healthcare (DNV).
- A copy of the valid state license.
- A copy of the current Liability Insurance Coverage face sheet.
- Verification of current Medi-Cal License Number.

Skilled Nursing Facilities / Long-Term Care Facilities:

- Accreditation by an acceptable organization or a survey report or letter from the Centers for Medicare and Medicaid Services (CMS) or the California Department of Public Health (CDPH) stating that, within the last three years, the organization has been reviewed and passed inspection.
  - » Acceptable accrediting organizations are: TJC, Commission on Accreditation of Rehabilitation Facilities (CARF) or Continuing Care Accreditation Commission (CCAC), Accreditation Association for Ambulatory Health Care (AAAHC).

- Copy of the valid state license.
- Copy of the current Liability Insurance Coverage face sheet.
- Verification of current Medi-Cal License Number.

Freestanding Surgical Centers:
- All Freestanding Surgical Centers must be accredited by an acceptable organization.
- Copy of a current certificate from TJC, American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), Accreditation Association for Ambulatory Health Care (AAAHC), Institute for Medical Quality (IMQ).
- Copy of the valid state license.
- A copy of the current Liability Insurance Coverage face sheet.
- Verification of current Medi-Cal License Number.

Home Health Agencies / Hospice Providers:
- Accreditation by an acceptable organization or a survey report or letter from CMS or CDPH stating that, within the last three years, the organization has been reviewed and passed inspection.
- Copy of a current accreditation by TJC, Community Health Accreditation Program (CHAP), Accreditation Commission for Home Cared, Inc. (ACHC), or CCAC.
- Copy of the valid state license.
- Copy of current Liability Insurance Coverage face sheet.
- Verification of current Medi-Cal License Number.

Freestanding Acute Rehabilitation Facilities:
- Accreditation by an acceptable organization or a survey report or letter from CMS or CDPH stating that, within the last three years, the organization has been reviewed and passed inspection.
- Copy of accreditation by TJC or CARF.
- Copy of the valid state license.
- Copy of current Liability Insurance Coverage face sheet.
- Verification of current Medi-Cal License Number.

Freestanding Birthing Centers:
- Birthing centers must be accredited by one of the following agencies (a copy of the certificate is required): TJC, AAAHC, Critical Access Certification for hospitals, Commission for the Accreditation of Birth Centers (CABC).
- A copy of the Division of Health Services regulation license for each site (or a letter attesting to all covered sites), if applicable.
- A general liability insurance face sheet for each site (or a letter attesting to all covered sites). It must include current coverage dates, provider name, address and limits of coverage. Minimum coverage for all networks is $1 million per occurrence / $3 million aggregate.
- A copy of the policies and procedures for coverage arrangements with a participating provider and hospital in the event of an emergency, is required.
- City business license (if applicable).
- Medi-Cal and Medicare certification.

Non-Accredited Organizational Providers:
GCHP may substitute a CMS or state review in lieu of the required site visit. The CMS or state review may not be older than three years at the time of verification. GCHP will obtain the survey report or letter from CMS or the state, from either the provider or the agency, stating that the facility was reviewed and passed. Non-Accreditation substitution is not applicable to hospitals, freestanding surgical centers, and freestanding birthing centers, as they are required to be accredited by an acceptable organization.

Facility Site Review (FSR) for Primary Care Office Locations

Before the credentialing verification process is finalized, a nurse from GCHP will visit each PCP location to conduct a Facility Site Review (FSR). After the site review and complete processing of the information provided (including license status, wheelchair access, fire extinguishers, etc.), the initial credentialing and re-credentialing files are submitted to the Credentials / Peer Review Committee for review and approval. If a provider's credentials are approved, the chairperson of the committee or their designee will formally authorize the provider's Service Agreement.

Notification of Adverse Actions Taken Against You or Your Staff

Federal and state laws require that you notify GCHP immediately by phone (followed-up by written notification) if any of the following actions are taken against you or any practitioner on your staff:

- Revocation, suspension, restriction or non-renewal of license, certification, or clinical privileges.
- A peer review action, inquiry or formal corrective action proceeding or investigation.
- A malpractice action or government action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the state licensing board or similar organization or the National Practitioner Data Bank (NPDB) of adverse credentialing or peer review action.
- Any material changes in any of the credentialing information.
- Sanctions under the Medicare or Medicaid programs.
- Any incident that may affect any license or certification or that may materially affect performance of the obligations under the Service Agreement with GCHP.

Appealing Adverse Decisions by the Credentials / Peer Review Committee

If the Credentials / Peer Review Committee should make a decision that alters the condition of a provider's participation with GCHP based on issues of quality of care or service, the provider may appeal the adverse decision.

Upon written notification from GCHP of a notice of action or proposed action to the provider, the provider will have 30 days from the date of receipt to request a fair hearing. The provider must submit a written request to GCHP directed to the director of the Quality Improvement Department. Failure to request a hearing within 30 days will be deemed a waiver of the right to a hearing on the matter.

If a provider fails to meet the credentialing standards or if their license, certification or privileges are revoked, suspended, expired or not renewed, GCHP must ensure that the provider does not render any services to the Plan's members. Additionally, any conduct that could adversely affect the health or welfare of a member will result in written notification instructing the provider not to render services to members until the matter is resolved to the Plan's satisfaction.

Debarment, Suspension, Ineligibility or Voluntary Exclusion

In accordance with 45 CFR (Code of Federal Regulations) Part 76, GCHP receives indirect federal funding through the Medi-Cal program and, therefore, must certify that it has not been debarred or otherwise excluded from receiving these funds. Because GCHP receives this funding, GCHP is considered a "lower tier participant" under this rule.

As subcontractors, GCHP's providers — who essentially receive federal funding by nature of their agreement with the Plan — are also considered "lower tier participants" and must also attest to the fact that, by signing the Provider Service Agreement, they have not been debarred or otherwise excluded by the federal government from receiving federal funding. Pursuant to this certification and your agreement

with GCHP, should you or any provider with whom you hold a subcontract become suspended or ineligible to receive federal funds, you are required to notify GCHP immediately.

Fraud, Waste and Abuse Reporting Program

As a provider, you are required to report to the Plan any incident of fraud, waste and/or abuse that may have occurred by members, providers, or employees within 10 days from the date when you first became aware of, or were put on notice of, such activity.

To report fraud, waste and abuse, call GCHP's Compliance and Fraud Hotline at 1-866-672-2615 or email **https://gchp.alertline.com**. All calls and emails can remain anonymous. Please refer to Section 17 for further details.

Provider Contract Termination

To ensure that medically-necessary, in-progress, covered medical services are not interrupted due to the termination of a provider's contract, GCHP assures continuity of care for its members, as well as for newly-enrolled individuals who have been receiving covered services from a non-participating provider.

Additionally, GCHP shall make a good faith effort to notify members who received their primary care from, or were seen on a regular basis by, the terminated contracted provider within 15 business days of receipt of issuance of the termination notice from the provider and at least 30 calendar days prior to the effective date of the termination.

In the case of unforeseen circumstances, if GCHP receives less than 30 calendar days' notice of a change in the provider contract, GCHP shall notify members of the change within 14 calendar days prior to the effective date of the change.

Primary care providers and specialists shall notify GCHP members no less than 60 days prior to terminating their contract. This allows time to assist beneficiaries with a new assignment. If GCHP terminates a provider's contract without prior notice as a result of his or her endangering the health and safety of members, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, GCHP shall provide written notification to affected members within 30 days of the date of the contract termination. If GCHP determines that it is in the best interest of the member, GCHP may modify the notification period to the members.

Upon contract termination, the provider will, at the Plan's option, continue to provide covered services to members who are under the care of the provider at the time of the termination until the services being rendered are completed, unless the Plan has made arrangements for the assumption of such services by another physician and/or provider. The provider will help the Plan in the orderly transfer of the members to the provider they choose or to whom they are referred after termination, including, but not limited to, the transfer of the member's medical records. The transition of a member's care post termination shall be in accordance with the phase-out requirements set forth in the Medi-Cal agreement. Payment by the Plan for the continuation of services by the provider after the effective date of termination will be subject to the terms and conditions set forth in the agreement.

In the event of a natural disaster or emergency, GCHP shall notify members of any significant changes in the availability or location of covered services within 14 calendar days of the change.

Continuity of Care

When a practitioner's contract is terminated or discontinued for reasons other than medical discipline, fraud, or other unethical activity, a member may be able to receive care from the practitioner after the

contract ends. Continuity of care is permitted for:

- A chronic condition.
- A serious chronic condition and/or a terminal illness.
- A pregnancy and care of a newborn child from birth to 36 months (not to exceed 12 months from the contract termination).
- Surgery or other procedure that has been authorized and documented by the provider to occur within 180 days of the contract termination.
- Any other covered service dictated by good professional practice.

The practitioner must continue to treat the member and must accept the payment and/or other terms of the GCHP service agreement. For an acute or terminal condition, the services shall be covered for the duration of the illness or episode of care.

Section 4: California State Programs

Coordination of Care

Gold Coast Health Plan (GCHP) encourages and supports coordination and continuity of care across the care continuum. Primary Care Providers (PCP) play an important role in coordinating the care of their GCHP members. To ensure that PCPs understand the importance of their role in coordinating care, provider training, provider bulletins and other means of communication are used.

Community agencies also provide critically-needed support to GCHP's members. Some of the community agencies integral to service delivery include:

- Ventura County Child Health and Disability Prevention (CHDP) Program
- Ventura County California Children's Services (CCS)
- Ventura County Behavioral Health Department (VCBHD)
- Ventura County Regional Centers
- Women, Infants, and Children (WIC) Program
- Ventura County Public Health Department (VCPHD)
- School-based program(s)

To facilitate collaboration with the county's public health agencies, GCHP develops and signs Memorandums of Understanding (MOU). These MOUs provide a framework for working collaboratively to ensure coordination of the member's care.

California Children's Services (CCS)

CCS is a statewide program managed by the Department of Health Care Services (DHCS) and administered by the Ventura County Health Care Agency's (VCHCA) CCS office. CCS provides medical case management and financial assistance to GCHP members under the age of 21 who are eligible to receive CCS services.

Conditions that qualify for CCS coverage are those that limit or interfere with physical function but can be cured, improved or stabilized.

Only providers who have been approved by CCS are eligible for reimbursement under the CCS program. CCS reimbursement is separate from any reimbursement under GCHP and is billed directly through the CCS program. GCHP will not cover CCS-eligible services denied by CCS because the rendering provider is not paneled by CCS.

CCS-qualifying conditions include birth defects, handicaps present at birth or later developed, and injuries from accidents or violence, such as congenital heart disease, endocrine disorders (including diabetes), organ transplant, prematurity, AIDS, major trauma, craniofacial anomalies, inherited metabolic disorders, chronic renal disease and hemophilia. These are conditions that tend to be relatively uncommon, chronic rather than acute, and are costly. They generally require the care of more than one health care specialist.

If you determine that a member may have a CCS-qualifying condition, you must refer the member to CCS for case certification, case management and treatment.

Please notify GCHP's Health Services Department at 1-888-301-1228 immediately about any potential CCS-qualifying condition.

Members under the care of CCS will continue to remain enrolled in GCHP for primary care services and referrals unrelated to the CCS conditions. The PCP relationship remains intact for all health care interventions unrelated to the CCS condition.

GCHP's Health Services Department will help identify CCS-eligible conditions through a review of referrals, claims and encounters for diagnosis categories, as well as during hospital concurrent reviews. In addition, GCHP will work with providers, admitting physicians, hospital discharge planners, perinatologists, neonatologists, or hospital pediatricians, as appropriate, to ensure that potential candidates are referred to CCS.

GCHP and CCS have a shared goal of establishing a consistent process that will ensure every GCHP member within the CCS program has a specified and documented medical home. GCHP care teams work together with families, providers and CCS to match medical homes for optimal outcomes.

For information on how to become a CCS provider, contact the local CCS office at 1-805-981-5281.

Child Health and Disability Prevention (CHDP)

CHDP is a program to ensure periodic health assessments and services for low-income children and youth in California. CHDP is funded by both state and federal governments to ensure the provision of a pre-specified maximum number of preventive-care visits for children under 21 years of age who are enrolled in Medi-Cal.

Health assessments are provided by CHDP-approved providers, local health agency departments, community clinics, managed care plans, and some local school districts. As noted previously, GCHP pediatricians and family practice specialists who treat children should receive prior certification from CHDP to join the GCHP network. Providers interested in becoming approved CHDP providers should contact the local CHDP office at 1-805-981-5291.

Some of the services covered by CHDP include, but are not limited to:

- Dental screenings
- Developmental assessments
- Health and development history
- Immunizations
- Laboratory tests and procedures (including tests for serum levels of lead)
- Nutritional assessments
- Periodic health examinations
- Psychosocial screenings
- Speech screenings
- Vision screenings

For members under the age of 21, the Initial Health Assessment (IHA) and the scheduled health appointments outlined by the American Academy of Pediatrics (AAP) are to include age-specific assessments and services required by the CHDP program. Complete guidelines for CHDP services are available **here**.

Comprehensive Perinatal Services Program (CPSP)

CPSP provides a wide range of services to pregnant women from conception to 60 days postpartum. Women receive enhanced services in addition to standard obstetric services, including nutrition, psychosocial support and health education. This comprehensive approach has proven to reduce problems

and medical complications caused by low birth weight infants, thus reducing costs of care and adverse outcomes.

For more information, refer to CPSP's website or call a CPSP Perinatal Services Coordinator at 1-866-241-0395.

Members with Developmental Disabilities or Developmental Delay

The IHA is performed when enrolling new children into your practice. During the IHA, you will identify those who have, or are at risk of acquiring, developmental delays or disabilities, including those who have signs and symptoms of mental retardation, cerebral palsy, epilepsy or autism. Additionally, developmental screening is a required part of each well-baby and well-child visit. Children who are at risk for developmental delay may also be identified during prenatal examinations when developmental histories as well as physical and neurological examinations are conducted.

A developmental disability is a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions similar to mental retardation that starts before the age of 18, is likely to continue indefinitely, and constitutes a significant handicap for the individual. A developmental delay is an impairment in the performance of tasks or the meeting of milestones that a child should achieve by a specific chronological age.

GCHP covers all medically-necessary and appropriate developmental screenings, primary preventive care, diagnostic and treatment for members who have been identified with, or are suspected of having, developmental disabilities, and for members who are at high risk of parenting a child with a developmental disability. GCHP assures that members identified with developmental disabilities receive all medically-necessary screening, preventive and therapeutic services as early as possible.

As noted earlier, GCHP has entered into an MOU with various agencies to coordinate its activities in serving members with special needs. For example, some members are referred to the appropriately-funded agency, such as the Local Education Agencies (LEA). Other agencies in Ventura County are part of a statewide system of locally-based regional centers that offer supportive services programs for California residents with developmental disabilities. Regional centers provide intake and assessment services to determine client eligibility and needs and work with other agencies to provide the full range of early intervention services. Regional centers can provide specific information on the services available in the member's service area. Services include respite day programs, supervised living, psychosocial and developmental services, and specialized training.

Members with developmental disabilities are linked to a PCP, who provides them with all appropriate preventive services and care, including necessary Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Preventive care is provided per the current guidelines of the American Academy of Pediatrics (AAP) and the U.S. Preventive Services Task Force (USPSTF) for adults.

As a PCP, you are required to provide or arrange for medically-necessary care to correct or ameliorate developmental disabilities and provide / arrange for all medically-necessary therapies and items of durable medical equipment within the scope of your practice. For services that are beyond the scope of your practice, you should make the necessary referrals and coordinate with the appropriate funding agency.

Early Start Program for Infants and Toddlers

The Early Start Program is California's response to federal legislation ensuring that early intervention and medically-necessary diagnostic and therapeutic services are provided to infants and children up to 3 years of age to prevent disabilities — and that such services are provided in a coordinated, family-centered network.

GCHP members eligible for early intervention services are infants and toddlers from birth to 36 months for whom documented evaluation and assessment confirms that the child has a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing.

State legislation requires that you refer children between 0 to 36 months to the Early Start Program for evaluation if they exhibit a significant developmental delay, have multiple risk factors, or have an established risk factor. The referral must take place within 48 hours of the assessment.

GCHP has entered into an MOU with the local Early Start Program administered by Tri-Counties Regional Center to coordinate services to members.

Community-Based Adult Services (CBAS)

GCHP manages the CBAS benefit for Medi-Cal members. The state eliminated the Adult Day Health Care (ADHC) benefit in 2012 and replaced it with this Medi-Cal benefit.

CBAS provides services and support to eligible Medi-Cal or eligible GCHP members to keep them healthy and help them live safely at home. Providers should identify potential members to determine if they qualify for CBAS. If you identify a potential member who would benefit from the services provided through the CBAS program, you should refer the member to GCHP for an evaluation.

To qualify, members must be:

- 18 years old or older.
- Diagnosed with a significant physical, behavioral, or memory problem that impedes activities of daily living (ADLs).
- At risk for institutionalization in a long-term care facility

Please adhere to the following claims pre-submission check list:

- Eligibility must be verified prior to billing.
- National Provider Identifier (NPI) must be actively registered with GCHP.
- Prior authorization is required for initiation of all CBAS services.
- Claims must be billed on a UB-04 claim form.
- Claims must be submitted within six months of the date of service.
- All required fields must be completed, or your claim will be rejected.
- Providers and clearinghouses are required to enroll as a trading partner to submit claims electronically.

For more information about CBAS benefits, including eligibility and referral to providers, please visit GCHP's **website**.

Other Health Coverage Premium Payment (OHCPP) Program

GCHP may pay private health insurance premiums for certain qualified Medi-Cal beneficiaries. For example, a member may qualify for OHCPP if they have a high-cost medical condition, chronic condition, private health insurance, and/or high-cost monthly premiums. If you believe a member qualifies for this benefit, please have the member contact GCHP's Member Services Department at 1-888-301-1228 to obtain the necessary forms and instructions on how members may apply for OHCPP.

Objectives of OHCPP

The OHCPP program was established by the enactment of Assembly Bill 3328 (AB 3328, Margolin 1989) and it is codified in the Welfare and Intuitions Code (W & I, Section 1412491) and the California Code of Regulations (CCR, Title 22, Section 50778). These statutes authorize GCHP to pay private health coverage premiums for its members whenever it is cost-effective to do so, thus ensuring that GCHP is the payer of last resort. Medi-Cal / GCHP is billed first only for beneficiaries with health coverage provided through the Indian Health Act (1905B), the Ryan White Act (Title SS V12617b 3F), Title V Programs (1902) (i.e., CCS, or Special Education Programs (1903.c)). The chart below summarizes the eligibility requirements as well as the documents needed for a member to participate in OHCPP.

Eligibility and Documentation Requirements for OHCPP

Eligibility Requirements	Documentation Requirements
The applicant is CURRENTLY on full-scope Medi-Cal.	A completed and signed Health Insurance Questionnaire.
The applicant is a resident of Ventura County.	A completed and signed OHCPP Application along with: • Release of Information Form • Payee Data Record • OHCPP Disclosure Statement • A copy of current insurance card and policy booklet
The applicant has a high cost chronic medical condition.	A signed and dated provider's statement of diagnosis, prognosis and treatment plan.
The average monthly savings to GCHP is at least twice the monthly premiums.	A copy of the latest insurance premium payment notice or signed COBRA election form.
The applicant's health coverage policy is not issued through the state's Major Risk Medical Insurance Board.	Copies of the Explanation of Benefits (EOB) required from the insurance company detailing the medical costs of the last six months.
The applicant's health coverage policy covers the seriously chronic high cost medical condition.	A list of current medications including dosage and cost.

Despite a member's participation in OHCPP, the member will continue to receive medical benefits from GCHP. GCHP implements the OHCPP by purchasing the health coverage for its members only when the expected savings are at least double the amount of the premium cost. In addition, for GCHP to continue to pay the premiums, each case must be re-evaluated annually to determine if it remains cost effective; annual re-evaluation will also be performed for patients who have organ transplants or AIDS. When a GCHP member participates in OHCPP, the Plan's responsibilities are to:

- Review and process the required forms.
- Establish a beneficiary case and tickler file for re-evaluation to be conducted annually.
- Initiate premium payments to the insurance carrier, employer, or beneficiary.

Vision Services

GCHP contracts with local optometrists to provide limited vision services to Medi-Cal members.

On July 1, 2009, the state excluded optometry services from coverage for adults under the Medi-Cal program. As of July 26, 2010, the state reinstated optometry services as a Medi-Cal covered benefit for members 21 years of age or older. This benefit is limited for adults. It only includes routine eye examinations, office visits, and certain diagnostic, ancillary and supplemental procedures used for the evaluation of the visual system. A routine eye exam is covered once every 24 months. Members with diabetes are entitled to an annual eye exam. Services relating to the supply, replacement or repair of eyeglasses and other eye appliances will remain non-covered benefits for adult members.

Medi-Cal will pay for eyeglasses, contact lenses or other corrective measures to assist with the vision needs of the following members:

- Pregnant women, only if the doctor says that not having eyeglasses will be harmful to the baby or pregnancy.
- People under 21 years of age who have full scope Medi-Cal.
- Members who live in a nursing home.

Services for new eyeglasses or to repair eyeglasses will continue to be available every two years for members under 21 years of age.

The eye examination, eyeglass prescription and basic low-cost frames will be provided by GCHP contracted optometrists, but lenses must be provided by the Prison Industries Authority (PIA) under contract with DHCS. For more information about this benefit, contact DHCS's Vision Services Branch at **vision@dhcs.ca.gov** or go to the websites for **DHCS** or **Medi-Cal**. You may also call GCHP's Customer Service Department at 1-888-301-1228 or DHCS at 1-800-541-5555.

Routine vision care services for GCHP members are managed by VSP. Please call VSP at 1-800-877-7195 for information on participating optometrists, benefits and details of coverage.

For information on becoming a participating provider with VSP for GCHP, please call the VSP Provider Network Department at 1-800-852-7600 ext. 5339.

Carved-Out Services and Limited Benefits

Certain medical or allied-health services are covered benefits but are not administered by GCHP. GCHP is not responsible for authorizing or providing those services. They are covered directly by the state Medi-Cal program. These are referred to as "Carved-Out Benefits." The following is a list of the benefits that are administered by and billed directly to the state Medi-Cal program:

- Dental services: Call Denti-Cal at 1-800-322-6384 for assistance in locating a Medi-Cal dentist or to obtain prior authorization for service.
- Specialty Mental Health: Providers are required to provide assistance to GCHP / Medi-Cal members needing specialty mental health services (for serious mental illnesses) by referring them to Ventura County Behavioral Health Services.
- In addition, providers should coordinate services with the designated mental health provider, as appropriate. Contact the Ventura County Behavioral Health Department's STAR Program and/or Crisis Team at 1-866-998-2243 for referral information.
- Substance Use Disorder Services: Treatment for substance use disorders is available through the Ventura County Behavioral Health Department's Alcohol and Drug Programs at 1-805-981-9200. Voluntary inpatient detoxification is also a Medi-Cal benefit.
- Laboratory services provided under the state serum alpha-fetoprotein testing program and administered by the Genetic Disease Branch of DHCS.
- Targeted case management services as specified in Title 22 CCR Section 51351.
- Services rendered in a state or federal hospital.
- Home and community-based waivered services (e.g., In Home Operations, HIV/AIDS Home and Community Based Services Waiver, Multipurpose Senior Services, Community Based Adult Services).
- CCS providers must identify and refer members with CCS-eligible medical conditions to the local CCS program for authorization of such services. GCHP's CCS Liaison Case Manager will guide you through the CCS referral process. Call the care manager at 1-888-301-1228. The number for CCS in Ventura County is 1-805-981-5281.
- Early Start Program for early intervention and medically-necessary diagnostic and therapeutic services provided to infants and children ages 0 to 36 months that have, or are at risk for developing, disabilities.
- Members with developmental disabilities who shall be referred to the appropriate agency, such as the Local Education Agencies (LEA).

For details about any of these programs, call GCHP's Customer Service Department at 1-888-301-1228 to obtain current referral or contact information.

LIMITED BENEFITS

Audiology

Audiology evaluations (hearing tests) are a limited benefit. This service is covered only for the following members:

- Pregnant women (only as part of pregnancy-related care).
- Members residing in a licensed nursing home such as a Skilled Nursing Facility (SNF), Intermediate Care Facility / Developmentally Disabled (ICF-DD), or Sub Acute Facility.
- Children / young adults 20 years old and younger receiving full-scope Medi-Cal (Children / young adults 20 years old and younger with suspected hearing loss of 30 db or greater should be referred to CCS.).

Hearing aids are a covered benefit.

To obtain this benefit, the following steps need to be completed:

- Referral by a PCP to an Otolaryngologist.
- Referral for hearing aid evaluation from an Otolaryngologist.
- Evaluation by an audiologist with results forwarded back to the Otolaryngologist.

For members who do not qualify for audiology services under Medi-Cal, the evaluation by an audiologist is performed at the member's expense.

Audiology results must include:

- Pure tone air conduction threshold and bone conduction test of each ear.
- Speech tests (aided and unaided).
- Speech Reception Threshold (SRT).

Behavioral Health Care

Outpatient mental health services for the treatment of mild-to-moderate mental health conditions are a benefit covered by GCHP / Beacon Health Options. Contact Beacon Health Options at 1-855-765-9702 or **click here** for the Primary Care Provider Referral Form. These services include:

- Individual and group mental health testing and treatment (psychotherapy).
- Psychological testing to evaluate a mental health condition.
- Outpatient services that include lab work, drugs, and supplies.
- Outpatient services to monitor drug therapy.
- Psychiatric consultation.

Services for relational problems are not covered. This includes counseling for couples or families for conditions listed as relational problems. Relational problems are problems with your spouse or partner, parent-child problems, or problems between siblings.

Applied Behavioral Analysis (ABA) and Behavioral Health Treatment (BHT) for children under the age of 21 are also covered benefits through Beacon Health Options. Members may receive ABA or BHT for the medically-necessary treatment of disorders related to developmental delays. These members are often linked to Tri-Counties Regional Center (TCRC). Any member with qualifying diagnoses not associated with TCRC will begin ABA / BHT services with GCHP / Beacon Health Options directly. The following elements apply:

- Any GCHP member with qualifying diagnoses up to the age of 21 will be eligible for ABA / BHT services.

- After a diagnostic work-up and prescription from a physician or psychologist is obtained, ABA / BHT services can be provided by a qualified autism service provider or a service professional or a paraprofessional supervised by a qualified autism service provider.

- The diagnosis of developmental delay must be made by a physician or psychologist and a prescription for ABA / BHT services is necessary before services can be provided. If a physician feels qualified to make this diagnosis, a prescription for ABA / BHT must be written and a referral to Beacon Health Options should be made.

Beacon providers will then perform a comprehensive diagnostic evaluation (CDE) and develop an ABA / BHT treatment plan. If a physician does not feel comfortable making this diagnosis, the member can be referred to Beacon to obtain the diagnosis from a licensed psychologist.

The following services are not covered:

- Respite care
- Custodial care
- Educational services

GCHP services cannot duplicate services received through other agencies, such as those outlined in an Individualized Educational Program (IEP) from a Local Educational Agency (LEA). For questions, contact Beacon Health Options at 1-855-765-9702.

Chiropractic

Chiropractic treatment is available to GCHP members when provided at a contracted Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). GCHP covers chiropractic services only when they are:

- Limited to a maximum of two services per calendar month without prior authorization.
- Limited to treatment of the spine by means of manual manipulation.

Note: Only one chiropractic manipulative treatment code, 98940 – 98942, is reimbursable when billed by the same provider for the same recipient and date of service.

- The diagnosis must be listed that shows anatomic cause of symptoms, such as sprain, strain, deformity, degeneration or malalignment.

Acupuncture

Acupuncture services are available to all GCHP members. There is no authorization necessary; however, the following provisions must be followed (as defined in Title 22 CCR § 51308.5):

1. Services must be rendered by a physician, dentist, podiatrist or certified acupuncturist enrolled in the Medi-Cal program and who is eligible to provide Medi-Cal services.
2. Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally-recognized medical condition.
3. Acupuncture is covered either with or without electric stimulation of the needles.

Section 5: Medi-Cal Eligibility

Categories of Medi-Cal Eligibility: Aid Codes

GCHP does not determine Medi-Cal eligibility. Eligibility resides with the state, the Ventura County Human Services Agency (VCHSA) and the Social Security Administration (SSA) for members with Supplemental Security Income (SSI). There are more than 160 categories of Medi-Cal eligibility, also known as aid codes. These aid codes are assigned by eligibility staff at VCHSA or the SSA (for members with SSI) based on the federal and state guidelines.

The Medi-Cal aid code is the two-digit number or combination of letters and numbers that indicates the specific Medi-Cal program category under which the individual qualifies. The aid code can be found on the Medi-Cal eligibility website. The aid codes for GCHP members can be found when checking eligibility on GCHP's Provider Web Portal. The GCHP ID card does not provide the member aid code.

Any requests related to eligibility aid codes not covered by GCHP should be directed to the Medi-Cal field office at 1-888-472-4463 or VCHSA at 1-866-904-9362.

Types of Medi-Cal: Levels of Benefits

Medi-Cal is California's version of the federal Medicaid program. With a combination of federal and state funding, Medi-Cal provides health care coverage to families, children, and those who are elderly and disabled who meet certain income and asset thresholds. Medi-Cal offers three basic levels of benefits — full scope, limited scope, special programs, and share of cost (SOC).

Full-Scope Medi-Cal

The majority of GCHP's Medi-Cal beneficiaries are eligible for full-scope Medi-Cal, which provides coverage for the full range of Medi-Cal covered services. A person may be eligible for full-scope Medi-Cal with or without an SOC.

Limited-Scope or Restricted Medi-Cal

Limited-scope or restricted Medi-Cal provides coverage only for emergencies, pregnancies, services related to breast and cervical cancer, and long-term care services. An individual may be eligible for limited-scope Medi-Cal with or without an SOC. GCHP currently covers only a few limited-scope aid codes. Most other limited-scope aid codes are under fee-for-service (FFS) Medi-Cal, which is administered directly by the state.

Special Programs

Medi-Cal also has aid codes that provide a limited scope of coverage. These special-program aid codes include Tuberculosis (TB) and minor-consent services.

Share of Cost (SOC)

SOC is the amount that the individual or family is required to pay out-of-pocket for medical expenses before becoming eligible for Medi-Cal benefits during that month. It is comparable to what a commercial health insurance plan refers to as a "deductible." For example, if a person has an SOC of $150, the member must pay that amount out of pocket on medical expenses before you may bill Medi-Cal for any services rendered that month that are in excess of the member's SOC. An SOC is a monthly obligation - it

must be met each month in order for the individual to be covered by Medi-Cal that month. SOC Medi-Cal recipients do not become GCHP members until they have met their SOC for that month.

Once they meet their SOC, they become administrative members of GCHP and may receive care from any willing Medi-Cal provider in GCHP's service area.

Providers can post monies paid for services toward a member's SOC via the Medi-Cal Point of Service (POS) system (SOC amounts should be posted on the day the member paid for the service). Call the POS / Internet Help Desk at 1-800-541-5555 for assistance with installing the equipment and executing the connectivity test transaction. Please do not contact GCHP for assistance with posting a member's SOC.

Administrative vs. Regular Member

A "regular" or "full-scope" member of GCHP is an individual who has selected or has been assigned to a PCP. An "administrative" member is one who is not assigned to a specific provider or clinic and, therefore, may see any willing Medi-Cal provider or GCHP contracted provider. Administrative members will have "Administrative Member" listed on their GCHP ID cards in the PCP section rather than the name of a doctor or clinic. Some GCHP Medi-Cal members will be administrative members and they are subject to change based on eligibility for services in specific aid categories.

The change of a member's status from regular to administrative or vice-versa is not automatic. If the member's eligibility status should be changed, contact the member's eligibility worker to discuss the circumstances. The member's eligibility worker – not GCHP – is responsible for coordinating the process of changing the member's eligibility.

Claims for services rendered to administrative members are sent to GCHP unless the member is also in the CCS program and the claim is for CCS-related care, in which case the claim should first be forwarded to the CCS office. If the member has other health coverage, the claim should be sent to the primary payer. All covered services that are provided to eligible administrative members for which GCHP is responsible are reimbursed on a fee-for-service basis in accordance with the state fee schedule during the effective dates of service.

Eligibility, Enrollment and Member ID Cards

Individuals and families apply for Medi-Cal through the VCHSA. Elderly and disabled individuals who receive SSI automatically receive Medi-Cal along with their SSI benefit.

Eligibility for Medi-Cal is month-to-month. Most Medi-Cal recipients must re-certify their eligibility every 12 months. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Eligibility for Medi-Cal can also be effective retroactively in some cases. Please note that a member's eligibility must be verified with GCHP before delivery of services — the GCHP ID card alone is not a guarantee of eligibility.

Selection of a Primary Care Provider (PCP)

The major elements of the selection process for members who are eligible as full-scope or managed care members are:

- Selection of a PCP upon enrollment.
- New members receive an enrollment package containing a PCP Directory.
- Members must complete the PCP Selection Form indicating their choice of PCP and return it to GCHP.

- If GCHP receives a member's PCP Selection Form prior to the last business day of the month, the member will be enrolled with their PCP on the first calendar day of the following month.
- If a member does not choose a PCP, GCHP will auto-assign the member to a PCP based on a predetermined algorithm.
- A member may change their PCP for any reason, but not more frequently than every 30 days. The change will be effective the first day of the month following the change request, but only if the request is made prior to the last business day of the month.
- Members may request to change their PCP by contacting GCHP.
- Members may choose any of the doctors or clinics listed in the GCHP Primary Care Provider section of the Provider Directory as their PCP. If the PCP is not open to new members, GCHP will ask the member to choose another PCP.

How to Verify Eligibility

To check member eligibility online, you will be required to register at the **Provider Web Portal**. When you visit the portal, you will be guided through the registration process by using the Web Portal User Guide. Please refer to the state Medi-Cal website if you need to verify fee-for-service Medi-Cal status.

The online and automated eligibility systems will provide you with the following information:

- The member's PCP. Check to ensure that you are the assigned PCP before making an appointment.
- Whether the member is an administrative or regular member.
- The member's eligibility for CCS (if applicable, on the Medi-Cal website). Other ways to verify eligibility are to:
  - Call GCHP's Member Services Department at 1-888-301-1228 Monday through Friday from 8 a.m. to 5 p.m. When you call, please provide all of the following:
    - The member's full name.
    - The member's GCHP ID number.
    - The member's date of birth.
    - The date(s) of service for which you want to check eligibility.

Please remember that not all Medi-Cal beneficiaries will be GCHP members. If you cannot verify eligibility for a Medi-Cal member through GCHP, swipe the Benefits ID Card (BIC) or check the state's Medi-Cal **website**.

Member ID Card

The state issues a plastic Medi-Cal ID card known as the Benefits ID Card (BIC). The BIC shows the member's name, date of birth, 14-digit ID number, and the date the card was issued. Use this information to verify eligibility with the state. VCHSA may issue a temporary paper card when the member cannot wait for the state-issued BIC.

The GCHP ID card identifies Medi-Cal recipients enrolled with GCHP and shows the member's GCHP ID number, which is comprised of the first nine digits of the BIC. However, this ID card is not a guarantee of eligibility or payment for services. It is the responsibility of the provider to verify eligibility and PCP assignment before providing services. To view an example of the ID cards, please visit the Member Handbook **here**.

Out-of-Area Medi-Cal Beneficiaries

Medi-Cal beneficiaries who become eligible for Medi-Cal benefits in a county other than Ventura and are not assigned to GCHP are not the responsibility of GCHP. Medi-Cal providers who render services to these beneficiaries should submit claims to the state Medi-Cal program or the appropriate Medi-Cal managed care plan.

When a member moves out of the area, they must notify their Medi-Cal eligibility worker or, for those receiving SSI, the Social Security Administration.

If you become aware of GCHP members who have moved or are planning a permanent move out of GCHP's service area, please contact the Plan's Member Services Department at 1-888-301-1228 and provide the out-of-area address so that it may be confirmed that the member has reported the move to their eligibility worker. The majority of GCHP members who leave the service area will eventually become the financial responsibility of the new county of residence and cease to be GCHP members. The timeframe in which this change will take place depends on several factors and can take from one to two months.

Relocation out of the Plan's service areas will not result in a change of responsible county when it involves the placement of foster / adoptive children out of the Plan's service area or other out-of-area placement of children or residents of LTC facilities when there is a local conservator or guardian involved.

Benefits

For a complete summary of benefits for GCHP Medi-Cal members, please refer to the **Member Handbook**. If assistance or clarification is required, please call the Customer Service Department at 1-888-301-1228 / TTY 1-888-310-7347.

Section 6: Responsibilities of the Medical Home and Primary Care Provider (PCP)

The medical home has the primary responsibility of coordinating and structuring preventive and disease management care for Gold Coast Health Plan (GCHP) members. The PCP is the main provider of health care services in the medical home and is responsible for leading their team to ensure appropriate and timely delivery of health care to members. The PCP is contractually obligated to provide GCHP with office hours, staffing and any on-call or after-hours coverage arrangements. Office hours and an emergency 24-hour number must be clearly displayed in the provider's office. The PCP is responsible for supervising, coordinating, and providing primary care services to members and for maintaining the continuity of care for the members who select or are assigned to the medical home. PCPs include general and family practitioners, internists, OB/GYNs, pediatricians, physician assistants, and nurse practitioners.

Access to Care

Medical home responsibilities include, but are not limited to, the following:

- Providing the full scope of quality primary care health services to GCHP members who have chosen them as their medical home, including preventive, acute and chronic health care.
- PCPs who administer vaccines to children are required to participate in the Vaccine for Children (VFC) Program.
- PCPs should ensure access to care 24 hours per day, seven days per week. The medical home should have an adequate phone system to handle the member call volume.
- PCPs should ensure or facilitate patient access to the health care system and appropriate treatment interventions.
- PCPs are responsible for arranging consultations with referral specialists, including initiating and coordinating referrals to specialists or other GCHP participating providers as needed.
- PCPs are responsible for follow up and monitoring of appropriate services and resources required to meet the needs of the member, including identifying any clinical problems unique to your particular patient population.
- PCPs are to ensure that no unnecessary or duplicate medical services are being provided.
- PCPs should ensure that each GCHP member health record includes the information needed to facilitate both appointment scheduling and patient recall. The information should include the member's Medi-Cal number, alternate contact numbers, language needs, and any special access needs.
- The medical home is responsible for establishing a good medical records system for tracking regularly-scheduled routine appointments, failed scheduled appointments and for procedures needing completion prior to the member's next scheduled visit.
- The medical home should develop a method for patient notification for preventive care.
- The medical home should give consideration to severity of medical condition when rescheduling of appointments for unforeseen circumstances.
- General office visits, including accessibility to care at the site, should be monitored by the staff.
- The medical home should also recognize any patient complaints or comments and take them into consideration when making changes to the access and availability of care.
- PCPs are responsible for ensuring backup coverage during their absence, including while the PCP is handling an emergency call at the hospital.
- PCPs should ensure that members are not discriminated against in the delivery of services based on race, ethnicity, national origin, religion, gender identity, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.
- The medical home shall consider special needs of GCHP members when scheduling appointments.

- The medical home should have recorded instructions for GCHP members calling after hours. The members should be advised by a recorded outgoing message that if the situation is a true medical emergency, they should hang up and call 911 or go to the nearest hospital. This message should be recorded in at least English and Spanish and possibly other languages if the provider has GCHP members that speak languages other than English and Spanish.
- The medical home with an after-hours answering service should contact the PCP or designated covering physician within 30 minutes for urgent questions. The PCP or designee is required to call the member back within 60 minutes for probable urgent problems and within four hours for probable non-urgent matters.
- The PCP is responsible for coordinating and directing appropriate, medically-necessary services, risk assessment, treatment planning, including the following:

Routine Appointments

Primary non-emergency appointments should be available within 10 business days of the request for an appointment. These visits are described as care appropriate at a primary care level for evaluation and treatment of non-acute problems for new or established patients.

Physical Examinations

Appointments for routine physical examinations should be available within six weeks of the request. If possible, special consideration should be given to GCHP members who require a physical examination as part of their employment.

Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessment (IHEBA)

DHCS requires that each PCP complete a comprehensive IHA and IHEBA for all newly-assigned members within 120 days of the member's enrollment, unless the PCP has determined that the member's medical record is sufficiently current to enable an assessment of the individual's health status. At a minimum, an IHA should consist of a comprehensive history and physical examination and the IHEBA.

The IHEBA is to be included in the member's medical record and available during subsequent health visits. Providers must make repeated attempts to contact the member to schedule an IHA. At least three documented attempts that demonstrate the provider's unsuccessful efforts to contact a member to schedule an IHA and IHEBA are required. Contact methods must include at least one phone call and one mail notification. Providers shall document in the medical record that the IHA and IHEBA were completed. If the member declined to complete the IHEBA form, it must also be documented in the medical record.

Staying Healthy Assessment (SHA)

The SHA is the DHCS-sponsored and approved IHEBA. The SHA forms may be found on GCHP's website or the DHCS website. The SHA is available in multiple languages.

In addition, screening using the age-specific IHEBA-SHA must be included in the IHA. The tool and instructions can be found **here**.

- If the SHA is completed by the member, providers should explain to the member the SHA's purpose and how it will be used by the PCP.
- Providers shall offer SHA translation, interpretation, and accommodations for any disability, if necessary. Providers and their staff can contact GCHP's Cultural and Linguistics Department at **CulturalLinguistics@goldchp.org**.
- Providers should assure members that the SHA responses will be kept confidential in the member's medical record and that the member has the right to skip any questions.

- If the member refuses to complete the SHA, providers must document the refusal on the SHA and refer to the SHA instruction sheet for information on documenting the refusal in the medical record. The SHA provider instructions may be found on the GCHP or DHCS websites.
- A parent / guardian must complete the SHA for children under 12.
- For those ages 12 to17, providers may encourage patients to complete the SHA without a parent or guardian.
- The adult SHA is for ages 18 to 54; the senior SHA is for ages 55 and above.

Specialty Care

Whenever possible, specialty care will be provided by GCHP providers within the Plan's service area. If a medically-necessary specialty service is unavailable within the Plan's service area, contact GCHP staff to coordinate care outside of the area.

Specialist (SPC) responsibilities include, but are not limited to, the following:

- Appointment with an SPC within 15 business days of the request.
- The SPC should ensure access to care 24 hours a day, seven days a week. The SPC's office should have an adequate phone system to handle the member call volume.
- The SPC must ensure that each GCHP member health record includes information needed to facilitate both appointment scheduling and patient recall. The information should include the member's Medi-Cal number, alternate contact numbers, language needs, and any special access needs.
- The SPC may arrange referrals to other specialists for consultation without referring the member back to the PCP; however, the SPC should continue to keep the PCP informed of the member's health.
- The SPC is responsible for establishing a good system for tracking regularly-scheduled appointments, failed-scheduled appointments and for procedures needing completion prior to the member's next scheduled visit.
- The SPC's office should give consideration to the severity of the medical condition when rescheduling appointments for unforeseen circumstances. If possible, patients should have same-day appointments.
- General office flow, including accessibility to care at the site, should be monitored by the staff. The SPC's office should also recognize any patient complaints or comments and take them into consideration when making changes to the access and availability of care.
- The SPC is responsible for ensuring backup coverage during their absence, including while the SPC is currently handling an emergency call at a hospital.
- The SPC should ensure that members are not discriminated against in the delivery of services based on race, ethnicity, national origin, religion, gender identity, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.
- The SPC should consider the special needs of GCHP members when scheduling appointments.
- The SPC's office should have recorded directions for members calling after hours. Members should be advised by a recorded outgoing message that if the situation is a medical emergency, they should hang up and call 911 or go to the nearest hospital. This message should be recorded in English and Spanish and possibly other languages if the provider has GCHP members who speak other languages.
- The SPC's after-hours answering service should contact the SPC or designated covering physician within 30 minutes for urgent questions. The SPC or designee is required to call the member back within 60 minutes for probable urgent problems and within four hours for probable non-urgent matters.

First Prenatal Visit

The first prenatal visit must be scheduled within two weeks of the member's request.

Preventive Care

As a PCP, you are required to provide preventive health care according to nationally-recognized criteria. If you need assistance with Preventive Care Guidelines for either children or adult patients, the GCHP prevention guidelines are based on the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF) recommendations. **Click here** to view the recommended immunization schedule for adults and children.

24/7 Availability

GCHP will ensure that a Plan health care professional or a physician will be available 24 hours a day, seven days a week to coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically-necessary post-stabilization services, and for general communication with hospital emergency room personnel.

Timely member access to health care, delivered in an appropriate, cost effective setting, will be ensured through a monitoring process using acceptable performance standards. Below is a brief description of the access standards for GHCP Medi-Cal members:

Type of Care	Wait Time
Emergency Services	Immediately
Urgent Care	Within 24 hours (no prior authorization required)
Primary care	Within 10 business days of request for appointment
Behavioral Health	Within 10 business days of request for appointment
Specialty care	Within 15 business days of request for appointment
Phone wait time	Within 3 to 5 minutes whenever possible
Ancillary services for diagnosis or treatment	Within 15 business days of request for appointment
Initial Health Assessments (IHA) and Individual Health Education Behavioral Assessments (IHEBA)	Within 120 calendar days of enrollment
Waiting time in office	Not to exceed 45 minutes after time of appointment
Sensitive services	Ensure confidentiality and ready access to sensitive services in a timely manner and without barriers – NO AUTHORIZATION REQUIRED

Medical Records

The medical home is responsible for maintaining adequate medical records of patient care. Records should be maintained in accordance with applicable state and federal privacy laws. GCHP has the right to review records for claims and service authorization. All medical records should be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for seven years after the termination of the contract with GCHP and for the period of time required by state and federal laws and membership contracts, including the period required by the Knox-Keene Health Care Service Plan Act and Regulations and the Medicare and Medi-Cal programs.

Access to and Copies of Records

GCHP's Health Services, Quality Improvement or Compliance departments may request records from your office for a covered member for several reasons, including:

- Quality Improvement studies mandated by the state, such as the Healthcare Effectiveness Data and Information Set (HEDIS®) or Consumer Assessment of Healthcare Providers and Systems (CAHPS®).
- Prior authorization requests.
- Claims payments issues.
- Assistance with case coordination.
- Possible CCS referrals for CCS-eligible conditions.
- Follow-up to a member complaint.

For complete details on provider responsibilities relative to medical records, please refer to your signed service agreement with GCHP.

Reporting Encounter Data

Encounter data is detailed information about individual services rendered by a provider contracted with a managed care plan. The level of detail about each service reported is similar to that of a standard claim form. (Encounter data for capitated providers where no claims payment is expected since services are prepaid are also sometimes referred to as "shadow claims" or "dummy claims.")

Capitated providers are required by GCHP to submit claims for all services, even though they are pre-paid by capitation. Claims that have been pre-paid via capitation are considered "encounter data" in that the claim describes the details of patient encounters with the PCP. The Plan requires that you submit encounter data at least once a month, as the information is critical for disease management programs and HEDIS® studies. Most importantly, this data is used by the state to set future GCHP revenue, which has a direct impact on the Plan's payments to providers.

PCPs may transmit encounter data as paper or electronic files using the Health Insurance Portability and Accountability Act (HIPAA)-compliant, Ansi 837 format. Detailed guides are available **here**.

If you would like to send this information electronically, please contact GCHP's Customer Service Department at 1-888-301-1228 for assistance and possible referral to the Plan's Information Technology (IT) vendor, ACS.

Confidentiality of Information

Providers are responsible for maintaining the confidentiality of information about members and their medical records, in accordance with applicable federal and state laws. The names of any members receiving public social services must be kept confidential and protected from unauthorized disclosure. This includes all information, records and data collected and maintained for the operation of the agreement. Providers may not use any such information for any purpose other than carrying out the terms of their agreement. In compliance with the HIPAA regulations and the privacy rules for Protected Health Information (PHI), members are entitled to an accounting of any disclosure of their confidential information.

Primary Care Provider (PCP) Request for Member Reassignment

Requesting member reassignment should be the last resort for an untenable patient / provider relationship. It is a measure not taken lightly. Policies and procedures governing a PCP request for member reassignment are as follows:

The medical home must notify GCHP's Provider Relations Department in writing regarding the PCP's desire to reassign a member. Complete documentation regarding the nature of the problem must be included with the request. Requests to reassign a member will be considered based on criteria outlined in this Provider Manual.

A Provider's request to transfer the member to another medical home requires the Plan's approval. Such requests for transferring a member to another medical home will be granted for the following reasons:

1. Significant lack of cooperation, understanding and/or communication between the doctor and patient. In such cases, the medical home and the Plan will use their best efforts to provide the member with the opportunity to be served by a PCP with whom a satisfactory provider / patient relationship can be developed. If the Plan is unable to make such arrangements and the member is in active care, the PCP will continue to serve the member according to the PCP's best professional judgment until the Plan is able to change the member's PCP, for a period not to exceed two months.
2. A provider can cease providing care for a non-assigned member when the provider / patient relationship becomes unsatisfactory. In these cases, the provider must notify the member in writing that they will no longer provide care for the member.
3. A specialist can cease providing care for any member when the provider / patient relationship becomes unsatisfactory. In these cases, the specialist must notify both the PCP and the patient that they will no longer provide care to the patient. The PCP will refer the member to another participating specialist for care and treatment if specialist care is still medically necessary.

Requests to transfer a member to another medical home due to the patient's medical condition resulting in high costs or frequent visits will not be granted.

Requests will be reviewed and the medical home will be notified of the Plan's decision. Once the PCP has been notified of the reassignment, it is expected that the medical home will notify the member in writing regarding the PCP's decision to terminate the member from their practice and that the PCP will no longer be responsible for the member's medical care as of the date of the reassignment. GCHP's Member Services Department will contact the patient to facilitate assignment with a medical home.

The medical home will send a copy of the letter to the Provider Relations Department for storage. Exceptions to this policy will be considered on a case-by-case basis.

Member requests for change of PCP will be reviewed by the Plan's Member Services Department.

Change of PCP requests from members during active treatment require special review by the Plan's chief medical officer (CMO). Normally, such member requests will not be granted until the treatment plan is completed. However, if the new PCP is willing to accept the transfer of the member in active care, the request will generally be granted.

Transportation from PCP Office to Hospital

When a PCP determines that a member requires immediate hospitalization from his or her office, the PCP may determine, at their own medical discretion, which is the most appropriate and safe mode of transportation – emergency, non-emergency or non-medical.

Non-Emergency Medical Transportation (NEMT) Requests

NEMT services are a Medi-Cal covered benefit. If a GCHP member is not able to ride public or private transportation, the member may qualify for NEMT services under their Medi-Cal benefit. There is no cost when transportation is authorized by the Plan.

Who Qualifies for the Medi-Cal NEMT Benefit

NEMT is covered only when a member's medical and physical condition does not allow the member to travel by bus, passenger car, taxicab or another form of public or private conveyance. A member meets the NEMT benefit if they:

- Are in a wheelchair and are not able to move in and out of the chair into a seat, or are not able to move the wheelchair without assistance.
- Need to travel with specialized services, equipment or a caregiver.
- Are not able to sit up and must ride lying down.

How the NEMT Benefit Works

A few important points about the NEMT benefit:

- A physician or specialist must submit an NEMT form to GCHP which constitutes a prescription and attestation of the medical necessity for transportation service.
- All NEMT services are subject to GCHP review and the NEMT form verification process.
- The verification process for the NEMT form takes no longer than five business days.
- NEMT requires at least 48-hour notice for all standard requests.
- If the transportation request is of an urgent nature and needs to occur in less than 48 hours, call GCHP's Member Services Department at 1-888-301-1228.
- NEMT is not covered if the member is seeking care that is not a service that is covered by Medi-Cal or Medicare.

How to Request NEMT Services for a Member

1. Verify the member's eligibility using GCHP's Provider Portal, GCHP's IVR System, Medi-Cal's AEVS system, or Medi-Cal's eligibility website.
2. Provider must complete the **NEMT form**.
3. Fax the NEMT form to GCHP's Health Services Department at 1-855-883-1552.
4. After GCHP receives the NEMT form, GCHP will begin the verification process of the form.
5. Once the NEMT form is verified by GCHP, the Plan will then forward the form to the transportation vendor.
6. NEMT vendor will contact the member and provider to schedule and verify the medical appointment.

What to Include on the NEMT Form

These elements must be completed on each NEMT form for each medical appointment:

1. The medical purpose of the transportation.
2. The frequency of the necessary medical transportation or inclusive dates of the requested medical transportation.
3. Caregiver request and reason the member needs a companion for their medical appointment.
4. Medical or physical condition that makes normal public or private transportation inadvisable.
5. Member attestation that they have no means of transportation.
6. The NEMT form must be dated and signed by a physician, physician assistant, nurse practitioner, certified nurse midwife, physical therapist, speech therapist, occupational therapist or mental health / substance use disorder provider consistent with their scope of practice. When a medical home provider submits an NEMT Prescription / Attestation form, all requests for transportation to any medically-necessary, GCHP-covered appointment will be fulfilled with that single request form.
7. When an NEMT Prescription / Attestation form is received from a provider other than the member's medical home provider, NEMT services will be approved for transportation to and from that provider location only.

Non-Medical Transportation Requests

NMT is transportation to and from all medically necessary-services covered by Medi-Cal, even those not covered by GCHP, when an ambulance, litter van or wheelchair van is not medically needed. NMT is provided by VTS using passenger vehicles at no cost to GCHP members.

Prior authorization is not required for NMT and members may contact VTS directly at 1-855-628-7433 or 1-800-855-7100 (California Relay Services).

For questions, call GCHP's Member Services Department at 1-888-301-1228.

Member Procedures / Rights for Emergency Care

All providers should have a phone prompt that says, "If this is an emergency, please hang up and call 911 or go to the nearest emergency room."

In any emergency, in accordance with GCHP's Member Handbook, members have a right to access care at any hospital or facility. Once the member is post-stabilized, the member will be moved to a contracted facility if it is medically necessary.

Section 7: Quality Improvement

Gold Coast Health Plan's (GCHP) Quality Improvement Program (QIP) strives to continuously improve the care and quality of service for its members in partnership with its contracted provider network as exhibited by its dedication to the concept of measurement and re-measurement, and documenting strong actions taken and results. These goals are aligned with the current version of the DHCS Strategy for Quality Improvement in Health Care and with the state's mission to preserve and improve health.

GCHP's quality program is centralized under the Plan's chief medical officer (CMO). The scope of the QIP encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:
   - Preventive services
   - Chronic disease management
   - Prenatal care
   - Family planning services
   - Behavioral health care services
   - Medication management
   - Coordination and continuity of care
   - Care management
2. Quality of nonclinical services including, but not limited to:
   - Accessibility
   - Availability
   - Member satisfaction surveys
   - Grievance process
   - Cultural and Linguistic appropriateness
3. Patient safety initiatives including, but not limited to:
   - Facility site reviews
   - Credentialing of practitioners
   - Peer review
   - Sentinel event monitoring
   - Health education
4. A QI focus which represents:
   - All care settings
   - All types of services
   - All demographic groups

QIP Goals

The QIP goals include:

- Continuously improving the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Measuring and enhancing member satisfaction with the quality of care and services provided by the Plan's network providers.
- Maintaining compliance with state and federal regulatory requirements.
- Identifying opportunities and making improvements based on the measurement, validation and interpretation of data.
- Providing oversight of delegated entities to ensure compliance with GCHP standards as well as state and federal regulatory requirements.

GCHP's Quality Improvement Committee (QIC) oversees the monitors established by GCHP's committees. Performance indicators are tracked to maintain a continuous focus on the Plan's operational and clinical priorities for improvement.

Quality Improvement Committee (QIC)

The QIC is responsible for the monitoring and enhancement of organization-wide quality improvement processes to ensure the delivery of quality customer service and access to high quality medical services. It is accountable to the Ventura County Medi-Cal Managed Care Commission (VCMMCC).

The QIC's objectives are to:

- Ensure that QIC members can have candid discussions about barriers to achieve quality goals and objectives, and to facilitate the removal of such barriers.
- Ensure that a communication process is in place that enables horizontal and lateral communications to adequately track open and resolved action items on the annual QI Work Plan.
- Integrate the QIP with other operational functions of GCHP.
- Conduct an annual evaluation of the QIP.
- Establish and conduct an annual review of quality and performance improvement projects (PIP) related to significant aspects of clinical and non-clinical services.
- Identify opportunities for improvement through analysis of information collected from the HEDIS® performance measures and utilization management patterns of care.
- Encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve how care and services are delivered.

GCHP addresses the needs of its members with complex as well as non-complex health needs through its Care Management Program. GCHP offers care management for the coordination of health care and continuity of care. Through the provision of care coordination, targeted education and resource management, GCHP promotes member wellness, autonomy, and appropriate use of services and financial resources. Members can refer themselves to the Care Management Program. Referrals can also come from caregivers, providers and internal departments; hospitals and GCHP discharge planners; community agencies; as well as review of data and utilization patterns.

The QIC's responsibilities are to:

- Facilitate data-driven indicator development for monitoring access, care and service, and quality improvement project interventions.
- Review quarterly committee meeting minutes, action item logs and reports regarding monitoring of health plan functions and activities.
- Suggest interventions or corrective actions that adhere to the rapid cycle improvement methodologies.
- Oversee the annual review, analysis and evaluation for achievement of goals and effectiveness of the QIP, quality improvement policies and procedures, and the QI Work Plan for presentation.
- Recommend policy changes or implementation of new policies to GCHP's administration and commission.

External Accountability Set (EAS) Performance Measures

DHCS selects a set of performance measures annually, known as the External Accountability Set (EAS), to evaluate the quality of care and services delivered to the Plan's members. DHCS selects most EAS measures from the National Committee for Quality Assurance (NCQA) HEDIS® measure set, which provides DHCS with a standardized method to objectively evaluate the Plan's delivery of care and services. The Plan must collect data to calculate and report rates for EAS measures annually. To meet this requirement, providers will receive a request for electronic or hard copies of medical records each year.

Plans must follow NCQA's timeline for collecting, calculating and reporting rates annually. Rates for the required measures are calculated per HEDIS® guidelines and/or other specified guidelines required for

the reporting year. The Plan must also calculate and report performance rates at the county level, unless directed otherwise by DHCS. The final rates will be reviewed and approved by the External Quality Review Organization (EQRO) and reported to DHCS and NCQA.

To ensure the rates reported by GCHP meet the standardized reporting requirements to allow comparability of performance rates within the health care industry, the Plan must complete an annual onsite performance measure validation audit that is conducted by the EQRO and follows NCQA's HEDIS® Compliance Audit™ methodology.

DHCS will publicly report the audited results of each DHCS-required performance measure (HEDIS® and/or other performance measurements) for each plan, along with the Medi-Cal managed care program average and comparisons to national benchmarks. Plans must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required HEDIS® measure (excluding the utilization / use of services measures). DHCS establishes a High Performance Level (HPL) for each required performance measure and publicly acknowledges plans that meet or exceed the HPLs.

GCHP must submit an improvement plan (IP) for each measure that does not meet the DHCS-established MPL or it is given an audit result of Not Reportable (NR). The IP must include an analysis of barriers, targeted interventions, and relevant data to support its analysis. IPs must also include justification for using new or existing interventions, prioritization of barriers and interventions and a mechanism for evaluating the outcome of interventions.

IPs must be signed and approved by the MCP's medical director prior to its submission to DHCS. GCHP must submit the required IPs within 60 days of being notified by DHCS of each measure for which an IP is required.

Facility Site Review (FSR)

GCHP conducts a DHCS-required, full-scope facility site review (FSR), medical records review (MRR), and physical accessibility review survey (PARS) of PCP sites as part of its provider credentialing and re-credentialing process. GCHP uses state-mandated tools prior to the PCP being assigned members. PCPs are not eligible to be assigned members until they pass the DHCS-required Site Review Survey. GCHP conducts an FSR every three years for each primary care site. GCHP staff will contact the provider about scheduling the FSR.

The purpose of the FSR, MRR and PAR is to ensure that the Plan's PCPs meet certain minimum state-required standards for their office sites for maintenance of patient medical records and to ensure physical accessibility for members with disabilities.

The FSR includes an on-site inspection and interview with the office personnel.

The MRR is based on a survey of 10 randomly-selected medical records per PCP and is comprised of five pediatric and five adult (or obstetric) records. The MRR review includes, but is not limited to, a review of format, legal documentation practices, and documentary evidence of the provision of preventive care and coordination of primary care services.

PAR surveys the facility site access for members with disabilities to parking, the building, elevators, doctor's office, exam rooms and restrooms. The survey will also identify if an exam room has a height adjustable exam table and accessible weight scale for those with disabilities.

If GCHP identifies deficiencies during the FSR, the Plan will give the provider a Corrective Action Plan (CAP), which will include specific time frames for addressing identified deficiencies to provide care to its members until the identified deficiencies have been corrected.

Performance Improvement Projects (PIP)

GCHP is required to conduct and/or participate in a minimum of two Performance Improvement Projects (PIPs) each year. PIP topics are chosen in consultation with DHCS and the QIC. PIP topics should align with demonstrated areas of poor performance, such as low HEDIS® scores. The status of the PIPs are reported at the quarterly QIC meetings.

Performance Improvement Methodology

GCHP uses the Institute for Health Care Improvement's (IHI) Plan-Do-Study-Act Cycle (PDSA) model for improvement to implement and test the effectiveness of interventions.

For more information about GCHP's Quality Improvement System, please call the Plan's Quality Improvement Department at **1-888-301-1228** for referral to the appropriate resource.

Delegation

GCHP delegates activities in accordance with the terms and conditions identified in individual contracts. GCHP will perform oversight of an entity's applicable activities to ensure full compliance with applicable Plan policies, delegation agreements and the most current NCQA, federal, state and GCHP standards.

GCHP monitors each entity's compliance with delegated functions and responsibilities, makes recommendations for improvement and monitors corrective actions.

Delegation oversight includes:

- Desktop and annual onsite reviews.
- Monitoring.
- Continuous improvement activities.

Annual Audit

Each delegate is audited at least annually to verify compliance with GCHP requirements and continued ability to perform delegated functions. The Delegation Oversight Audit evaluates the delegate's capabilities in QI, Utilization Management (UM), Credentialing / Re-credentialing, Member Rights (MR), Grievances and Appeals, DHCS (when applicable) and GCHP standards.

Audit Process

Delegation Oversight Audits are performed using the following audit tools which abide by the most current NCQA, state, federal and GCHP standards:

- Credentialing: Most current ICE Tool
- Claims: Most current ICE Tool
- QI: GCHP QI Delegation Oversight Audit Tool
- UM: GCHP UM Delegation Oversight Audit Tool
- RR: GCHP RR Delegation Oversight Audit Tool

Reporting Requirements

Reporting requirements are identified in the Delegated Service Standards / Delegation Agreement included as an attachment to each contract. Delegates are responsible for the timely submission of reports as outlined in the contract.

Non-Compliance

Findings from the annual evaluation, file audit and reports are used to identify areas of improvement and to implement a CAP when warranted. GCHP reserves the right to revoke the delegation of responsibilities when delegate entities demonstrate non-compliance.

Section 8: Care Management Program

CARE MANAGEMENT PROGRAM

The Gold Coast Health Plan (GCHP) Care Management (CM) Program is a collaborative process that includes phone contact with the member and communication with the medical home.

The Plan's CM Program is designed to support GCHP's mission "*to improve the health of our members through the provision of high quality care and services.*" GCHP strives to empower high-risk members and those who are potentially high risk to gain control of their health care needs by coordinating quality services through an appropriate, cost-effective, and timely care management plan.

The Plan's care managers are licensed registered nurses and licensed clinical social workers with specialty certifications specific to their role. The Plan's care managers are supported by care management coordinators who are familiar with Plan and community resources.

The purpose of the CM Program is to:

- Facilitate improvement in the health status and quality of life of members with both complex and non-complex medical needs.
- Decrease unnecessary hospitalization and emergency room (ER) visits by facilitating improvement in member self-management skills.
- Provide proactive coordination of care and services to members who have experienced a critical event or diagnosis requiring the extensive use of resources and who need assistance navigating the health care system.
- Coordinate care with community agencies and other resources to provide additional services not available from the Plan.

Care Management Process

Through telephone interactions with the member, the member's designated representative, and providers, the care manager collects and analyzes data about the actual and potential care needs to develop a comprehensive, goal-driven care plan. Care managers strive to empower members to exercise their options and access the services appropriate to meet their individual health needs, promoting quality outcomes.

All eligible members have the right to participate in or decline to participate in the CM program. Care coordination is provided as identified per need on a case-by-case basis.

This is done by following GCHP's guiding principles to:

- Build a trusting partnership with members through evidence-based intervention.
- Use a comprehensive, holistic approach.
- Empower members by providing education through evidence-based techniques, informed choice, and linkage to community resources.
- Apply the principle of autonomy to preserve the dignity of the member and family to promote self-determination.
- Facilitate member understanding of physician and treatment plans.
- Facilitate self management of chronic conditions through evidence-based care models.
- Facilitate the improvement of health outcomes by using evidence-based behavioral change models.

Types of Care Management

CARE COORDINATION

- What is care coordination?
  Care coordination involves short-term interventions for members with potential risks due to barriers or gaps in services, poor transitional care, and/or co-morbid medical issues that require brief care management interventions. Care coordination focuses on improving the link between members and providers to reduce inefficiencies that can lead to higher utilization.

- Who is eligible for care coordination?
  1. New members who have returned Health Information Forms (HIFs) and have a recognized need for short-term care coordination to establish care with a medical home.
  2. Members who are generally healthy or stable and engaged, and whose only need may be education or assistance with navigation of the health care system.
  3. Members who may have provider, transportation, social or other short-term issues requiring a minimal number of contacts.

- What services might be rendered under care coordination?
  1. Appointments
  2. Referrals
  3. Transportation
  4. Durable Medical Equipment (DME) needs
  5. Pharmacy
  6. PCP selection and information

- What is the primary staffing model for care coordination?
  Care management coordinators; licensed case managers as needed.

COMPLEX CASE MANAGEMENT

- What is complex case management?
  Complex case management provides intensive, personalized case management services and goal setting for members who have complex medical needs and require a wide variety of resources to manage their health and improve their quality of life. It is a collaborative process that assesses, develops, plans, implements, coordinates, monitors, and evaluates the options and services needed to meet the member's health and human service needs. It is characterized by advocacy for member engagement, communication, and resource management.

- Who is eligible for complex case management?
  1. Members who are medically fragile, have one or more severe conditions with co-morbidities which require complex care management and have a significant likelihood of exacerbations and multiple ER visits and/or re-hospitalizations.
  2. Members who may have a single severe condition or two or more conditions across multiple domains of care and whose needs must be monitored on a regular basis.
  3. Members who are being managed by other agencies for specific conditions that would benefit from coordination of care for preventive care and transitions away from the other agency as care evolves. Examples of this may be CCS clients who are also GCHP members.

- What conditions might benefit under complex case management?
  1. Multi-diagnoses
  2. Poly-pharmacy (multiple medications)
  3. Psychosocial needs

4. High users of ER / IP services
5. Needing assistance with activities of daily living (ADLs)
6. CCS coordination of care and transitions to adulthood

- What is the primary staffing model for complex case management?
  Licensed case manager (RNs and LCSWs)

DISEASE MANAGEMENT / POPULATION HEALTH:

- What is disease management / population health?
  Disease management / population health involves short-term interventions, as well as intense personalized wellness coaching, designed to address the member's needs. It is a collaborative process with a focus on self-management. Members receive coaching and education on risk factors, guidance and support on health issues, recommendations on ways to improve their health and reduce their risk. By empowering members to take control of their health, the Plan promotes the triple aim of better health care quality, lower costs, and improved patient experiences.

- Who is eligible for disease management / population health?
  1. New members who have returned a HIF with an identified health risk, such as diabetes, pre-diabetes, or asthma.
  2. Members who may have provider, transportation, social or other short-term issues requiring a minimal number of contacts.
  3. Members who may have a single severe condition or two or more conditions across multiple domains of care that may benefit from wellness coaching.

- Which members might benefit from disease management / population health?
  1. Members with asthma
  2. Members with diabetes
  3. Members with pre-diabetes
  4. High users of ER / IP
  5. Other targeted populations

- What is the primary staffing model for disease management / population health?
  Care management coordinators; licensed case managers (RNs); health navigators

Care Management Program Goals

The goals of the Care Management Program are to:

- Plan, facilitate and advocate for members through the continuum of care, consistent with accreditation standards and standards of practice.
- Collaborate and communicate with the member, significant others and family members, physicians and other members of the health care team to develop and implement a care plan that is driven by the member's goals for health improvement.
- Facilitate accomplishment of the agreed-upon goals in the member's individualized care plan.
- Provide the member / member advocate and family members with information and education that promotes self-care through self-determination.
- Promote independence by reinforcing self-care through motivational and supportive techniques.
- Educate and involve the member and family in the coordination of services.
- Facilitate optimization of available benefits.
- Strive for excellence in communication to maintain member and provider satisfaction.
- Provide timely intervention to increase effectiveness and promote efficiency of care and/or services provided to the member.

- Promote effective utilization and monitoring of health care resources while ensuring that the services that are arranged or coordinated are appropriate for the member.
- Proactively promote health improvement, independence and optimal functioning.

Referrals to GCHP Care Management

Care Management referral forms are available **here** on GCHP's website.

The form can be completed and emailed to **CareManagement@goldchp.org** or faxed to 1-855-883-1552.

Section 9: Services Requiring Prior Authorization

Prior authorization requests are reviewed by a nurse according to predetermined criteria, protocols, and the medical information from the physician or other provider. In some cases, the nurse may need to contact the provider directly to request additional information. Only licensed medical professionals employed by Gold Coast Health Plan are able to make decisions about prior authorization requests. Only the chief medical officer (CMO), medical director, or other physician reviewers have the authority to deny service authorization requests. Authorization decisions are based on evidence-based GCHP policies as well as nationally-recognized standards including:

- MCG Care Guidelines
- U.S. Preventive Services Task Force (USPSTF)
- State of California Department of Health Care Services (DHCS)

Nationally-recognized standards of practice from organizations, such as:

- American Academy of Family Physicians (AAFP)
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians (ACP)
- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American Diabetes Association (ADA)
- American Gastrointestinal Association (AGA)
- American Medical Association (AMA)
- American Urological Association (AUA)
- Centers for Disease Control and Prevention (CDC)
- National Cancer Institute (NCI)

Members must obtain a referral from their PCP before scheduling an appointment with any other provider, except for the self-referral services described below under “Self-Referral.”

Medical Services Requiring Prior Authorization

Prior authorization requests must be submitted prior to the provision of a service unless it is medically urgent or will result in an unnecessary extension of a hospital stay.

If, under exceptional circumstances, a request must be submitted after a service has been provided or initiated to a GCHP member, it must be received by GCHP within 60 calendar days of initiation of the services or the request will be denied for non-timely submission. If the request is submitted for a member who has obtained retroactive eligibility, it must be received by GCHP within 60 calendar days of the member obtaining Medi-Cal eligibility or it will be denied for non-timely submission.

Medical services or procedures that require prior authorization include, but are not limited to:

- MRIs and CT scans
- Outpatient surgery
- Dermatology therapy
- Home health services
- Physical, occupational and speech therapy
- Non-emergency hospitalizations, except for an obstetrical delivery
- Requests for referral to an out-of-area provider / facility or a non-contracted provider / facility (referred to as “out-of-plan” or “non-par” to indicate a non-participating or non-contracted provider)

- Drug or treatment interventions not included in GCHP's Formulary (or if the quantity requested is more than a 90-day supply for maintenance drugs and a 30-day supply for all other agents)

You will find a more detailed list of services that require either a request for direct referral or prior authorization **here**.

Self-Referral: No Authorization Required

GCHP Medi-Cal members may access certain services without a referral from a PCP, as long as the provider they choose is a member of GCHP's network and is within the Plan's service area for:

- Diabetes education.
- Other health education programs.

Female GCHP members may self-refer to any willing OB/GYN specialty provider who is contracted with the Plan and is within GCHP's service area for routine well-woman care. The Plan recognizes Medi-Cal midwives for prenatal and postnatal care at registered birthing centers.

Prior authorization is not required for emergency services, urgent services or emergency hospital admissions.

Emergency Admissions

While admission for emergencies does not require prior approval, hospitals MUST notify GCHP's Health Services Department within 24 hours of the patient admission or the next business day. All days will be reviewed for medical necessity.

Emergency Services are covered as necessary to enable stabilization or for the evaluation of an emergency medical condition. An emergency medical condition is one that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of a bodily organ or part.
- Death.

Post-Stabilization Services

Post-stabilization services are covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's condition. Prior authorization is not required for coverage of post-stabilization services when these services are provided in any ER or for services in an observation setting by a provider. GCHP has a health professional available 24 hour a day, seven days a week to coordinate a member's transfer of care when their emergency condition is stabilized, to authorize medically-necessary post-stabilization services, and for general communication with ER personnel. Please call 1-888-301-1228.

Administrative Members

Members with other health care coverage may self-refer to any willing in-county Medi-Cal provider for covered benefits. In addition, authorization from GCHP is not required for members with other health

coverage, including full scope. For members who exhaust their other coverage, GCHP must be notified to ensure ongoing coverage of services. In some cases, a member's care may be transitioned to an in-network GCHP provider.

Family Planning and Sensitive Services: No Prior Authorization Required

GCHP Medi-Cal members also may self-refer without prior authorization to any willing Medi-Cal provider for family planning and sensitive services.

Family planning services include birth control, pregnancy testing and counseling. Sensitive services include pregnancy testing and counseling, birth control, HIV/AIDS testing, sexually transmitted infection (STI) testing and treatment, and termination of pregnancy. These services are listed alphabetically below:

- Abortion (legal, unspecified, failed)
- Candidiasis / monilia
- Condyloma acuminatum
- Contraception and contraceptive management
- Diagnosis and treatment of STIs if medically indicated
- Dysplasia
- Essure (Permanently implanted birth control device for women)
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Genital herpes
- Health education and counseling necessary to make informed choices and understand contraceptive methods
- High-risk sexual behavior
- Inflammatory disease of the uterus, except the cervix
- Some laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods
- Limited history and physical examination
- Observation following alleged rape
- Pregnancy exam or test, pregnancy unconfirmed
- Provision of contraceptive pills / devices / supplies
- Rape examination
- Scabies
- Screening, testing and counseling of at-risk individuals for HIV and other STIs and referral for treatment of Syphilis and other venereal diseases
- Trichomonas
- Tubal ligation
- Vasectomy
- Viral warts, both specified and unspecified

How to Submit a Request for Prior Authorization:

Electronically

Electronic submission is the preferred, most-efficient way for providers to submit a request for prior authorization. This can be done using the Provider Web Portal. To do so, complete the registration process using your GCHP provider ID number.

- Visit the **Provider Portal**.
- The **"Provider Web Portal User Guide"** will walk you through the process, step by step.

Fax

- Complete the **Pre-Authorization Treatment Request Form (PTRF)**.
- Fax the form to GCHP at 1-855-883-1552.

Adherence to the following checklist for effective submission of the form will ensure the timeliest decision:

- Please type the form – an illegible, handwritten form may be returned to the provider.
- Be sure to include your name, address, phone number and fax number.
- Be sure to include the member's name, address, age, sex, date of birth, and identifying information such as the member ID number.
- The Medi-Cal ID number must be correct. Refer to the Medi-Cal card if necessary.
- Enter the description of the diagnosis and ICD-10 or CPT code into the appropriate box with modifiers that most closely describe the member's condition.
- Use the correct GCHP provider ID number. If the patient is hospitalized, the hospital name or provider number must be used.
- Attach documentation to the form that supports the medical necessity of the request (in addition to providing the documentation required in the history / medical justification area).
- Be sure to sign and date the form (if required, it must be signed by the referring provider).
- Submit a separate PTRF for each service request per member. The form will be given a unique number that is used to facilitate reimbursement.

Member Requests

When a member requests a specific service, treatment, or referral to a specialist, it is the PCP's responsibility to determine medical necessity. If the service requested is not medically indicated, discuss an alternative treatment plan with the member or their representative.

Routine Pre-Service Requests

You must complete a request for prior authorization before the service is performed. For routine pre-service requests, GCHP will usually make a determination within five business days from receipt of the request and the appropriate documentation of medical necessity.

In certain circumstances, a decision may be deferred for up to 14 days when the member or provider requests an extension, or if the original request did not contain sufficient clinical information.

Decisions to approve requests will be made and communicated to the provider by fax / mail within one business day of the decision. It is the responsibility of the provider to inform the member about the decision.

Decisions to modify or deny will be communicated to the member in writing within two business days of the decision; a copy will be sent to the provider. When a request is concurrent with services being provided, GCHP will ensure that medically-necessary care is not interrupted or discontinued until the member's treating provider has been notified of the decision and a care plan has been agreed upon by the treating provider / PCP that is appropriate for the medical needs of the patient.

Expedited / Urgent Requests

In medically-urgent situations, the provider may request an expedited review by calling GCHP's Customer Service Department at 1-888-301-1228 or by indicating URGENT on the request form. Expedited requests for prior authorization will be reviewed within 72 hours of the receipt of the request when the provider indicates that following a standard timeframe could seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function.

Out-of-Area and Out-of-Plan Referrals

When a member needs specialty care or procedures, the member's PCP should refer the member to a participating provider available within Ventura County. The PCP may refer the member to a non-contracted provider (non-par) within the service area only with Plan approval. Please refer to the next section, "Specialist Referrals," for the appropriate process to refer members to participating and non-participating providers. In general, the reasons for referring to a provider out of GCHP's service area or out-of-plan are:

- The necessary procedure or service is not available through one of the Plan's in-area network providers.
- The expertise required for consultation is beyond what is available through the Plan's in-area provider network.
- The member's medical needs are sufficiently complex to require service out of the area.

In the event of an urgent / emergency medical situation outside of the GCHP service area, the non-contracted (non-par) provider or facility providing the service is required to contact GCHP within one business day to confirm eligibility and service authorization.

All services requested will be reviewed for clinical appropriateness by a GCHP nurse, with final decisions made by a GCHP physician reviewer.

For more information on out-of-area or out-of-plan (non-par) referrals, please call GCHP's Customer Service Department at 1-888-301-1228.

Specialist Referrals

A **Direct Referral Authorization Form (DRAF)** is used when referring members for specialty care to a contracted provider (par) within GCHP's service area. This form is sent directly to the specialist by the referring provider.

PCPs must use a PTRF when referring members for specialty care to a provider outside of GCHP's provider network (non-par) or outside of Ventura County (par and non-par). As with PTRFs, DRAFs are not required for administrative members.

The referring provider is responsible for verifying the list of contracted providers to ensure that the referral is being made to an appropriate GCHP network provider. Referrals to non-contracted and/or out-of-network providers will be reviewed by a GCHP physician reviewer and will be authorized under compelling medical circumstances and/or when medically-necessary services are not readily available within the GCHP network.

The referral specialist is responsible for informing the PCP of the patient's status and proposed interventions throughout the course of treatment. The PCP is responsible for maintaining the referral tracking system.

Post-Service Retroactive Authorization Requests

If it was not possible for the provider to obtain authorization before providing a medically-necessary

service, GCHP will respond to a post-service PTRF if it is received within 60 calendar days of initiation of the service. If it is received later, the retrospective PTRF will be denied for non-timely submission. Please note that a post-service PTRF must be accompanied by documentation explaining why the authorization was not requested earlier. The Plan's response will inform the provider of the decision to approve, modify or deny the request, including communication to the provider and the member or their designated representative.

While elective surgery requires prior authorization, the Plan may provide authorization after the fact under exceptional medical circumstances.

If a PTRF is submitted for a member who has obtained retroactive Medi-Cal eligibility, it must be received by GCHP within 60 calendar days of the date on which the member obtained Medi-Cal eligibility or it will be denied for non-timely submission.

A PTRF may be submitted for post-service consideration under the following conditions:

- The member's Medi-Cal eligibility was delayed.
- When other health coverage (OHC) will not pay the claim.
- Wheelchair repairs exceeding $500.
- When the patient fails to properly disclose Medi-Cal eligibility.

For more information on the timely submission of prior authorization requests, please go to the **Request for Authorization** listing on GCHP's website.

Authorization Requests for Ancillary Services

Prior authorization is required for ancillary services such as home health care, rehabilitation services and durable medical equipment (DME). Ancillary services requiring prior authorization include, but are not limited to, the following:

- DME (purchase or rental)
- Physical / occupational therapy
- Speech pathology
- Home Health Agency services
- Non-Emergency Medical Transportation (NEMT)

NEMT Services

It is the provider's responsibility to determine eligibility and medical necessity for a member to receive NEMT services. The provider must complete the NEMT form and fax it to GCHP at 1-855- 883-1552. GCHP will review the form for completeness and communicate NEMT eligibility to its vendor, Ventura Transit System (VTS). The verification process will not take longer than five business days. Once verified, VTS will contact the member within 48 hours to arrange transportation. If the transportation request is of an urgent nature and needs to occur in less than 48 hours, please call GCHP's Customer Service Department at 1-888-301-1228.

The NEMT / NMT Prescription / Attestation of Medical Necessity Form is available **here**.

Hospital Inpatient Services

Admissions to an acute-care facility or Ambulatory Surgery Center for scheduled surgery require prior authorization. All requests must be accompanied by the appropriate medical documentation including, but not limited to:

- Laboratory test results.
- X-rays.
- Medical records.
- Other reports that have relevance to the planned admission (e.g., pre-operative history and physical examination report).

Emergency and urgent admissions do not require prior authorization. However, GCHP must be notified by the facility of emergency admissions within one business day.

Discharge planning is initiated upon admission to facilitate the transition of members to the next phase of care. The discharge planning team is multi-disciplinary and consists of the treating provider and hospital discharge planners.

Provider responsibility includes participation in coordinating member discharge planning and referrals to appropriate post-discharge settings. GCHP staff will work with the hospital's discharge planning staff, as needed, to determine the most appropriate post-discharge setting.

Hospital Observation

Hospital Observation Services shall be approved without an authorization for the first 24-hour period. For observation services in excess of the initial 24-hour period, the hospital shall notify GCHP to request the Plan's review of medical necessity to extend observation services and the Plan's authorization to extend observation services. Any extension of observation services in excess of an initial 24-hour period shall be limited to one additional 24-hour period only (i.e., the total period for observation services shall not exceed 48 hours). The Plan will conduct subsequent review of medical necessity for such extended observation services by no later than the end of the next business day. Should the hospital fail to notify GCHP to request the Plan's review of medical necessity to extend observation services and the Plan's authorization for an extended period of observation services for a member, payment for any claims submitted by the hospital for such additional observation services are subject to the Plan's review and determination that such additional observation services were medically necessary. Accordingly, the Plan shall not be responsible for payment of any observation services that the Plan determines are not medically necessary. In no event shall the Plan be responsible for payment for observation services in excess of 48-hours (i.e., two 24-hour periods or two calendar days).

Nursing Facilities

GCHP is responsible for Medi-Cal covered long-term care services. GCHP pays the facility daily rate for members who need out-of-home placement in a long-term care facility due to their medical condition. Medi-Cal does not pay for assisted living or for board-and-care facility services.

Nursing facilities include:

- Long-Term Care (LTC) Facilities
- Skilled Nursing Facilities (SNF)
- Intermediate-Care Facilities (ICF)
- Intermediate-Care Facilities of the Developmentally Disabled (ICF / DD), Developmentally Disabled Habilitative (ICF / DDH), or Developmentally Disabled Nursing (ICF / DDN)
- Sub-acute Care Facilities
- Congregate Health Living Facilities (CHLF)

Nursing Facility Authorizations

It is GCHP's responsibility to assist its nursing facility providers with instructions for the submission

requirements of prior authorization requests. In order to expedite approvals and claims processing in a timely manner, it is essential that the documents submitted are complete and legible.

The admitting facility is required to submit medical justification and obtain authorization from GCHP within five business days of the member's arrival to the facility. All admissions for skilled nursing level of care require prior authorization.
The physician referring the member or ordering the admission will be responsible for providing the following information about the member:

- Medications, diet, activities and medical treatments; wound care and labs
- Current history and physical
- Diagnosis / diagnoses
- The name of the physician who will be following the member once the member is admitted to the facility

Unless otherwise determined, the PCP relationship with the member continues during the limited LTC stay.

Nursing Facility Admission Notification

Nursing facilities must notify GCHP when the Plan's members are in their facility. The notification must include those GCHP members with other health coverage. The facility must complete a prior authorization request and submit it to the GCHP Health Services Department. GCHP is a Medi-Cal provider and as such, is always the payer of last resort.

Other Health Coverage (OHC)

If a member has OHC and the skilled level of care is denied by the member's primary insurer, GCHP will require a denial letter from the OHC. If the member has Medicare as their primary insurance, the nursing facility should notify GCHP on or before the 21st day of their stay.

Reauthorization Request

A request for reauthorization should be submitted to GCHP prior to the expiration of the current authorization.

Long-Term Care (LTC) Facilities

The following is required for an LTC admission review:

1. **Pre-authorization Treatment Request Form (PTRF)**. This form is to be used for each admission and reauthorization.
2. **Preadmission Screening / Preadmission Screening and Resident Review (PAS / PASARR)**. Sections I through VII are required.
3. Medicare or other health care insurance denial letter.
4. Minimum Data Set (MDS)
    - Version 3.0 Nursing Home Comprehensive (NC) Version 1.10.4 Effective 4/1/2012. (Admission)
    - Version 3.0 Nursing Home Quarterly (NQ) Version 1.10.4 Effective 4/1/2012. (Need for Authorization)
    - Include all the sections listed below:
        a. Identification, admission information
        b. Hearing, speech, vision
        c. Brief Interview for Mental Status (BIMS)
        d. Behavior: wandering, inappropriate behavior, refusing or rejecting care

    e. Functional status
    f. Bowel and bladder
    g. Active Diagnosis — on admission and as condition changes.
        » Confirm Principal Diagnosis Code by checking List of Unacceptable Diagnosis Codes, Manifestations Not Allowed as Principal Diagnosis and Questionable Admissions. See Section 10 of the February 26, 2013 edition of the Provider Operations Bulletin **here**.
    h. Swallowing, nutrition, G-Tubes
    i. Skin ulcers, wounds, precautions
    j. Special treatments, oxygen, dialysis
5. Sufficient chart documentation to justify the level of care requested.

Short-Term Skilled Nursing Care

The following is required for a Short-Term Skilled Nursing admission review:

1. PTRF
2. Physical therapy, occupational therapy, and speech therapy clinical notes submitted every two weeks
3. Sufficient chart documentation to justify the level of care requested

Intermediate Care

The following is required for an Intermediate Care nursing admission review:

1. PTRF
2. **Certification for Special Treatment Program Services (HS 231)** from Tri-Counties Regional Health

Sub-Acute Level of Care

The following is required for a Sub-Acute level of care admission review:

1. PTRF
2. Preadmission Screening / Preadmission Screening and Resident Review (PAS / PASARR)
3. **Information for Authorization / Reauthorization of Subacute Care Services - Adult Subacute Program (DHCS 6200 A)**
4. Sufficient chart documentation to justify the level of care requested

Hospice Care

Only general inpatient hospice requires prior authorization following the standard prior authorization process.

Serious and Complex Medical Conditions

Providers should develop a written treatment plan for members with complex and serious medical conditions. The plan must provide for a standing referral or extended referral to a specialist, as appropriate. Regardless of the length of the standing referral, all specialist providers are required to send the PCP regular reports on the care and status of the patient.

The written treatment plan should indicate whether the patient will require:

- Continuing care from a specialist or specialty care center over a prolonged period of time.

- Standing referral visits to specialists.
- Extended access to a specialist because of a life-threatening, degenerative or disabling condition involving coordination of care by a specialty care practitioner. (For extended specialty referrals, the requesting provider should indicate the specific health care services to be managed by the specialist vs. the requesting provider.)

Standing Referrals to an HIV / AIDS Specialist

Patients with HIV or AIDS are designated as administrative members and are deemed as having "a condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative, or disabling" — thus assuring that the member has a standing referral to a specialty HIV / AIDS provider.

- To qualify as an HIV / AIDS specialist, a provider must have a valid license to practice medicine in the state and meet at least one of the following criteria:
  - » Credentialed as an HIV specialist by the American Academy of HIV Medicine.
  - » Board certified or a Certificate of Added Qualifications in the field of HIV medicine granted by the American Board of Medical Specialties.
  - » Board certified in the field of infectious diseases by the American Board of Medical Specialties and has, in the immediately preceding 12 months, both effectively managed the medical care for a minimum of 25 patients with HIV and successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients.
- In the immediately preceding 24 months, has effectively managed the medical care for a minimum of 20 patients infected with HIV and has completed any one of the following:
  - » In the immediately preceding 12 months, has obtained certification or recertification in the field of infectious diseases from the American Board of Medical Specialties.
  - » In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients.
  - » In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients, and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Obtaining a Second Opinion

Members may request a second opinion about a recommended procedure or service. GCHP honors all requests for second opinions without the need for a prior authorization as long as the second provider is within the GCHP participating provider network and Ventura County service area.

Second opinions may be rendered only by a provider qualified to review and treat the medical condition in question. Referrals to non-contracting medical providers or facilities may be approved only when the requested services are not available within the GCHP network. Second opinions should not be sought from providers affiliated with the same provider who rendered the first opinion.

If the provider giving the second opinion recommends a treatment, diagnostic test, or service that is medically necessary and covered by GCHP, the PCP must provide or arrange for the service.

Status of Authorization Requests

GCHP's prior authorization team will review PTRF forms for completeness and will help you with any aspect of the process, including answering questions regarding the status of PTRFs. Please call 1-888-301-1228 for assistance.

Deferrals and Denials

Decisions about requests for authorization may be deferred or denied. Deferrals occur when the request is forwarded to another agency, such as CCS, for review and possible coverage determination. The requesting provider will receive a letter notifying them of the deferral.

When a request is denied by another agency, a Notice of Action letter will be mailed to the provider, the requesting facility, and the member. When a request is denied by GCHP, a denial letter will be mailed to the provider, requesting facility and the member no later than the second business day after the decision. If the denial is a result of insufficient information from the provider, the Plan will inform the member that the case will be reopened when complete information is received. The denial letter will explain the reason for denial and will provide information about the member's right to appeal the decision. If you need clarification of the reason your request was denied, please call Customer Service at 1-888-301-1228.

Assistance with Referral Consultation Requests

If you are unable to determine if a referral is required after reading this chapter, please call Customer Service at 1-888-301-1228.

Section 10: Claims and Billing

How Gold Coast Health Plan (GCHP) Claims are Processed

GCHP's goal is to ensure timely and accurate claims processing. To accomplish that, this section is intended to provide guidance to provider billing offices regarding the claims submission process. These guidelines do not, however, supersede any regulatory or contractual requirements published in legally binding documents or notices.

GCHP strives to process all claims in a timely manner and respond courteously to all inquiries from providers. GCHP is contractually bound to process 90% of clean claims within 30 calendar days of receipt. All claims are processed daily on a first-in / first-out basis. Claim payments are generated and mailed weekly.

GCHP processes medical claims primarily per Medi-Cal guidelines and uses key industry standard codes. Each claim is subject to a comprehensive series of edits and audits. All information is validated to determine if the claim should be paid, contested or denied.

Claims that fail an edit or audit check will be flagged for manual review by a claims examiner. Claims examiners cannot correct claim submission errors. Claims requiring medical review will be reviewed by a qualified medical professional in accordance with the California Code of Regulations (CCR), Title 22 and policies established by DHCS.

Refer to GCHP's **Provider Web Portal** to view claim status and details. Claim status can also be obtained by calling GCHP's Customer Service Department at 1-888-301-1228 and using the automated IVR system. For questions about a claim, please call Customer Service between 8 a.m. and 5 p.m., Monday through Friday, except holidays.

There are two ways to submit a claim:

- Electronic Data Interchange (EDI)
- Paper or hard copy

Electronic Data Interchange (EDI)

GCHP strongly encourages electronic claims submission. It is cost effective and promotes the effective use of resources. Providers receive an electronic confirmation of claim submission.

Submit claims electronically through a Plan-approved electronic billing systems software vendor or clearing-house. Completion of electronic claims submission requirements can speed claim processing and prevent delays.

If you use EDI, you must include:

- Billing provider name
- Rendering provider
- Legal name
- License number (if applicable)
- Medicare number (if applicable)
- Federal provider tax ID number
- Medi-Cal ID number
- Member's name as it appears on their GCHP ID card
- National Provider Identifier (NPI)

Contact your vendor or billing service for instructions on how to ensure that the Plan Provider ID is coded as a GCHP NPI and to determine how to submit your claim.

If you are not currently submitting claims electronically and would like to learn more about EDI and how to get connected, please **click here** or contact EDI Customer Support at 1-800-952-0495 or by email **EDICommercialSupportTeam@conduent.com**.

Refer to the instructions to learn how to register to become a Trading Partner. If you use a clearinghouse to submit electronic claims on your behalf, please refer your clearinghouse to the Plan's website in order for them to register.

Paper Claim Submission

Paper claims are scanned for optimal processing and recording of data. Paper claims must be legible and provided in nationally-accepted standard formats to ensure scanning capabilities. The following paper claim submission requirements can speed claim processing and prevent delays:

- Use the correct form and be sure it meets Centers for Medicare and Medicaid Services (CMS) **standards**.
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it.
- Use the "Remarks" field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to GCHP and retain the copy for your records.
- Separate each individual claim form. Do not staple original claims together, as GCHP would consider the second claim an attachment and not an original claim to be processed separately.
- Use the member's name as it appears on their GCHP ID Card.

Attachments to Paper Claims
Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.

Mail paper claims to GCHP using the following address to facilitate timely processing and payment:

ATTN: CLAIMS
Gold Coast Health Plan
P.O. Box 9152
Oxnard, CA 93031

Clinical Submission Categories

The following is a list of claims categories of which the Plan may routinely require submission of clinical information before or after payment of a claim.

Claims involving pre-certification / prior authorization / pre-determination (or some other form of utilization review) include, but are not limited to:

- Claims pending for lack of pre-certification or prior authorization.
- Claims involving medical necessity or experimental / investigative determinations.
- Claims for pharmaceuticals requiring prior authorization.
- Claims involving certain modifiers.
- Claims involving unlisted codes.

- Claims for which it cannot be determined from the face of the claim whether it involves a covered service. Thus, the benefit determination cannot be made without reviewing medical records (including, but not limited to, emergency service and benefit exclusions).
- Claims that GCHP has reason to believe involve inappropriate (including fraudulent) billing.
- Claims that are the subject of an audit (internal or external), including high-dollar claims.
- Claims for individuals involved in care management or disease management.
- Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated, or litigated).
- Other situations in which clinical information might routinely be requested.
- Credentialing.
- Coordination of Benefits (COB).

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

GCHP cannot be responsible for claims that are never received. Providers must work with their vendors to make sure files are successfully submitted and that there was proper follow-up on paper claims. Failure of a third party to submit a claim to GCHP may put the provider's claim at risk for being denied for untimely filing if those claims are not successfully submitted during the filing limit.

Claims Processing

Once a claim is received by GCHP, it is assigned a unique Document Control Number (DCN). The DCN identifies and tracks claims as they move through the Claims Processing System. The number contains the Julian date, which indicates the date the claim was received. It monitors timely submission of a claim.

Claims entering the system are processed on a line-by-line basis, except for inpatient claims. Inpatient claims are processed on an entire claim basis, unless otherwise indicated in a provider's contract. Each claim is subject to a comprehensive series of check points called edits. The edits verify and validate that the claim information is compliant with all nationally-accepted claim billing procedures and coding regulations and to determine if the claim should be paid, denied, or suspended for manual review.

Providers are responsible for all claims submitted with their provider number, regardless of who completed the claim. Providers using billing services must ensure that their claims are handled properly.

Claim Return for Additional Information

If a claim is returned to the provider for correction or additional information, GCHP refers to this claim as a rejected claim. GCHP will indicate what information is missing or needs to be corrected by the provider in order to process the claim. Timely filing requirements still apply.

Timely Filing Requirements

Claims must be submitted within 365 calendar days of the date of service unless the provider's contract specifies a different limitation. Claims received after 365 calendar days will be denied for timely filing unless circumstances prevented the claims from being filed within 365 calendar days, e.g., if the member has other insurance and the provider has to wait for the primary carrier to process the claim before being able to submit the claim to GCHP. If the member has other insurance, the claim must be received within 180 calendar days from the date of the other insurance's Remittance Advice (RA). Corrected claims must be submitted within 180 calendar days from the date of last action. For information related to claim payment disputes, please refer to Section 17.

If a provider files a claim with the wrong payer and provides documentation verifying the initial timely claims filing (within the applicable claims filing time limits set forth in this section from the date of the other carrier's denial letter or RA form), GCHP will process the provider's claim without denying it for failure to adhere to the timely filing limits.

Claims Payment

When a provider's claim is received, it is analyzed to determine if the services are covered and to identify the corresponding amount to be paid. Once the claim is finalized, GCHP generates an Explanation of Payment (EOP) summarizing services rendered and payer action taken and then sends the appropriate payment amount to the provider, where the claim is payable.

Providers should receive a response from GCHP 90% of the time within 45 calendar days of the Plan's receipt of a clean claim.

If the claim contains all the required information, the claim is entered into GCHP's Claims Processing System and the provider is sent an EOP at the time the claim is finalized.

Child Health Disability Prevention (CHDP) Claims Submission

Providers must be CHDP paneled in order to provide CHDP services. Only providers who are paneled will be reimbursed for these services.

All encounters and claims for CHDP should be submitted to GCHP on a CMS 1500 form, using the American Medical Association (AMA) Current Procedural Terminology (CPT).

The following preventive CPT codes are to be billed with the EP modifier when used for CHDP:

New Patient	
99381	Initial Evaluation and Management of Healthy Individual < 1 year of age
99382	Early Childhood – ages 1 to 4
99383	Late Childhood – ages 5 to 11
99384	Adolescent – ages 12 to 17
99385	18 to 39 years (CHDP services are only covered up to age 21)

Established Patient	
99391	Periodic Re-evaluation and Management of Healthy Individual < 1 year of age
99392	Early Childhood – ages 1 to 4
99393	Late Childhood – ages 5 to 11
99394	Adolescent – ages 12 to 17
99395	18 to 39 years (CHDP services are only covered up to age 21)

Claims Submission by FAX

GCHP is unable to accept or process claims submitted via fax. Claims must be submitted either electronically via EDI or by paper to the P.O. Box indicated above.

Pharmacy Claims

OptumRx is the Pharmacy Benefit Manager (PBM) contracted by GCHP for processing and paying pharmacy claims billed with NDC numbers. Please do not submit pharmacy claims to GCHP.

Claim Forms Used by Different Types of Providers*

Claim Form	Type of Provider	Services Billed on this Form
CMS-1500	PCPs	All professional services.
CMS-1500	Referral Specialists	All professional services.
CMS-1500	Clinics	All professional services.
CMS-1500	Pharmacies	Pharmacies may also use this for durable medical equipment (DME), medical supplies, incontinence supplies, orthotics and prosthetics.
CMS-1500	Medical Laboratories	All covered services not requiring prior authorization.
CMS-1500	Allied Health Practitioners	All covered services delivered by Allied Health Care Professionals.
UB-04	Hospitals / Clinics / FQHCs / SNFs / Surgicenters	All professional or facility services.
CMS-1500	Imaging Centers	Professional X-ray and related services.
25-1C	Long-Term Care (LTC)	All LTC services.

* ***All claims should be submitted no later than 180 calendar days from the date of service, with the exception of other health coverage. If there is another carrier involved (e.g., Medicare, commercial health insurance, etc.), the claim must first be submitted to the other carrier since Medi-Cal is the payer of last resort. Once the primary carrier has processed the claim, the provider should submit the claim, along with the primary carrier's Explanation of Benefits (EOB) form to GCHP within 180 calendar days from the date of the primary carrier's EOB. GCHP will then consider the claim as the secondary carrier and will determine if any additional payment is due as appropriate up to the Medi-Cal maximum allowable payment amount.***

Section 11: Coordination of Benefits

Some Gold Coast Health Plan (GCHP) members have other health coverage (OHC) in addition to their GCHP coverage. Specific rules govern how benefits must be coordinated in these cases. State and federal laws require that all available health coverage be exhausted before billing Medi-Cal. As such, when a Medi-Cal member has OHC, GCHP becomes the secondary (or sometimes tertiary) payer, with Medi-Cal always the payer of last resort.

OHC includes any non Medi-Cal coverage that provides or pays for health care services. This can include, but is not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health Maintenance Organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champus VA.
- Medicare, including Medicare Part D plans, Medicare supplemental plans and Medicare Advantage (Preferred Provider Organization (PPO), HMO, and fee-for-service) plans.

When a GCHP Medi-Cal member also has another primary medical insurance, the member must treat the other insurance plan as the primary insurance company and access services under that company's rules of coverage. For example, if the other coverage is a PPO plan with a closed panel, the member must see a provider within the PPO network. If it is an HMO or a Medicare Advantage plan, the member must receive services from his or her provider under that plan. Any referrals or prior authorizations required by the primary insurance must be obtained before receiving services.

If the member has an HMO as their primary insurance, and the HMO requires a referral in order for a member to see a specialist or other provider, the referral will need to come from the member's PCP in the primary insurance plan. If a member is eligible for the CCS program, please contact CCS for a referral. If a member with OHC needs services requiring prior authorization, the provider must obtain the authorization from the primary insurance company.

GCHP is not liable for the cost of services for members with OHC who do not obtain the services in accordance with the rules of their primary insurance. If a member elects to seek services outside of the framework of their primary insurance coverage, the member is responsible for the cost.

Exceptions to the 365 calendar day billing limit will be made with OHC claims based on the date of the EOB. You have 180 calendar days from the date of the EOB to submit the claim to GCHP.

Dual Coverage by Medicare and Medi-Cal (Medi / Medi)

In accordance with the transaction and code sets adopted by the secretary of the Department of Health and Human Services through a final rule published in 45 CFR 162, GCHP is now able to accept electronic Coordination of Benefits Agreement (COBA) crossover claims for dual eligible members (Medi-Medi).

GCHP receives both Medicare Part A and Part B crossover claims only directly from the Benefits Coordination Recovery Center (BCRC) for dual eligible members (Medi-Medi).

GCHP does not receive any COBA Medicare Part C (Medicare Advantage) electronic crossover claims.

GCHP is responsible for the processing and coordination of Medi-Medi claims. Do not send claims to the state for coordination; they will be denied.

Exceptions to the 365 calendar day billing limit will be made with Medi-Medi claims based on the date of the Medicare Explanation of Benefits (MEOB). You have six months from the date of the MEOB to submit (crossover) the claim to GCHP.

The primary insurance must be billed prior to GCHP. Include an EOB issued by the primary carrier with your claim.

You will not receive additional reimbursement for services that are capitated by GCHP.

If Medicare covers the service and GCHP does not pay as the primary carrier, procedures which normally require prior authorization by GCHP will not require it (with the exception of pharmacy services).

Medicare / Medi-Cal (Medi / Medi) Crossover Claim Process

California law limits Medi-Cal reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services. (Refer to Welfare and Institutions Code, Section 14109.5.) The following provides three different examples of crossover claims processing results (dollar amounts are for demonstration only and do not reflect actual allowed amounts for either Medicare or Medi-Cal):

CPT Code	Billed Amount	Allowed	Deductible/ Coinsurance	Medicare Paid	Medi-Cal Allowed	Medi-Cal Paid
99215	300.00	100.00	20.00	80.00	50.00	0.00
No payment is due under Medi-Cal as the Medicare payment exceeds the Medi-Cal allowance.						
This is referred to as a "zero pay" claim.						
71020	100.00	80.00	16.00	64.00	70.00	6.00
$6.00 of the Medicare deductible / coinsurance can be picked up under Medi-Cal as that is the difference between what Medicare paid and the Medi-Cal allowance.						
10160	50.00	25.00	5.00	20.00	35.00	5.00
The entire Medicare deductible / coinsurance amount of $5.00 can be picked up as that amount combined with the Medicare paid amount of $20.00 does not exceed the Medi-Cal allowance.						

Providers who accept persons eligible for both Medicare and Medi-Cal cannot bill them for the Medicare deductible and coinsurance amounts. These amounts can be billed only to Medi-Cal for consideration. Providers should, however, bill Medi-Cal members for any Share of Cost (SOC).

Note: Providers are strongly advised to wait until they receive the Medicare payment before collecting SOC to avoid collecting amounts greater than the Medicare deductible and/or coinsurance.

Claims for Medi / Medi members must be submitted to Medicare prior to billing GCHP, except for services that Medicare does not cover. GCHP may reimburse providers for non-covered, exhausted or denied services when billed to GCHP with the appropriate Medicare denial attached.

Share of Cost (SOC)

Patients with SOC are not eligible for Medi-Cal benefits coverage until they meet their SOC for each month of service. The SOC is comparable to a commercial health insurance deductible in that the carrier does not pay until the deductible is met.

The provider should ask for or accept obligation from the patient for their Medi-Cal SOC. Remember that when Medi-Cal pays for any portion of the service, the total reimbursement received for the service may not exceed the Medi-Cal maximum allowable amount.

Examples of two SOC scenarios for a patient with dual coverage are presented in the chart below.

Examples of SOC: Medi-Cal + Medicare

EXAMPLE A	EXAMPLE B
Provider's Charges = $250.00	Provider's Charges = $250.00
Medicare Allows $200.00	Medicare Allows $200.00
Medicare Pays 80% allowed of $200.00 = $160.00	Medicare Pays 80% allowed of $200.00 = $160.00
Medi-Cal Allowable $180.00 Difference = $20.00	Medi-Cal Allowable $190.00 Difference = $30.00
Member's SOC = $25.00 GCHP would pay $0 if the SOC is not met.	Member's Share of Cost = $25.00 GCHP would pay $5.00 after the SOC is met.

GCHP Members with Veterans Benefits

If the GCHP member is a veteran and is eligible for Veteran's Administration (VA) health care benefits, they may choose to use VA services (hospitals, outpatient and other government clinics). A description of the services offered to veterans can be found **here**.

Members with VA benefits may use their own discretion in choosing whether to receive care through the VA system or GCHP — GCHP cannot require or request that they do so; but, if the member wishes, the Plan will facilitate and coordinate their care.

Section 12: Member Services

Gold Coast Health Plan's (GCHP) Member Services Department supports providers by helping Medi-Cal members:

- Choose or change their PCP, which may be a clinic or physician.
- Learn about their eligibility and benefits.
- Receive their claim status.
- Understand how to access care within a managed care health plan.
- Understand member benefits and how to access services.
- Understand their rights and responsibilities.

New members are sent a welcome packet, which includes a letter, GCHP's Provider Directory, and a form to select a PCP from the directory. A Health Information Form (HIF) / Member Evaluation Tool (MET) is also included.

A GCHP ID card will be issued after the member's first month of enrollment, along with a Member Handbook that serves as the state-required Evidence of Coverage (EOC) that explains how to navigate the Plan. The ID card will have the name of the member's PCP.

Administrative members are mailed a welcome letter, their GCHP ID card, and GCHP's Member Handbook. A HIF / MET is also included in all welcome packets.

Every year, members also receive three newsletters, which include articles on health education topics, service and benefit reminders, and information about how to use the Plan's services.

Member Services Staff

You may seek assistance and support in dealing with member service issues by calling GCHP's Member Services Department at **1-888-301-1228 / TTY: 1-888-310-7347** Monday through Friday from 8 a.m. to 5 p.m.

If a member loses eligibility for Medi-Cal but returns as a member within 12 months, the member will remain linked to the previous PCP unless that participating provider is closed to new patients or no longer available. Members who are assigned to Kaiser as their PCP will not be re-linked to Kaiser.

Section 13: Cultural and Linguistic Services

Overview of Services

Gold Coast Health Plan (GCHP) understands that health literacy and cultural diversity are key factors to building a healthy community. GCHP is committed to delivering culturally- and linguistically-appropriate health care services to its diverse membership, including free language assistance and translation services for members whose primary language is not English. If you need language assistance or translation services for your GCHP patients, contact GCHP's Cultural and Linguistic Services at 1-805-437-5603 or call GCHP's Customer Service Department at 1-888-301-1228 / TTY 1-888-310-7347. Providers can also email **CulturalLinguistics@goldchp.org**.

Language Assistance

GCHP adheres to federal and state guidelines that require health plans to ensure that Limited English Proficiency (LEP), non-English speaking, or monolingual Medi-Cal beneficiaries have free access to interpreters and translation services at all key points of covered services. GCHP strongly discourages the use of unqualified interpreters, including bilingual office staff, friends or family members - especially minors.

GCHP's Cultural and Linguistic Services coordinates interpreting and translation services for the Plan's members and providers. GCHP trains the Plan's providers and their staff on language assistance, cultural diversity, and sensitivity related to Seniors and Persons with Disabilities (SPD). The Center for Disability Issues and the Health Professions (CDIHP) offers online training videos to health care providers at no cost. Contact GCHP's Cultural and Linguistic Services for more information on trainings.

For help getting an interpreter or assistance with the translation of documents into a member's preferred language or format, contact GCHP Cultural and Linguistic Services at 1-805-437-5603 Monday through Friday from 8 a.m. to 5 p.m. or email **CulturalLinguistics@goldchp.org**.

Telephone Interpreting Services

Telephone interpreting services are available to providers 24 hours a day, seven days a week for covered services. GCHP contracts with a vendor that provides telephone interpreting services in more than 200 languages. Providers may contact GCHP's Cultural and Linguistic Services at 1-805-437-5603 to request the toll-free phone number for the interpreting service and a provider access code.

In-Person Interpreting Services

GCHP works with various vendors to provide in-person interpreter services. An interpreter request form can be requested via email at **CulturalLinguistics@goldchp.org**. It is important to submit the in-person request form to GCHP Cultural and Linguistic Services via efax at 1-805-248-7481 or email at **CulturalLinguistics@goldchp.org** at least 5 to 7 business days in advance of the request for a covered service. To cancel an in-person interpreting request, contact Cultural and Linguistic Services at 1-805-437-5603 at least 25 business hours prior to the appointment.

Sign Language Interpreting Services

GCHP complies with the Americans with Disabilities Act (ADA) to ensure that members who are in need of services from a sign language interpreter receive those services. GCHP has contracted with an agency to provide sign language interpreting for members during covered services. The request form must be submitted to GCHP at least 5 to 7 business days in advance of the covered service. Submit your request form via eFax to 1-805-248-7481 or email at **CulturalLinguistics@goldchp.org**.

When Requesting Interpreter Services:

- Verify the GCHP member's Medi-Cal eligibility before requesting an interpreter.
- Provide advance notice of at least 5 to 7 business days before any scheduled covered service.
- Provide the member's name; GCHP / Medi-Cal ID number; the type of service; assignment address; name and phone number of the provider who will be seeing the member; and the date and time of the covered service.

How to Access Sign Language Interpreter Services:

- For sign language interpreter services, provider(s) may call GCHP's Customer Service Department at 1-888-301-1228 / TTY: 1-888-310-7347, GCHP's Cultural and Linguistic Services at 1-805-437-5603, and LIFESIGNS at 1-888-930-7776.
- For emergency, same-day or urgent requests during business hours, call LIFESIGNS, Inc. directly at 1-888-930-7776 and Cultural and Linguistic Services at 1-805-437-5603.

Translation of Documents

GCHP provides translation services to members whose primary language is not English. Providers can request assistance for translation of written materials for GCHP members at no cost.

Alternative Formats
GCHP offers information in the following alternative formats:

- Large print
- Braille
- Audio, accessible electronic formats and other formats

Plain Language
Evidence shows that patients often do not understand much of the information given by health care providers. GCHP recognizes that using simple language is essential for the effective delivery of health care. Simple language makes it easier for everyone to understand and use health information. One way to promote health literacy is by assuring that member-informing materials are at or below a sixth grade reading level.

For more information or if you need assistance, contact GCHP's Cultural and Linguistic Services at 1-805-437-5603 or **CulturalLinguistics@goldchp.org** Monday through Friday between 8 a.m. and 5 p.m.

Cancellation Policy:

- Providers and/or their staff must call or email GCHP's Cultural and Linguistic Services at least 25 business hours in advance to cancel appointments lasting less than two hours.
- When cancelling a request for services lasting longer than two hours, GCHP requires that Cultural and Linguistic Services be notified at least 49 business hours in advance.
- Email cancellation notices to **CulturalLinguistics@goldchp.org** or send them via eFax to 1-805-248-7481.
- To cancel a sign language interpreter request, you will need to fax a cancellation notice to LIFESIGNS, Inc. at 1-888-227-5021 and GCHP's Cultural and Linguistic Services. It is important to indicate the member's name, GCHP ID number, the type of service, the name, address, and phone number of the provider who will be seeing the member, and the date and time of the covered service.

Cultural and Linguistic Resources

GCHP routinely distributes information on interpreting and translation services to provider offices. GCHP makes promotional / educational materials available to providers free of charge to assist with cultural and linguistic requirements, services, and resources.

Providers are required to display the Language Identification poster in their medical office and/or an area visible to members. To order materials, request the Cultural and Linguistic Services Provider Material Request Form, fill it out, and email it to **CulturalLinguistics@goldchp.org**.

Seniors and Person with Disabilities (SPD) Training

DHCS sponsors an online SPD training through the Center for Disability Issues and the Health Professions (CDIHP). The training outlines key areas for health care and related accommodation needs for SPD. Individuals in your office who work directly with SPD members need to complete the training. To access the four online training videos, **click here**. Upon completion of the SPD training, an attestation form must be signed and emailed to **CulturalLinguistics@goldchp.org** or sent via eFax to 1-805-248-7481.

Section 14: Health Education

Introduction

The goal of Gold Coast Health Plan's (GCHP) Health Education Department is to ensure that all members have access to health education services, health promotion programs and classes. GCHP will work collaboratively with local health agencies, clinics, hospitals, community-based organizations, and PCPs to provide quality health education classes and materials at no charge to GCHP members.

Members may be referred by GCHP, their PCP, or they may self-refer for health education services, programs and classes. Contact the Health Education Department for a referral form.

No prior authorization is necessary for members to attend and participate in health education services, health promotion activities, or classes. For program details, providers may call Customer Service at 1-888-301-1228 / TTY 1-888-310-7347 to reach GCHP's Health Education Department or email **HealthEducation@goldchp.org**.

Health Education Contract Requirements for Plan Providers

Providers are required to make available to members health education programs and services at no charge. All health education activities must be documented in the member's medical record. For a listing of approved health education materials, contact GHCP's Health Education Department.

Staying Healthy Assessment (SHA)

DHCS requires contracted PCPs to administer a SHA to new members. The SHA is also known as the Individual Health Education Behavioral Assessment (IHEBA). All new Medi-Cal managed care members must complete the SHA within 120 days of enrollment with GCHP and providers must periodically re-administer the SHA questionnaire during subsequent visits. The SHA forms can be found on GCHP's website or the DHCS website. The SHA is available in multiple languages. For more information on the SHA, review Section 6.

Health Promotion, Disease-Prevention Programs and Health Education Classes

As a benefit of partnering with GCHP, the Plan offers providers helpful information about health promotion, disease prevention programs, and health education classes. Health education materials and information about local health education activities are available on GCHP's **website**. Additionally, GCHP's website has a calendar that allows providers to view a list of upcoming events and health education classes for members. Providers can also view flyers for the corresponding classes for detailed information, such as a description of the event, date and time.

Below is a sample of health education services available for members. To obtain a complete listing, visit GCHP's **website** or call Customer Service at 1-888-301-1228 to reach GCHP's Health Education Department.

- **Diabetes Education** – GCHP works with providers and local agencies to identify diabetes self-management classes and support groups. If you would like to hold classes in your clinic or office, please contact the Health Education Department or call Customer Service. New classes are continually being held in cities through different public and private providers.
- **Asthma Education** – GCHP works with providers and local agencies to host asthma education classes. Classes are held at various locations. If you are interested in partnering with GCHP to hold an asthma education class, please contact the Health Education Department.

- **Weight Management and Physical Activity** – GCHP collaborates with local public health agencies, community clinics, hospitals, and doctors to ensure that Plan providers have information about local support groups and exercise and nutrition classes.
- **Breastfeeding Support** – GCHP works with the Ventura County Women, Infants, and Children (WIC) program to promote the benefits of breastfeeding and provide information on the support groups available to women.
- **Prenatal / Postpartum Care** – GCHP's website maintains a health library with information about prenatal and postpartum care. Members can sign up **here** to receive an e-newsletter on pregnancy.
- **Tobacco Cessation** – GCHP works with various agencies to promote tobacco cessation classes throughout the county. GCHP also has a Quit Smoking brochure available for its members. The brochure outlines all the services available throughout Ventura County for members who want to quit smoking. For information on free tobacco cessation classes, support groups and nicotine replacement products, contact the Health Education Department or the California Smokers' Helpline at 1-800-NO-BUTTS (1-800-662-8887); for information in Spanish, call 1-800-45-NO-FUME (1-800-456-6386).
  The Ventura County Health Care Agency (VCHCA) offers free "Call It Quits" classes. The program consists of eight, 1½-hour sessions. Registration is required. For program information, call 1-805-201-STOP (7867) or email **CallItQuits@ventura.org**.
- **Urgent Care Brochure** – Health Education has a brochure available for members who would like information on GCHP's contracted urgent care centers.
- **Centers for Disease Control and Prevention (CDC)** – Health Education also uses the CDC's website to provide the Plan's members with the most current immunization schedules and other useful health information. Materials available on the CDC's website are available in English and Spanish.
- **My Plate** – GCHP's Health Education Department also encourages members to access the U.S. Department of Agriculture's (USDA) **Choose My Plate** website. Materials from the site are provided for members to use as a guide. Materials are available in English and Spanish. Providers can also download materials in other languages.
- **Rethink Your Drink** – The state Department of Public Health's website maintains a list of materials and resources for the Rethink Your Drink campaign. Materials may be downloaded directly from the website. Contact GCHP's Health Education Department for more information about materials.

Health Navigator Program

GCHP offers a Health Navigator Program to help link members with services in the community. The health navigators work with members who frequent the emergency rooms for non-emergency conditions to help them connect with their PCP. In addition, the program also helps link members who have chronic health conditions with the Plan's disease management program. Health navigators work closely with clinical staff and refer members to care management if deemed appropriate. To learn more about the program, call Customer Service at 1-888-301-1228 to reach GCHP's Health Education Department.

Women's Health

GCHP's **Health Library** has information available to help support women's efforts to stay healthy. Information and education about routine breast and cervical cancer screening exams can be found there, as well as information on prenatal and postpartum care and obstetrics (OB) tours.

Health Promotion Materials

GCHP continues to collaborate with local clinics and other agencies to promote support groups and classes to members. Below is a list of additional health promotion and disease prevention topics that GCHP providers may access:

- AIDS / HIV screening
- Breast and cervical health
- Childhood obesity
- Children's health
- Diabetes and Pre-diabetes
- Family planning
- High blood pressure
- High cholesterol
- Immunizations
- Men's health
- Pregnancy and postpartum
- Breastfeeding
- Sexually transmitted infections (STI)
- Tobacco Cessation

Contact GCHP's Health Education Department for help completing a provider order form. The Health Education Department is continually developing new classes on various topics. If there is a class that you would like to see taught, please email **HealthEducation@goldchp.org**.

Materials on Other Topics or In Different Languages

GCHP acknowledges the role that language barriers can play in reducing the quality of care to monolingual and Limited English Proficiency (LEP) members. The Health Education Department works with Plan providers to ensure that health promotion materials are available for distribution in English and Spanish and that GCHP members have equal access to services. Contact GCHP's Health Education Department at **HealthEducation@goldchp.org**.

Provider Training

The Health Education Department provides ongoing trainings to contracted providers. Contact the Health Education Department if you have questions on specific trainings. Many of the trainings are approximately an hour and can be scheduled at the provider's convenience. The trainings offered by GCHP are:

- Staying Healthy Assessment (SHA)
- Seniors and Persons with Disabilities (SPD) training
- Health Education and Nutrition (review of MyPlate with members)
- Health Education program overview
- Tobacco cessation training – The 5 A's
- Cultural Competence and Diversity Training

Provider Order Form

GCHP's Health Education Department created a list of approved health education resources for providers. The list is available for providers to order brochures and educational materials directly from the Health Education Department. Providers may contact the Health Education Department for the form by emailing **HealthEducation@goldchp.org**.

The health education materials and resources that are available in English and Spanish are:

- GCHP Mission Statement Pamphlet
- GCHP Tobacco Education and Quit Smoking Resource Guide
- California Smokers' Helpline brochures
- GCHP Winning Health member newsletter
- GCHP Health Education Referral Form
- GCHP Member Benefit Information Meetings
- GCHP Coloring Books on Healthy Eating
- DHCS – Staying Healthy Assessments
- GCHP Community Resource Guide
- GCHP Senior Resources Guide
- GCHP Urgent Care Brochure
- DHCS – Newborn Referral Form MC 330
- First 5 Kit for New Parents
- California Poison Control Magnet
- California Child Health and Disability (CHDP) Prevention Pamphlet
- Ventura County Women, Infants and Children (WIC)
- Ventura County Public Health Lead Brochure
- Safe Kids Ventura County – Child Passenger Safety Car Seat Check Locations
- Choose My Plate (10 Tips to Build a Healthy Meal) (link provided on form for direct ordering)
- Pre-diabetes and Diabetes materials
- Asthma materials
- Dairy Council of California: Health Eating Made Easier

Section 15: Pharmacy

GCHP contracts with OptumRx as its pharmacy benefit manager (PBM) to process prescriptions claims for all GCHP members. Members must go to a GCHP-participating pharmacy that has contracted with OptumRx to fill their prescriptions. There are numerous participating pharmacies located conveniently throughout the county.

Please see the pharmacy **listing** on the Plan's website for in-network pharmacy locations and contact information.

Drug Formulary

The GCHP Formulary has been developed by the GCHP Pharmacy and Therapeutics (P&T) Committee. The formulary is reviewed and updated quarterly due to advances in therapeutic treatment regimens and newly-approved FDA products. The updated formulary is posted by the first day of each calendar quarter (January 1, April 1, July 1 and October 1). Please refer to GCHP's **List of Covered Drugs** to find out if a particular medication is listed. You may download a copy of the formulary directly from the website. Please remember to update any formulary documents with the most recent versions as they become available.

The formulary does employ several mechanisms to help manage drug utilization. These mechanisms are step therapy protocols, prior authorizations, quantity limits and age restrictions. All restrictions are noted on the formulary to the right of each covered drug listed. Please refer to this section as needed.

- CPA: Clinical Prior Authorization
- QL: Quantity Limit
- Step: Step Therapy
- Age > X or Age < X: age restriction

Providers may request a change to the formulary by submitting a written request to GCHP, which will be reviewed by the P&T committee. Please submit all written requests with clinical justification to GCHP at the following address:

Gold Coast Health Plan P&T Committee
Attn: Director of Pharmacy
711 E. Daily Drive, Suite 106
Camarillo, CA 93010

Step Therapy Protocol

Members receiving a new prescription for a drug with a step therapy requirement will be required to receive an alternative drug, generally a lower cost generic product within the same drug class, before the drug can be covered. The pharmacist will receive a message from the PBM adjudication system when a prescription for a drug with a step therapy requirement is processed. Generally, the pharmacist will contact the prescribing physician to obtain approval to dispense the lower cost alternative drug. If the lower cost alternative drug is ineffective after an appropriate trial, or inappropriate for the member or the member's condition, then the originally-requested drug may be covered.

- Step therapy is based upon current medical findings, FDA-approved labeling information, and cost.
- All drugs within a step therapy protocol are FDA-approved and are used to treat the same condition.
- If medically necessary, a drug may receive an exception to bypass the step protocol. The physician must request coverage for the drug through the formulary exception process as described below. Please contact GCHP's Pharmacy Services at OptumRx at: 1-855-297-2870.

Prior Authorizations Requirements

Some drug products are included on the GCHP formulary with a prior authorization. A prior authorization is needed before the drug will be covered by GCHP. In order to obtain an authorization, please contact GCHP's Pharmacy Services at OptumRx at 1-855-297-2870. Once all documentation has been received, the prior authorization request will be reviewed within 24 hours or one business day.

Generally, all of the following documentation is necessary to complete the prior authorization as expeditiously as possible:

- Completed prior authorization form
- Chart notes
- Prior tried-and-failed medications and outcomes
- Lab values
- Any other documentation to support the diagnosis and use of the requested drug product

Formulary Exceptions

Approval of a drug product not listed on the GCHP formulary (called a non-formulary drug) and exceptions to the formulary restrictions (i.e., to obtain a quantity greater than the restriction noted) may be received. Generally, a member must have tried and failed treatment with all formulary alternatives or up to the current restriction and have documented treatment failures accompanied by claims history with GCHP or documentation in the member's medical record. Generally, all of the following documentation is necessary in order to complete an exception request as expeditiously as possible:

- Completed prior authorization form
- Chart notes
- Prior tried-and-failed medications and outcomes
- Lab values
- Any other documentation to support the diagnosis and use of the requested drug product

To request an exception, please contact the GCHP Pharmacy Department at OptumRx at 1-855-297-2870. Once all documentation has been received, the request will be reviewed within 24 hours or one business day.

Section 16: Outpatient Clinical Laboratory & Outpatient Imaging Services

Clinical Laboratory Services — Lab Specimens and Drawing Stations

Providers are able to select a clinical laboratory of their choice as long as it is contracted with GCHP or offered directly by a participating provider (such as a clinic or hospital). There are numerous locations throughout the county where members may go to have their blood drawn and lab tests performed. In addition, direct pick-up of lab specimens from the providers' offices may also be arranged. Outpatient Clinical Lab Providers are listed in the Specialist Provider Directory. The list of labs, locations and phone numbers is posted **here** on the Plan's website.

Outpatient Imaging Centers

There is a wide range of contracted imaging centers located conveniently throughout the county. Providers are able to select the outpatient imaging center of their choice as long as it is contracted with GCHP. In addition, several clinic providers have their own in-house imaging center that is contracted to provide services for GCHP. A list of the Plan's contracted imaging centers, their locations and phone numbers is posted **here** in the Provider Directory.

Lab Tests Performed in the Provider's Office

GCHP will also reimburse contracted providers for certain Clinical Laboratory Improvement Amendments (CLIA) waived lab tests that are performed in a provider's office, if the provider meets the requirements of 42 USC Section 263a (CLIA) and provides GCHP with a current CLIA Certificate of Waiver. These GCHP-approved waived tests include certain testing methods for glucose and cholesterol; pregnancy tests; fecal occult blood tests; rapid group A strep test; hemoglobin; and some urine tests.

A list of approved CLIA waived lab tests is provided below and is also available on the Plan's website. PCPs have some basic laboratory tests included as part of their monthly capitation payment.

CODE	DESCRIPTION
	Streptococcus, Group A
87650	Streptococcus, Group A, direct probe technique
87651	Streptococcus, Group A, amplified probe technique
87652	Streptococcus, Group A, quantification
87430	Streptococcus, Group A
	Fecal Occult Blood
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or triple card for consecutive collection)
82271	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or triple card for consecutive collection), other sources
82272	Blood occult, by peroxidase activity (e.g., guaiac), qualitative; feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative feces, 1-3 simultaneous determinations
	Glucose Performed on Waived Meter
82962	Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; quantitative, blood, reagent strip
82950	Glucose; quantitative, blood (except reagent strip), post glucose dose (includes glucose)
	Hemoglobin (Hgb)
85018	Hemoglobin (Hgb)
	Infectious Mononucleosis Antibodies
86663	Epstein-Barr (EB) virus, early antigen (EA)
86664	Epstein-Barr (EB) virus, nuclear antigen (EBNA)
86665	Epstein-Barr (EB) virus, viral capsid (VCA)
86308	Heterophile antibodies; screening
	Spun Microhematocrit
85013	Spun Microhematrocrit
	Urine Dipstick or Tablet Analytes, non-automated
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
	Urine Pregnancy
81025	Urine pregnancy test, by visual color comparison methods
	Influenza Testing (A and B)
87276	Influenza A virus Influenza
87275	B Virus
87400	Influenza, A or B, each
86580	Skin test; Tuberculosis, Intradermal

Section 17: Resolution of Disputes and Grievances

Gold Coast Health Plan (GCHP) members and providers may access the grievance process at any time. The Provider Reconsideration Request Form is located **here**.

Provider Dispute Resolution (PDR) Process

Providers have the right to file a dispute regarding administrative, contract, claims, or payment issues. If you have a dispute regarding a previously adjusted, contested or denied claim, or to dispute a request for reimbursement of an overpayment, you may participate in GCHP's PDR process. The Provider Dispute must be filed within 365 calendar days of the action or decision being disputed by submitting a Provider Reconsideration Request Providers must exhaust GCHP internal dispute resolution process before pursuing other available legal remedies.

PDRs are submitted by using the Provider Reconsideration Request Form and mailing the form to:

Gold Coast Health Plan
ATTN: Provider Dispute Resolution
P.O. Box 9176
Oxnard, CA 93031

Please be sure that any dispute includes all of the following information:

- Provider and/or group name.
- Provider, NPI and Tax ID number.
- Provider contact information, including email address.
- A clear explanation of the issue in question.
- Your position on the matter.
- If the dispute involves a claim or request for reimbursement of overpayment, please provide the original claim number and date of service.
- A clear explanation of why you believe the payment or other action is incorrect.
- If the dispute involves a member, you must include the member's full name, date of birth and complete nine-character GCHP ID number.

You also may include additional supporting clinical information if applicable. Please note that if the dispute does not include the above information and the Plan cannot readily obtain it, it will be returned to you for more information. Providers have 30 working days to submit an amended dispute to GCHP.

If a provider has multiple disputes addressing a single issue, they may file a single dispute by including a list of each claim associated with the issue, along with all other information required for filing multiple disputes.

GCHP will acknowledge the dispute within 15 calendar days of receiving it. GCHP will send a written resolution to the dispute within 60 calendar days from the date the dispute was received. For assistance in filing a dispute, please call GCHP's Customer Service at 1-888-301-1228.

Provider Grievances and Appeals

A provider Grievance & Appeal is the final step in the administrative process and a method for providers to resolve issues related to their claims. The request should be submitted only after a Provider Dispute has been submitted and the outcome of the dispute does not meet the provider's satisfaction. Grievances related to medical-necessity decision disputes must be submitted within 60 calendar days from the

date of the decision letter. Grievances related to claim dispute decisions must be submitted within 180 calendar days from the date of the action / inaction in writing to initiate the process. Failure to submit the request within this specified timeframe will result in the request being denied. GCHP reviews each case individually using the documents presented by the provider in order to render a fair decision.

All grievances received will be promptly acknowledged, reviewed and researched by GCHP's Grievance & Appeals team. Research may require the participation of staff from any relevant GCHP department depending on the nature of the grievance. All grievances must be acknowledged within five calendar days of receipt and resolved within 30 calendar days of receipt.

A Provider Grievance can be filed by completing the **Provider Reconsideration Request Form** then mail to:

Gold Coast Health Plan
Attn: Provider Grievance & Appeals
P.O. Box 9176
Oxnard, CA 93031

Provider Responsibilities

When a member brings a complaint to your attention, you must investigate and try to resolve the complaint in a fair and equitable manner. In addition, providers must cooperate with GCHP in identifying, processing and resolving all member complaints. Cooperation includes, but is not limited to, completing a provider statement, providing pertinent information related to the complaint, and/or speaking with GCHP Grievance & Appeals representatives to assist with resolving the complaint in a reasonable manner.
If a member asks to file a grievance or an appeal, the provider's office can give them the appropriate forms and instructions. Forms are available in English and Spanish.

Member Grievances

The member, a provider acting on behalf of the member, or an authorized representative may file a grievance at any time. The grievance can be submitted in writing, in person, or orally by contacting the Customer Service Department:

- Via phone, by calling GCHP's Customer Service Department:
  Call 1-888-301-1228 / TTY 1-888-310-7347

- In writing, by completing a Member Grievance form and/or written correspondence mailed to:

  Gold Coast Health Plan
  Attn: Member Grievance & Appeals
  P.O. Box 9176
  Oxnard, CA 93031

- In person, by meeting with a Member Services representative at GCHP's offices Monday through Friday from 8 a.m. to 5 p.m.

  Gold Coast Health Plan
  711 E. Daily Drive, Suite #106
  Camarillo, CA 93010

GCHP will send a written acknowledgement letter to the member within five calendar days of the receipt date of the grievance. The acknowledgement letter states to the member that the grievance has been

received, the date of receipt, and provides the name, telephone number and address of the Grievance & Appeals representative that may be contacted regarding the grievance.

GCHP will research and resolve standard grievances within 30 calendar days from the grievance receipt date. The written resolution will contain a clear explanation of GCHP's decision. However, in the event that the resolution is not obtained within 30 calendar days, GCHP shall notify the member in writing of the status of the grievance and the estimated date for the resolution that shall not exceed 14 calendar days.

A member can request an Expedited Grievance for cases that may involve an imminent and serious threat to their health, including, but not limited to, severe pain or potential loss of life, limb or major bodily function that does not involve the appeal of an Adverse Benefit Determination, yet are urgent or expedited in nature. GCHP will resolve these cases that meet criteria within 72 hours of receipt of the request.

Member Appeals

The member can request an appeal within 60 calendar days from the date on the Notice of Action (NOA). The member, an authorized representative or a provider acting on behalf of a member and with the member's written consent, may file a Member Appeal in writing or orally, by contacting the Customer Service Department. GCHP's customer service representatives are trained to initiate and assist with documenting the appeal request for the member. Unless the member is requesting an expedited appeal, an oral request for an appeal must be followed by a written and signed appeal that can be either faxed or mailed directly to GCHP's Grievance & Appeals Department. The member can contact customer service to get assistance in preparing a written appeal or be directed to the GCHP website to obtain a form, which can be either faxed or mailed to the department. The date of the oral request will be used as the appeal notification date.

- By phone, by contacting GCHP's Customer Service Department:
  Call 1-888-301-1228 / TTY 1-888-310-7347

- In writing, by completing a Member Appeal form and/or written correspondence mailed to:

  Gold Coast Health Plan
  Attn: Grievance & Appeals
  P.O. Box 9176
  Oxnard, CA 93031

- Via fax to GCHP's Grievance & Appeals Department:
  1-805-512-8599

A GCHP Grievance & Appeals representative will send an acknowledgement letter within five calendar days from the date the appeal is received. The acknowledgement letter shall advise the member that the appeal has been received, the date of receipt, and provide the name, telephone number and address of the Grievance & Appeals representative that may be contacted regarding the appeal. GCHP will provide a response to the member as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day GCHP receives the appeal. GCHP may extend the timeframe to resolve an appeal by an additional 14 calendar days if it demonstrates that there is a need for additional information and how the delay is in the member's interest. If the timeframe extension has not been requested by the member, GCHP will make reasonable efforts to give the member an oral notice of delay and give the member a written notice of the reason within two calendar days, including information on the right to file a Member Grievance for the delay. GCHP will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

Expedited Review

An expedited review of an appeal can be requested in certain cases. This request can be made by the member, an authorized representative or by the provider on behalf of the member. GCHP supports a process to resolve appeals in an expedited manner when a delay in a decision may seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function. The expedited appeal can be filed orally or in writing.

During the Expedited Appeal process, GCHP will ensure the member is informed of the limited timeframe for an Expedited Appeal. GCHP will provide a member notice as quickly as the member's health condition requires, or within 72 hours from the time and date the request is received. If the request for an Expedited Appeal does not meet criteria, the appeal will be handled as a standard appeal and be subjected to the timeframes for a Standard Appeal.

GCHP will provide the member with a Notice of Appeal Resolution (NAR) letter, which will include the results. The NAR letter will include the member's right to request a State Hearing, how to request a State Hearing, how to request the continuation of benefits, and the requirements to file a continuation within 10 calendar days of when the NOA was sent, or before the intended effective date of the proposed action.

If GCHP makes the decision to overturn the appeal, GCHP will authorize or provide the disputed services as promptly as the member's health condition requires, but no later than 72 hours from the decision date.

State Hearing

GCHP offers members only one level of appeal. Members must exhaust GCHP's internal process prior to proceeding to a State Hearing. Members may request a State Hearing after receiving a NAR stating that their member appeal is denied, or if they have exhausted the appeals process due to GCHP failing to adhere to the defined appeal notice and timing requirements. Members may request a State Hearing up to 120 calendar days from the date of the NAR.

The member request for a State Hearing will be considered as a standard hearing and the State Hearing unit will reach a decision within 90 calendar days of the date of the request. However, if the member requests an Expedited Hearing, the State Hearing unit will reach a decision within three working days from the date of the request. For any overturned decision, GCHP shall authorize or provide the disputed services as promptly as the member's health condition requires, but no later than 72 hours from the date of the notice reversing the determination.

You can ask for a State Hearing:

- By phone, by calling **1-800-952-5253**. This number can be frequently busy. You may get a message to call back later. If you use a TTY, please call **1-800-952-8349**.

- In writing, by filling out a State Hearing form or sending a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430
  Phone: 1-800-952-5253

Member Rights in the GCHP Grievance Process

- The member may authorize a friend or family member to act on their behalf in the grievance process.
- If the member does not speak English fluently, they have the right to interpreter services by phone via Customer Service at 1-888-301-1228.
- The member has the right to obtain representation by an advocate or legal counsel to assist them in resolving the grievance.

The state Office of the Ombudsman will help Medi-Cal members who are having problems with GCHP. The member may call 1-888-452-8609 / TTY 1-800-735-2922 and request assistance.

Section 18: Fraud, Waste and Abuse Identification Policy and Procedures

Purpose:

To establish a formalized organizational process for detecting, investigating, documenting and reporting suspected fraud, waste or abuse of any Gold Coast Health Plan (GCHP) program by a member, provider, employee, or any other person, in accordance with GCHP's contract with the state Department of Health Care Services (DHCS) and federal and state regulations.

Policy:

A. GCHP maintains a zero-tolerance policy towards fraud, waste and abuse.
B. GCHP complies with applicable statutory, regulatory and other governmental requirements, and contractual obligations or commitments related to the delivery of GCHP covered benefits, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.
C. All GCHP employees, contractors, temporary staff, vendors, providers and practitioners are responsible for reporting any suspected fraud, waste and abuse to GCHP. GCHP reports suspected fraud, waste or abuse to DHCS in accordance with its DHCS contract and this policy.
D. GCHP maintains a policy of non-retaliation toward employees, contractors, providers and practitioners who make such reports in good faith. GCHP employees, contractors, temporary staff, vendors, providers and practitioners are protected from retaliation under Title 31, United States Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections.
E. GCHP provides a Compliance Program for complete investigation of all reported suspected fraud, waste and abuse allegations. GCHP Compliance staff, under the supervision of the GCHP compliance officer, is responsible for activities associated with the investigation and reporting of suspected fraud, waste and abuse. Compliance staff will compile supporting evidence for the investigation, consult with legal counsel as appropriate, and function as the liaison between GCHP, DHCS, the Medical Board, the state Board of Pharmacy, and other licensing, law enforcement, or other relevant entities, as appropriate, and cooperate with those agencies related to any fraud, waste and abuse investigations or audits.
F. GCHP's investigative processes ensure that appropriate confidentiality protocols are followed relating to any investigation of a suspected fraud, waste or abuse violation. GCHP's compliance officer will report the status and results of all suspected fraud, waste or abuse investigations to the GCHP Compliance Committee.
G. GCHP's Compliance Program provides for regular training and information sessions for all GCHP employees, contractors, temporary staff, network providers and practitioners regarding GCHP's fraud, waste and abuse policies and procedures.
H. GCHP members will also be informed via Evidence of Coverage, Member Handbook and/or newsletters about how to report fraud, waste and abuse.

Definitions:

A. Fraud: An intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law (Title 42 CFR 455.2; Welfare and Institutions Code 14043.1(i)).
B. Waste: Overutilization of services and/or misuse of resources not caused by a violation of law.
C. Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that

are not medically necessary or that fail to meet professionally-recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (Title 42 CFR 455.2; Welfare and Institutions Code 14043.1(a)).

D. Retaliation: Adverse punitive action taken against an employee who reports fraud, waste or abuse.

E. Whistleblower: An employee, former employee, or member of an organization who reports misconduct, including, but not limited to, fraud, waste or abuse, to people or entities that have the power to take corrective action.

Procedures:

A. **Training of GCHP Staff and Provider Network**

Compliance staff will provide the training of new employees, contract employees and temporary employees. Providers are informed about fraud via the Provider Manual. In addition, contracts with the providers have verbiage that is inclusive of fraud reporting. The trainings for staff are held on an annual basis. Trainings are held on a quarterly basis for all new associates to ensure they receive training.

The process for detecting suspected fraud, waste and abuse, the specific provisions regarding fraud, waste and abuse under the False Claims Act, the reporting process, and the protections afforded to those who report such concerns in good faith are all reviewed during the trainings. All trainings are documented with all attendees noted. GCHP employees, contractors and temporary staff receive a certificate of completion for attending the training.

B. **Identification of Fraud, Waste or Abuse**

1. GCHP employees, contractors, temporary staff, vendors, members, providers and practitioners may detect fraud, waste or abuse perpetrated by a member in circumstances that include, but are not limited to, the following:
    a. Using another individual's identity, Benefits ID Card (BIC), GCHP ID card, Medi-Cal number, or other documentation of Medi-Cal or GCHP program eligibility to obtain covered services, unless such person is an authorized representative who is presenting such document or information on behalf of a member to obtain covered services for that member.
    b. Selling, loaning, or giving a member's identity, BIC, GCHP ID card, Medi-Cal number, or other documentation of Medi-Cal and GCHP program eligibility to another individual to obtain covered services, unless such person is an authorized representative who is obtaining services on behalf of a member.
    c. Making an unsubstantiated declaration of eligibility.
    d. Using a covered service for a purpose other than that for which it was prescribed or provided, including use of such covered service by an individual other than the member for whom the covered service was prescribed or provided. Soliciting or receiving a kickback, bribe, rebate or other financial incentive as an inducement to receive or not receive covered services.
2. GCHP employees, contractors, temporary staff, vendors, members, providers and practitioners may detect fraud, waste or abuse by a provider, provider group or practitioner in circumstances that include, but are not limited to, the following:
    a. Unsubstantiated declaration of eligibility to participate in the Medi-Cal program or the GCHP program as a provider, provider group or practitioner.
    b. Submission of a claim or a request for payment for:
        i. Covered services that were not provided to the member for whom such covered services were claimed.
        ii. Covered services substantially in excess of the quantity that is medically necessary for the member.
        iii. Covered services using a billing code that will result in greater payment than the billing code that reflects the covered services actually provided.

c. Soliciting, offering, receiving, or paying a kickback, bribe or rebate as an inducement to refer, or fail to refer, a member.
d. Failing to disclose any significant beneficial interest in any other provider to which the provider or practitioner may refer a member for the provision of covered services.
e. False certification of medical necessity.
f. Attributing a diagnosis code to a member that does not accurately reflect the member's medical condition for the purpose of obtaining higher reimbursement.
g. Submitting files or reports that contain: unsubstantiated data, data that is inconsistent with underlying clinical, encounter, or payment records or data that has been altered in a manner or for a purpose that is not consistent with GCHP's policies, contract, or applicable regulations and statutes.

3. GCHP 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 GCHP and provider's Fraud Prevention Program and fraud prevention activities at least annually.
   b. Developing a fraud program, implementing fraud prevention activities and communicating such program and activities to contractors and subcontractors.
   c. Communicating awareness, including identification of fraud schemes, detection methods and monitoring activities to contracted and subcontracted entities and to GCHP.
   d. Notifying GCHP of suspected fraudulent behavior and asking for assistance in completing investigations.
   e. Taking action against suspected or confirmed fraud, including referring such instances to law enforcement and reporting activity to GCHP.
   f. Policing and/or monitoring activities and operations to detect and/or deter fraudulent behavior.
   g. Cooperating with GCHP in fraud detection and awareness activities, including monitoring, reporting, etc., as well as cooperating with GCHP in fraud investigations to the extent permitted by law.

C. **Reporting of Fraud, Waste or Abuse**

GCHP provides for the reporting of suspected fraud, waste or abuse through various mechanisms, such as the GCHP website and toll-free phone numbers. GCHP's Compliance Department tracks and analyzes data for suspected fraud, waste and abuse trends.

1. The Fraud Hotline, 1-866-672-2615, or the **website** can be used to anonymously report a suspected fraud, waste or abuse incident. The hotline number is provided to employees, contractors, temporary staff, vendors, members, providers, and practitioners.
   a. GCHP employees use the hotline provided by Global Compliance at 1-866-672-2615 which provides a method to anonymously report suspected fraud, waste and abuse. Employees may also use the **website**. In the event an allegation is received via Global Compliance relative to any employee-related allegation that is not related to fraud, waste or abuse, the case will be referred to the Human Resources director. If the report involves a Board of Directors member, the compliance officer will contact general counsel immediately. In the event the report involves the CEO, the compliance officer will contact the board chair and general counsel.

D. **Investigation and Research**

GCHP treats the detection of suspected fraud, waste or abuse in a confidential manner by ensuring that Compliance staff adheres to GCHP's HIPAA confidentiality protocols in compiling only the information needed for the investigation to determine if the suspected violation is valid and ensure that GCHP will not retaliate or make retribution against any GCHP employee, provider, practitioner, or member for such detection. Upon receiving a report of a suspected fraud, waste or abuse incident, Compliance staff will review and perform an initial triage of the case and will:

1. Determine whether the case relates to GCHP programs and is appropriate for investigation by GCHP. (For example, if the claim is in regards to a Medicare issue / allegation, that type of case will be redirected).
2. In the event the report is determined not to be subject to investigation by GCHP, an acknowledgement response via Global Compliance will be available online. In addition, the reporter will also receive a report number and the reporter can contact Global Compliance 24 hours a day, seven days a week to request the status of their case.
3. Once it is determined the allegation is valid for GCHP to pursue, the compliance specialist(s) will:
    a. Assign the case a unique tracking number and establish a file to maintain documents, reports, evidence, and correspondence pertaining to the suspected fraud, waste or abuse, to include: the reported individual allegation or incident, the date, summary results of the investigation, resolution, and reports to/correspondence with the appropriate agency.
    b. Upon the receipt of a Suspected Fraud, Waste or Abuse Referral Form, GCHP's Compliance staff will transmit an acknowledgement notice to the party who submitted the form, including a request for additional documents (if needed) with a due date.
    c. Involve the appropriate department(s) based on the nature of the case in order to gather the appropriate documentation, e.g. member profiles, claims history, etc. The department(s) notified will review the allegation and gather any additional information as deemed necessary for a comprehensive report.
    d. The departments will return a written report of all necessary documents and information to Compliance within five business days of receiving the request.
    e. If necessary and upon request, Compliance will coordinate the investigation independent of other GCHP departments, including procuring the services of contracted investigators, as/if needed.
    f. In the event the allegation warrants reason to believe that an incident of fraud and/or abuse has occurred based on preliminary findings, Compliance will use the material reviewed by the department(s) in preparation to report and notify DHCS Medi-Cal Managed Care Division / Program Integrity Unit of the suspected fraud, waste or abuse by submitting an MC609 form: Confidential Medi-Cal Complaint Form.
4. Compliance staff will conduct, complete, and report to DHCS the results of its preliminary investigation of the suspected fraud, waste and/or abuse within 10 business days of the conclusion of the date GCHP first becomes aware of, or is on notice of, such investigation activity.

E. **Monitoring**

GCHP's compliance officer will provide quarterly reports and annual summaries that identify any trends for review and discussion for possible corrective action plans, as appropriate, to the Compliance Committee and the GCHP governing body.

References:

GCHP Contract with the Department of Health Care Services. Title 42. Code of Federal Regulations (C.F.R) Section 455.2 42 C.F.R. §Title 42, Code of Federal Regulations (C. F.R) Section 438.608

Section 19: Forms and Resources

Gold Coast Health Plan (GCHP) is continually posting forms to its website. If you require a form and it is not posted, please call the Plan's Customer Service Department at 1-888-301-1228. Below you will find a list of forms, along with a brief description of their intended use. To view or to download these or other GCHP-related business forms, please visit the **Provider Resources** section of the Plan's website.

Claims

- **CLAIM CORRECTION FORM** – Use this form to accompany corrected claim(s).
- **ELECTRONIC CLAIMS SUBMISSION** – Electronic claims submission instruction process.
- **PROVIDER RECONSIDERATION REQUEST FORM** – This form is to be used for disputes related to claim denials, overpayment and underpayment.

HEALTH SERVICES

Request for Authorization

- **PRE-AUTHORIZATION TREATMENT REQUEST FORM** – This form is used by providers to request prior authorization from the Plan for certain specified services that require advance approval.
- **DIRECT REFERRAL AUTHORIZATION FORM** – This form is used by Primary Care Providers (PCPs) and specialists to refer a member to another contracted provider located in Ventura County.
- **DISEASE MANAGEMENT REFERRAL FORM** – This form is used by providers to refer a member to a population health offering.
- **CARE MANAGEMENT REFERRAL FORM** – This form is used to request assistance with a member with unique or special needs.
- **NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) PRESCRIPTION / ATTESTATION OF MEDICAL NECESSITY** – This form is used by PCPs and specialists to determine eligibility and medical necessity for a member to receive NEMT services.

Member Services

- **PCP SELECTION FORM** – This form can be printed from GCHP's website and handed to members who would like to change their PCP. This form is available in English and Spanish.
- **MEMBER GRIEVANCE & APPEALS FORM** – This form can be printed out and handed to members who are interested in filing a complaint with GCHP's Member Services Department.

Provider Relations

- **PROVIDER RECONSIDERATION REQUEST FORM** – This form is to be used for disputes related to claim denials, overpayment and underpayment.
- **PROVIDER INFORMATION UPDATE FORM** – This form is used to update provider contact and practice information. Information includes the provider's address, phone number, contact information, payment address, and tax ID number.
- **PROVIDER REQUEST FOR CONTRACT** – If you are interested in becoming a GCHP provider and joining the Plan's network, please call Customer Service at 1-888-301-1228.
- **CERTIFICATION REGARDING LOBBYING** – EXHIBIT D(F) ATT 1 AND 2 – If payments to a provider under the GCHP services agreement total $100,000 or more, the provider must submit the "Certification Regarding Lobbying" form to GCHP.

If you require a form not found on this list or on GCHP's website, please call the Plan's Provider Relations Department for assistance at 1-888-301-1228 or email **ProviderRelations@goldchp.org**.

Appendix 1: Functions of Committees and Gold Coast Health Plan (GCHP) Staff

Quality Improvement Committee (QIC)

This QIC is chaired by the chief medical officer (CMO) and is responsible for advising the Plan's staff and the GCHP commissioners on the Quality Improvement Program (QIP), including:

- Facilitating data-driven indicator development for monitoring access, care and service and quality improvement project activities.
- Reviewing activities and monitoring the functions of all of the sub-committees that review the quality and safety of care provided to members.
- Approving and/or recommending changes to health plan policies, practice guidelines and reporting the committees' proposed action plans.
- Overseeing the annual review, analysis and evaluation for achievement of goals and effectiveness of the QIP, QI policies and QI Work Plan.

Pharmacy & Therapeutics (P&T) Committee

The P&T committee is chaired by the CMO, staffed by GCHP's Pharmacy director, and comprised of local physicians and pharmacists. The committee meets quarterly with the primary responsibility of developing, maintaining and monitoring a dynamic clinical formulary that ensures cost effective and quality drug management for GCHP members. P&T committee members are appointed by the CMO for a renewable two-year term. The GCHP formulary shall be reviewed at the quarterly meeting and revised as deemed necessary. The P&T committee reports to the board through the CMO and the QIC.

Credentials / Peer Review Committee (C / PRC)

Chaired by the CMO and staffed by the director of Network Operations, the C / PRC includes physicians from the contracted provider community, including primary care and specialty practices.

At its discretion, the C / PRC may invite additional specialists to review case records, either in writing or in person. Participants are bound by confidentiality and conflict of interest rules. The committee provides guidance and comments on the credentialing process, reviews and makes decisions for initial credentialing and re-credentialing and reviews credentialing policies annually.

This committee also reviews member and provider clinical complaints, potential quality issues involving clinical quality of care concerns and determines corrective action when necessary.

Medical Advisory Committee (MAC)

Chaired by the CMO, the committee includes physicians representing the contracted provider community. Its function is to offer input regarding issues related to the delivery of medical care, provide guidance on quality of care issues, and review, revise and approve clinical practice guidelines as well as preventive care guidelines.

Health Education, Cultural & Linguistics Committee (HE / CL Committee)

The HE / CL Committee is chaired by the Health Education manager and staffed by the QI and Member Services managers, the Network Operations and Health Services directors, and others, as appropriate. The committee shall meet at least quarterly and reports to the QIC.

GCHP's HE / CL department includes interpretation and translation services, provider education and resources, and cultural competence training for GCHP and contracted staff. Committee objectives are to increase access to high quality care for all GCHP members, reduce health disparities among different cultural groups, and to improve communication among staff, providers and members.

Provider Advisory Committee (PAC)

Comprised of a broad spectrum of community providers, the PAC meets quarterly and offers input to the CMO, commission and management team regarding GCHP policies that involve provider activity and the integrity of the provider network. The GCHP commission appoints PAC members to a one-year term that is renewable. Recommendations for policy revisions and innovations, if adopted as resolutions by a majority of the appointed members of the PAC, are forwarded to the commission.

Chief Medical Officer (CMO)

The CMO is the principal GCHP position that provides oversight of the provider credentialing process, quality monitoring, evaluation and improvement activities.

The CMO shall be responsible for the day-to-day guidance and direction of quality monitoring and improvement activities, and seeking input from specialists as needed to provide guidance in addressing quality issues relevant to a specific area of expertise.

Specific functions include:

1. Fulfillment of and adherence to QIP goals and all regulatory agency and accreditation body requirements.
2. Fulfillment of and adherence to UM / CM Program goals and all regulatory agency and accreditation body requirements.
3. Development and coordination of the peer review process.
4. Serving as chair for the Credentials / Peer Review Committee.
5. Remaining on-site or available via phone for consultation with the Health Services, UM, and Quality directors and other staff, as appropriate.
6. Guiding and assisting in the development and revision of quality improvement criteria, practice guidelines, new technology assessments and performance standards, as appropriate, and the development and implementation of quality improvement strategies.
7. Presenting periodic updates on quality improvement and utilization management activities to committee chairs and to the commission as appropriate.

Appendix 2: FAQs about Claims and Electronic Billing

1. Does Gold Coast Health Plan (GCHP) follow the same timeliness guidelines as Medi-Cal?

Yes. GCHP requires providers to submit claims within 365 calendar days from the date of service unless the provider's contract specifies a different limitation. If the member has other health coverage, the claim must be received within six months from the date of the primary carrier's Explanation of Benefits. However, GCHP does not follow the payment reduction step-down for claims received within 7 to 12 months from the date of service that Medi-Cal fee-for-service follows.

2. What is GCHP's processing time for my claims?

GCHP is contractually bound to process 90% of clean claims within 30 working days of receipt of the claim and 99% of clean claims within 60 calendar days of receipt of the claim. Claims are processed daily and payments are generated once a week. When a holiday falls on a check run day, checks will be processed on the next business day.

3. What is GCHP's capitation check schedule?

GCHP processes capitation checks to PCPs on the 10th of each month. When a holiday falls on a check run day, checks will be processed on the next business day.

4. Am I required to submit claims for capitated services for members linked to my practice?

Yes. GCHP requires and specifies in your provider contract that all capitated service encounters must be reported every month as "shadow claims" or "dummy claims" that are not paid.

5. Will GCHP accept electronic claims?

Yes. GCHP accepts and encourages electronic claims submission by network providers. If your practice or facility is interested in submitting claims electronically, please see information **here** about becoming a Trading Partner to submit Electronic Claims or call EDI Support at 1-800-952-0495. If you use a clearinghouse, please provide this information to your clearinghouse vendor.

6. When and how should I follow up on claims that I believe have not been processed by GCHP?

Please consider the date that the claim was submitted to estimate an appropriate follow-up / re-bill period. GCHP processes claims based on the date they are received in the Plan's office. For most practices, the appropriate timeframe for follow up would be 45 calendar days after the claim was originally mailed. The Plan suggests that providers use the electronic claims tracking available through the Provider Web Portal or contact Customer Service at 1-888-301-1228 before resubmitting any claims.

7. What about the ability to resubmit via the web?

Providers can use GCHP's Provider Web Portal to search for claims and can resubmit previously denied claims through the Conduent **EDI Gateway**. If your office has not registered and is not using the Provider Web Portal, please do so. Instructions to register for the Web Portal are available **here**, for EDI click **here** or contact the Plan's Provider Relations department at 1-888-301-1228 or **ProviderRelations@goldchp.org**.

8. What form should I use to bill Child Health and Disability Prevention (CHDP) program claims?

CHDP services should be billed on a CMS-1500 claim form (formerly known as HCFA-1500) using standard CPT codes. GCHP is following the CHDP guidelines provided by the state.

9. How should claims for newborns be submitted?

Services rendered to an infant may be billed with the mother's ID number for the month of birth and for the following month if the child has not received their own Medi-Cal ID number. After this time, the infant must have their own Medi-Cal ID number. If you are billing using the mother's ID number, please add her ID number and information in box 58 and box 60 of the UB form.

For the CMS-1500 form, use box 1a and box 4. Additionally when billing for NICU infants, use the child's ID number.

10. How does GCHP handle claims for children eligible for California Children's Services (CCS)?

CCS services are not the financial responsibility of GCHP and should be billed directly to fee-for-service Medi-Cal. Original claims billed with a CCS diagnosis and/or CCS-eligible condition will be returned to you with a denial letter that includes CCS billing instructions. A denial will also appear on a subsequent Explanation of Payment (EOP). GCHP's review of potential CCS claims is based on the member's diagnosis.

11. How should I handle Share-of-Cost (SOC) collection and billing?

SOC collection and billing is an important function for every provider. The Medi-Cal **website** will inform you of a member's outstanding SOC and allow you to clear the amount collected (or the amount that the patient is obligated to pay). Once the amount collected (or obligated) is cleared, the member will be a GCHP member (or, if there is a remaining SOC amount, will be closer to eligibility). It is important for all providers to collect and clear SOC each month to ensure a member's ability to obtain services from other providers later that month.

Once the SOC has been cleared, GCHP will determine the Medi-Cal allowance and subtract the amount already paid by the member. If the member's SOC payment exceeds the Medi-Cal allowance, the GCHP reimbursement will be $0. If the member's SOC payment is less than the Medi-Cal allowance, then the net reimbursement will be the difference.

When using the CMS-1500 Claim Form: Enter the amount collected (or obligated) in box 10d or 19 of the CMS-1500 claim form. The amount collected (or obligated) should also be entered in box 29 and should be subtracted from the total balance due (box 30). Further explanation and samples can be found in the SOC tutorial section of the Medi-Cal website.

When using the UB-04 Claim Form: Enter code "23" and the amount of the patient's SOC in box 30. In box 55 enter the difference between "Total Charges" (box 47) and SOC collected. Further explanation and samples can be found in the SOC tutorial section of the Medi-Cal website.

When using the UB-04 Claim Form for Long-Term Care Billing: Enter one of the approved value codes RL, 23, 02, 31 or FC. When using these value codes, the monetary amount submitted should only be the net for the claims statement period being billed.

12. How are refunds or reversals / take backs processed?

GCHP's Recovery Department assesses and identifies overpayments on claims. Research is completed to identify overpayments related to over-utilization of procedures, claims billed incorrectly, duplicate payments, overpayments due to lack of coordination of benefits with members' primary health care insurance policy (such as private health insurance, Medicare coverage, or an open case with CCS).

Typically the overpaid amount is recovered either by the provider issuing a lump-sum check payable to GCHP and mailed to:

Gold Coast Health Plan
Attn: Claims Department
P.O. Box 9152
Oxnard, CA 93031

Alternatively, an overpayment may be reversed from monies due to the provider on the same NPI until the recovery is completed. This will only be done as a last resort if the provider does not respond in writing to the notification from the Plan that there is an overpayment that must be reconciled or if the provider asks GCHP to offset the overpaid amount.

When an overpayment is identified by GCHP, the provider will be notified with a letter explaining the overpayment and a request for a refund check in the amount of the overpayment. If the provider does not remit the overpayment, GCHP will notify the provider of its intent to offset the overpayment from future claim payments.

If a provider is not expected to receive money in future payments or does not have a large volume paid out for a particular NPI number from GCHP to recoup the overpayment, the offset(s) must be completed by using the same NPI that were initially paid incorrectly.

Example: A claim was paid for services rendered to John Doe. GCHP discovers that Mr. Doe is not your patient and takes back the payment. The initial payment was paid to NPI #1234567890; therefore, GCHP should be able to recoup the monies owed (excluding any issue beyond the Plan's control) from any following payment made to that NPI. The Claims Department will mail, fax, or e-mail an "Identification of Overpayment" request if offsets are not viable. Payments are expected within 30 days from receipt of this notice.

If you have additional questions or concerns, please contact the Claims Department at 1-888-301-1228.

13. What do I do if I disagree with how a claim was paid or denied?

Claims are processed using Medi-Cal and standard National Correct Coding Initiatives (NCCI) guidelines. If a provider disagrees with either how a claim was priced / paid or whether or not it was denied appropriately, the provider should submit a Provider Dispute Resolution Form.

For further information, please see the dispute resolution process in Section 19 of this Provider Manual.

14. When can I bill a GCHP member for an unpaid service?

You may not bill a GCHP member for any un-reimbursed amount, including a deductible / co-insurance or co-pay amount, unless one of the following exceptions applies:

- The member has an unmet monthly Medi-Cal SOC amount.
- The member does not disclose their GCHP / Medi-Cal coverage.

- The member consents to receive services that are not covered by GCHP.
- The member chooses to see a physician / provider who does not accept Medi-Cal or is not a Medi-Cal provider.
- The member waives their Medi-Cal benefits.
- The member does not obtain or access primary insurance benefits correctly.

A member may be charged when they do not obtain primary insurance benefits correctly. Please note that unless you have provided benefits to the member according to the primary insurance authorization / benefit requirements, you may not charge the GCHP member for the service.

Appendix 3: Financial Disclosure and Reporting

By the terms of its contract with the state, Gold Coast Health Plan (GCHP) is required to monitor the financial viability of its contracting providers and Plan partners. The purpose is to establish that they are financially solvent and that their financial status is not deteriorating over time. The requirements for contracted providers are different from those of Plan partners.

GCHP will exercise discretion to only collect financial information from contracted providers if and when there is a clear need to do so in order to fulfill its obligations to the state. For example, PCPs who have only a small or limited number of members on their panel will not have to comply with these provisions, nor will tertiary care out-of-area providers that rarely treat GCHP's members or providers that are compensated on a straight fee-for-service rate schedule or case rate basis.

Plan partners must submit financial statements annually for the first three quarters of the fiscal year to GCHP's Compliance Department no later than 45 calendar days after the close of each applicable quarter for the fiscal year. For the purpose of this section, the quarterly financial statements will consist of the balance sheet, income statement, statement of change in net worth and cash flow statement.

The provider's financial statements should be prepared in accordance with Generally Accepted Accounting Principles (GAAP). Financial statements shall be in the same format and have the same content as the Quarterly Financial Reporting Forms (previously "Orange Blank") that are submitted to the state Department of Managed Health Care (DMHC).

On an annual basis, Plan partners shall submit to GCHP's Compliance Department financial statements audited by an independent Certified Public Accounting firm. Audited annual financial statements must be filed within 120 days of the end of each fiscal year and will be in the same format and content as the Annual Financial Reporting Form (previously "Orange Blank") submitted to DMHC.

GCHP will review the financial statement(s) to determine if the selected providers and partners meet the minimum acceptable liquidity, profitability, efficiency, and stop-loss protection levels.

The financial viability of each selected contracting provider and all Plan partners will be determined based on established criteria and DMHC-required grading criteria. For example, the following information will be calculated and analyzed:

Liquidity:

- Current and quick ratios to be equal to or greater than 1.0.
- Acid Test Ratio of liquid assets (cash) to current payables to be equal to or greater than 0.50 (DMHC-required grading criteria).
- A positive working capital of 1.0 or above (DMHC-required grading criteria).
- A positive tangible net equity (TNE) or net worth of 1.0 or above (DMHC-required grading criteria).

In addition, Plan partners shall estimate and document, on a monthly basis, the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other reasonable method.

1 GCHP reserves the right to request more frequent submissions.

On a discretionary basis, the GCHP Compliance Department will have the right to periodically schedule audits to ensure compliance with the above requirements. Since the financial solvency standards apply to the entity as a whole, the audits will be conducted for all books of business, not only for the lines of businesses contracted with GCHP. Representatives of the contracted providers and Plan partners shall facilitate access to the records necessary to complete the audit.

Appendix 4: FAQs for Members on Complaints / Grievances

*NOTE: This guide is provided to give basic assistance to provider offices in dealing with the types of questions they may receive from Gold Coast Health Plan (GCHP) members. For more complicated matters, please refer members to GCHP at **1-888-301-1228 / TTY 1-888-310-7347**.*

1. What is the GCHP grievance process?

It is the way in which GCHP works closely with members in order to provide them with the means to voice complaints, resolve disputes and settle any concerns they may have about the services they get as GCHP members.

2. When would a member file a complaint / grievance?

You could file a complaint / grievance if:

- You are having a problem getting services you feel you need (for example, if you are having problems getting medication or medical equipment, problems getting an appointment with your doctor or problems getting treatment at the hospital).
- You are not happy with the services you got from a health care provider.
- You disagree with the Plan when you are denied a service you feel you need.
- You are unhappy with any aspect of your health care.
- You feel that GCHP or a health care provider has not respected your privacy.

In most cases, you must file your complaint / grievance within 180 days of the event that caused you to be dissatisfied. If you are filing a complaint because the Plan has denied or modified a request for Prior Authorization, you must file your appeal within 90 days of GCHP's Notice of Action.

3. How do I file a complaint / grievance?

You can file a complaint / grievance by:

- Calling GCHP's Member Services Department at 1-888-301-1228 / TTY 888-310-7347.
- Writing your complaint / grievance and mailing it to:
  Gold Coast Health Plan
  Attn: Grievance & Appeals
  P.O. Box 9176
  Oxnard, CA 93036
- Going to GCHP's website to download a **Provider Reconsideration Request Form** and mailing it to the address above.
- Going to the GCHP office and filing your complaint / grievance in person Monday through Friday between 8 a.m. and 5 p.m.

  GCHP's office is located at:
  711 E. Daily Dr.
  Suite 106
  Camarillo, CA 93010

4. What if I prefer to speak a language other than English?

GCHP has staff who speak Spanish. Translation services are available for other languages through Member Services and the Cultural and Linguistics Department at 1-888-301-1228.

5. Do I have to use the GCHP grievance process to resolve my problem?

If you are a Medi-Cal member, no. If you are on Medi-Cal, you can ask for a State Hearing. You must ask for the hearing within 90 days from the date of the event that caused you to be dissatisfied. The state Department of Social Services (DSS) can help you. You can call DSS at 1-800-952-5253 / TTY: 1-800-952-8349 and tell them you want a hearing. You can also ask for a State Hearing by mail, phone or in person by contacting the local office in Ventura County:

Human Services Agency
855 Partridge Drive
Ventura, CA 93003
1-805-477-5100

As a GCHP member, you also have the right to file a complaint with the Department of Health and Human Services (HHS) at any time if you feel that your privacy has not been respected. You can file your complaint by contacting:

Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

6. Can I have someone help me file my complaint / grievance?

Yes, you may have a family member or a friend help you. The state Office of the Ombudsman will help Medi-Cal members who are having problems with their health plan. You can call them toll-free at 1-888-452-8609.

7. What happens after I file my complaint / grievance?

The Member Services Department will send you a letter within five days after you file your complaint / grievance. This letter tells you that your grievance was received. It explains your rights in the grievance process.

8. How does my complaint / grievance get settled?

Depending on the type of complaint you have, GCHP's staff may be able to resolve it right away to your satisfaction. If this is not possible, your complaint / grievance will be referred to the appropriate department within GCHP to be reviewed and resolved.

If the Plan needs more information, it will be requested. For example, if the CMO wants more information, the Plan may ask for medical records from the doctors involved. The Grievance & Appeals Department will send you the resolution in a Proposed Resolution Letter.

9. How long do I have to wait until I get the Proposed Resolution Letter?

The Member Services Department will send you the proposed resolution letter within 30 days from the day your grievance was received.

10. What if my complaint / grievance involves an immediate or serious threat to my health and well-being?

If you feel there is an immediate or serious threat to your health or well-being, you can request an expedited review of your complaint. If your complaint meets the criteria for an expedited review, the Member Services Department will let you know within one business day that your complaint has been received and will have a decision for you within three days.

11. What can I do if I don't agree with the Proposed Resolution Letter?

If you are on Medi-Cal, you have the right to request a State Hearing. You must ask for the hearing within 90 days from the date of the proposed resolution letter. The phone number for requesting State Hearings is 1-805-477-5100.

12. What if I have a complaint about my privacy?

You have the right to file a complaint with HHS at any time by contacting:

Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Index

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Gold Coast Health Plan℠
A Public Entity

For questions and Gold Coast Health Plan information, please call 1-888-301-1228.
www.goldcoasthealthplan.org

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