Gold Coast Health Plan℠
A Public Entity

2024

PROVIDER MANUAL

For Questions and Gold Coast Health Plan Information,
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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 GCHP's website). The manual will be updated and revised periodically as needed to reflect the Provider Operations Bulletin (POB), which is bi-monthly. Revisions and updates will be incorporated into the online version of the manual.

Provider Web Portal

Contracted 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 call Customer Service and request an access code and vendor number in order to obtain access to the portal. To start using these services, go to the **Provider Web Portal** and complete the registration process. For assistance, please contact the GCHP's Customer Service Department at 1-888-301-1228 or email **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), Specialist Physicians, and other Non-PCP Directories are also available in Spanish and Large Font (English and Spanish) in PDF format to download and print at your convenience.
- **Drug Formulary:** Information regarding the Drug Formulary can be found on the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/**.
- **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, subacute facility or other lower level of care as approved by Gold Coast Health Plan (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 Primary Care Provider (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 GCHP members.

Auto Assignment: This is the process used by GCHP 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 GCHP

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.

California Immunization Registry (CAIR2): The California Immunization Registry (CAIR2) is a secure, confidential statewide computerized immunization information system for California residents. The registry is accessed online to help providers and other authorized users track patient immunization records, reduce missed opportunities, and help fully immunize Californians of all ages.

California Advancing and Innovating Medi-Cal (CalAIM): A state Department of Health Care Services (DHCS) initiative to improve the quality of life and health outcomes of Medi-Cal members by implementing delivery system, program and payment reforms across the Medi-Cal program.

Capitation Payment: The prepaid monthly amount that GCHP 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 GCHP 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).

Centers for Medicare & Medicaid Services (CMS): An operating division of the Department of Health and Human Services (HHS), which is the federal agency that administers and oversees the nation's major health programs, including Medicare and Medicaid.

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

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.

Community Health Worker (CHW): A skilled and trained individual who is able to render clinically appropriate Medi-Cal covered benefits and services and is an, enrolled Medi-Cal provider.

Claim Form: Form UB-04 is used by participating hospitals, Federally Qualified Health Centers (FQHC), Long Term Care facilities, Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) services and other facilities to report to GCHP 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 GCHP 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 provides transportation to / from the facility-based service to eligible Medi-Cal beneficiaries.

Community Supports (CS): Substitute services or settings to those required under the California Medicaid State Plan that GCHP may select and offer to members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

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.

Concurrent Review: A part of a utilization management program in which health care is reviewed by GCHP 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 GCHP 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. GCHP 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®): CAHPS® are survey tools developed by the Agency for Healthcare Research and Quality (AHRQ) that ask patients to report on their experiences with a range of health care services at multiple levels of the delivery system. The state Department of Health Care Services (DHCS) uses CAHPS® surveys to periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) beneficiaries as part of its process for evaluating the quality of health care services provided by Medi-Cal Managed Care Plans (MCPs) to MCMC beneficiaries.

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

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) ProView: A nationally recognized central repository for providers to use to self-report professional and practice information to payers, hospitals, large provider groups and health systems.

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 GCHP, 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 GCHP'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 network providers receive training on cultural competency, diversity, equity, and inclusion (DEI). GCHP has training materials on the GCHP **website** for providers to review.

Delegated Provider: A contracted GCHP provider to whom certain services and processes have been delegated for oversight.

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.

Doula: A doula provides person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of members while adhering to evidence-based best practices. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants..

eApply: A secure web-based module that gives practitioners, groups, and facilities the tools to apply, attest and update their Credentialing information online.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit (also known as Medi-Cal for Kids & Teens): The EPSDT benefit provides comprehensive and preventive health services for children under 21 years of age who are enrolled in Medi-Cal. EPSDT is key to ensuring that children and

adolescents receive appropriate services, including routine physicals, well-child exams, immunizations, and screenings, such as developmental, dental, hearing, vision, and lead screenings.

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 GCHP's service area.

Emergency Medical Condition: A medical condition that 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.

Encounter Data Validation (EDV): The state Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an External Quality Review Organization (EQRO), to conduct an Encounter Data Validation (EDV) study that evaluates the completeness and accuracy of encounter data submitted to DHCS.

Enhanced Care Management (ECM): ECM is a foundational component of California Advancing and Innovating Medi-Cal (CalAIM) and is intended to increase coordination between medical and behavioral health services / systems, create infrastructure to support multi-system coordination and care delivery, and address homelessness / unstable housing of eligible members. ECM providers deliver comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referrals to community social supports.

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 GCHP 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 or decided on 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.

External Quality Review Organization (EQRO): External Quality Review Organization (EQRO), formerly referred to as an outside auditing firm.

Facility Site Review: GCHP conducts Facility Site Reviews (FSR) for new PCPs at the time of initial credentialing, and then triennially as a requirement for participation in the state Medi-Cal Managed Care Program regardless of the status of other accreditation and/or certifications. An FSR will be conducted using the state Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Site

Review Survey Tool and Medical Record Survey Tool. GCHP will conduct Physical Accessibility Reviews (PARS) at PCP sites, in addition to sites for providers of ancillary services and Community-Based Adult Services (CBAS), which serve a high volume of Seniors and Persons with Disabilities (SPD) beneficiaries using DHCS tools.

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 GCHP pursuant to its written service agreement will be compensated by GCHP 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 GCHP prepares and submits its financial reports. GCHP's fiscal year starts July 1 and ends June 30.

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 GCHP'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 GCHP 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.

Healthcare Effectiveness Data and Information Set (HEDIS®): HEDIS® is a set of standardized performance measures that are developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS® measures are used by health plans to monitor and track quality metrics and compare rates to national and regional benchmarks.

Healthcare Program for Children in Foster Care (HCPCFC): The Health Care Program for Children in Foster Care (HCPCFC) is embedded in local Child Welfare Departments providing Public Health Nurse consultation, oversight, and management of the medical, dental, behavioral, and developmental needs of youth in out of home placement. The program functions as a part of local Child Welfare Departments, bridging the unique social determinates of health experienced by this population, health outcomes, and providers of health services.

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).

Health Services Advisory Group (HSAG): Health Services Advisory Group (HSAG) is the largest External Quality Review Organization (EQRO) in the nation and provides quality review services for states that operate Medicaid managed care programs and fee-for-service programs. DHCS contracts with HSAG to provide auditing and oversight for HEDIS®, EDV, PIPs, and CAHPS.

Hospital: Any acute general care facility.

Hospital Observation Services: Hospital Observation Services shall be approved without an authorization for the first 48-hour period. For observation services more than the initial 48-hour period, the hospital shall notify GCHP to request GCHP's review of medical necessity to extend observation services. GCHP 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 GCHP's review of medical necessity to extend observation services and GCHP'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 GCHP's review and determination that such additional observation services were medically necessary. Accordingly, GCHP shall not be responsible for payment of any observation services that GCH determines are not medically necessary. In most circumstances GCHP shall not 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 GCHP 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.

Individual Health Appointment: The Initial Health Appointment (IHA) is a comprehensive assessment completed during a member's initial encounter with their Primary Care Provider (PCP). The IHA enables the member's PCP to assess and manage the acute, chronic and preventive health needs of the member. All new plan members must have a complete IHA within 120 calendar days of enrollment. This is a requirement of the state Department of Health Care Services (DHCS).

Inovalon: Inovalon, a nationally recognized and certified HEDIS® vendor, calculates GCHP's MCAS rates and conducts GCHP's MCAS related medical record retrieval and abstraction projects.

Language Assistance Services: Language assistance services shall be provided to GCHP members at no cost, be accurate and timely, and protect the privacy and independence of the limited English proficiency (LEP) individual on a 24-hour basis, seven days a week at key points of contact.

Limited Service Hospital: Any hospital that is under contract with GCHP, but not as a primary hospital because 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.

Managed Care Accountability Set (MCAS): A set of performance measures selected by DHCS that are used by Medi-Cal Managed Care Plans (MCPs) to report quality of care rates annually. MCAS includes measures from the National Committee for Quality Assurance (NCQA) HEDIS® measure set, the Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Measure Sets for Medicaid, and other standardized measures from recognized measure stewards, which provides DHCS and MCPs with a standardized method to report quality metrics.

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 for Kids and Teens: Medi-Cal refers to the federally mandated Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) Medicaid benefit as **Medi-Cal for Kids and Teens**.

Medi-Cal Managed Care Program: The program under which GCHP operates in accordance with its Medi-Cal agreement with the state 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.

Non-Traditional Provider: A provider who does not have a state-level Medi-Cal enrollment pathway for the covered services they provide.

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.

Nurse Family Partnership (NFP): Nurse-Family Partnership empowers first-time moms to transform their lives and create better futures for themselves and their babies. Nurse-Family Partnership works by having specially educated nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy and continuing through the child's second birthday.

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 GCHP'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 GCHP – to Medi-Cal members through a written agreement between the participating hospital and GCHP.

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 GCHP'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.

Performance Improvement Project (PIP): DHCS requires all Medi-Cal Managed Care Plans (MCPs) to participate in a minimum of two PIPs per year. The PIP topics selected are based on demonstrated areas of poor performance, such as low MCAS, HEDIS® or CAHPS® scores, or DHCS / EQRO recommendations, and must be aligned with the state's Quality Strategy for preserving and improving the physical health of Californians as well as the goals set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Initiative.

Physical Accessibility Review Survey (PARS): A DHCS standardized tool that requires reviewers to focus on the exterior and interior physical accessibility standards for members receiving services at primary care and high-volume specialty / ancillary provider sites.

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-Do-Study-Act (PDSA) Cycle: A scientific method that is used by the Institute for Healthcare Improvement's (IHI) Model for Improvement and adopted by DHCS as one of the tools used by Medi-Cal Managed Care Plans (MCPs) to conduct improvement projects. The PDSA methodology applies a rapid cycle / continuous quality improvement process that is designed to test, track and evaluate the effectiveness of interventions. DHCS may request MCPs to use the PDSA cycle methodology to test, document and evaluate the effectives of interventions used to improve performance measures.

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.

Potential Quality Issue (PQI): A suspected deviation from expected provider performance, clinical care or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists.

Primary Care Provider (PCP): A clinic, physician(s) or mid-level licensed professional practicing under physician supervision who has an agreement with GCHP 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 can 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 GCHP and serves as a platform to exchange ideas and present peer / community interests to GCHP 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 GCHP.
- Matters of a clinical or administrative nature that affect the interaction between physicians and GCHP.

Provider Information Update Form (PIUF): A universal form used by GCHP to document any adds, changes or terminations for a practitioner, group or facility.

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

Provider Preventable Condition (PPC): A medical condition or complication that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. PPCs include "Health Care Acquired Conditions" (HCACs) defined in §1886(d)(4)(D)(ii) and (iv) of the Social Security Act and Other Provider Preventable Conditions (OPPCs) per Title 42 CFR §434.6(a)(12)(i), 438.3(g), and 447.26.

Quality Improvement and Health Equity Transformation Program (QIHETP): The QIHETP supports GCHP's mission to improve the health of our members through the provision of high quality care and services by using systematic activities that monitor and evaluate clinical and non-clinical service, patient safety, and member experiences provided to members according to the standards set forth in statute, regulations, and GCHP's agreement with DHCS. The QIHETP consists of processes that measure the effectiveness and quality of care, identify problems, and implement improvement on a continuing basis towards identified targe outcomes and measurement. GCHP's QIHETP is overseen by the Quality Improvement and Health Equity Committee (QIHEC).

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

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.

Street Medicine Provider: A licensed medical provider (e.g., Doctor of Medicine [MD] / Doctor of Osteopathic Medicine [DO], Physician Assistant [PA], Nurse Practitioner [NP], Certified Nurse Midwife [CNM]) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be. Street medicine providers who choose to act as a member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care.

Urgent Care Services: Services furnished to an individual who requires services within 48 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 GCHP'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

Join Our Network

Gold Coast Health Plan (GCHP) requires the following institutions, practitioners, non-physician medical practitioners and allied health professionals to be credentialed and recredentialed. Providers interested in contracting with GCHP should contact **ProviderContracting@goldchp.org**.

Please Note: Providers listed are subject to change. Additional providers not listed below may also require credentialing and recredentialing. Please inquire by emailing **Credentialing@goldchp.org**.

To participate in the GCHP network, providers who have a state-level Medi-Cal enrollment pathway must meet the following criteria:

- Be enrolled with the state Department of Health Care Services (DHCS) Medi-Cal program.
- Have their credentials approved by GCHP's Credentials / Peer Review Committee.
- Sign a GCHP service agreement.

Medical Physicians:

- Allopathic Physicians (MD), including those anesthesiologists with pain management practices
- Chiropractor
- Osteopathic Physicians (DO)
- Podiatrist (DPM)
- Doctor of Dental Surgery (DDS), including oral surgeons
- Optometrists providing services covered under the medial benefits plan

Behavioral Healthcare and/or Substance Use Disorder Practitioners:

- Psychiatrist and other physicians, including addiction medicine specialist
- Doctoral or master's-level licensed psychologists
- Master's-level Licensed Clinical Social Workers (LCSW)
- Master's-level Clinical Nurse Specialists or Psychiatric Nurse Practitioners (CNS, PMHNP)
- Licensed Professional Clinical Counselors
- Certified Qualified Autism Service Providers
- Other behavioral health specialists who are licensed, certified, or registered by the state to practice independently

Non-Physician Medical Practitioners:

- Certified Nurse Midwife (CNM)
- Clinical Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA)
- Nurse Practitioner (NP, PNP, ANP)
- Physician Assistant (PA)

Allied Providers:

- Acupuncturist
- Audiologist
- Board Certified Behavioral Analyst (BCBA) or Board-Certified Associate Behavior Analyst (BCaBA)
- Certified Diabetes Educator
- Hearing Aid Dispenser
- International Board-Certified Lactation Consultant
- Occupational Therapist
- Physical Therapist
- Physical Therapist Assistant

- Registered Dietician / Nutritionist
- Speech Language Pathologist

Organizational Provider

- Hospitals
- Skilled Nursing Facilities / Long-Term Care Facilities
- Free-standing Surgical Centers
- Home Health Agencies / Hospice Providers
- Adult Day Health Care Providers of Community Based Adult Services
- Congregate Living Health Facilities
- Free-standing Birthing Centers
- Chronic Dialysis (End-Stage Renal Disease) Clinics
- Laboratories
- Behavioral Healthcare Providers, including Ambulatory, Residential, and Inpatient Facilities
- Substance Use Disorder Providers, including Ambulatory, Residential, and Inpatient Facilities

To participate in the GCHP network, non-traditional providers who do not have a state-level Medi-Cal enrollment pathway must meet the following criteria:

- Submit a Certification Application.
- Have their experience and/or certifications approved by GCHP's Peer Review Committee.
- Sign a GCHP service agreement.

Non-Traditional Providers

- Community Health Workers
- Community Supports
- Doulas
- Enhanced Care Management

Credentialing and Recredential Process

GCHP has a quality-of-care program designed to ensure GCHP health care providers meet professional standards for the delivery of health care to our members. As part of this program, providers are required to be credentialed, recredentialed, and provide any necessary updates / changes that may impact member care and/or contractual obligations. Providers are responsible for completing GCHP's credentialing application in a timely manner to avoid delays in processing and/or plan participation interruptions. Providers are also responsible for completing a Provider Information Update Form (PIUF) to notify GCHP of any updates that may impact member care and/or contractual obligations. Each provider must meet the minimum Credentialing Standards for participation in the GCHP Network. These guidelines are intended to comply with standards of GCHP, DHCS or its designee, NCQA, or any other applicable regulatory and/or accreditation entities where applicable.

GCHP conducts Credentials / Peer Review Committee meetings and reviews practitioner's information in a non-discriminatory manner. No practitioner will be denied privileges with GCHP, have any corrective actions imposed, or have their privileges suspended or terminated solely on the basis of race, ethnic / national identity, age, gender, sexual orientation, or the type of patient that the practitioner treats. Practitioners have the right to file any issues or concerns regarding fair and non-discriminatory practices in the credentialing / recredentialing process. Any issues or concerns regarding fair and non-discriminatory practices in the credentialing / recredentialing process should be submitted to **ProviderRelations@goldchp.org**.

Initial Credentialing

Once GCHP's Credentialing Department receives notification from the Contracting Department, providers will be provided with the following:

- A letter from the Provider Contracting Department with a fillable Credentialing Application.
- A copy of GCHP's credentialing policies is available on GCHP's website to assist providers in providing the information needed to begin credentialing. Criteria for credentialing can be found in the policies under "Minimum Professional Standards."
- A Notice to Practitioners of Credentialing Rights / Responsibilities will be sent to providers to sign.
- Additional items may be needed and will be sent to providers such as: Attestation / Release form, Attachments / Addendums, etc.
- If the provider is currently participating in the Council for Affordable Quality Healthcare (CAQH), some information may be used by credentialing staff to help with processing the credentialing application.

Below are additional credentialing pre-requisites for some physician specialties.

Additional Requirements: California Children's Services (CCS), Comprehensive Perinatal Services Program (CPSP), HIV/AIDS

For some physician specialties, there are additional credentialing pre-requisites. For example:

- 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.
- Primary care offices require Facility Site Reviews (FSRs).

For more information on these requirements, please contact GCHP's Provider Contracting Department at **ProviderContracting@goldchp.org**.

CREDENTIALING RESOURCES

Policies and Procedures

The following policies can be found on GCHP website. The policies include detailed information regarding practitioners' right to review information submitted to support their credentialing application, correct erroneous information, request the status of their credentialing / recredentialing application, and file any issues or concerns regarding fair and non-discriminatory practices in the credentialing / recredentialing process.

- **Practitioner Credentialing Policy**
- **Credentialing for Organizational Providers Policy**
- **Fair Hearing Policy**

Medi-Cal Enrollment

Medi-Cal enrollment is a separate process from credentialing. In addition to being credentialed, GCHP is required by federal law to ensure all GCHP contracted providers are enrolled in the state Department of Health Care Services (DHCS) Medi-Cal Program. If you are not sure if you are enrolled with Medi-Cal or became dis-enrolled, please contact the Contracting Department at **ProviderContracting@gchp.org** prior to credentialing.

Gemini Diversified Services (GDS)

Gemini Diversified Services (GDS) is a Credentialing Verification Organization (CVO) that has contracted with GCHP to verify primary source documentation for GCHP providers. GDS does not make any recommendations to approve or deny admission to GCHP's network. All initial credentialing and recredentialing decisions are the sole responsibility of the GCHP Credentials / Peer Review Committee.

Facility Site Review (FSR) for Primary Care Office Locations

Facility site reviews are conducted every three years as part of the credentialing verification process along with recredentialing and all changes in site location. A nurse certified as a facility site reviewer 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, physical accessibility, safety, etc.), the initial credentialing and recredentialing files will be 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.

FSR for Street Medicine

- Street medicine providers who are serving in an assigned PCP capacity are required to undergo appropriate level of site review process, which is either a full or a condensed review. For street medicine providers that are affiliated with a brick-and-mortar facility or that operate a mobile unit / RV, a full review process is conducted.
- For street medicine providers that are not affiliated with a brick-and-mortar facility or mobile unit / RV, a condensed FSR and MRR of the street medicine provider must be conducted to ensure member safety.

POTENTIAL CREDENTIALING ADVERSE ACTIONS

Notification of Adverse Actions Taken Against Practitioners

Federal and state laws require that practitioners 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 GCHP'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 GCHP'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 GCHP are also considered "lower tier participants." Provider's 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 GCHP 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 visit **secure.ethicspoint.com**. All calls and emails can remain anonymous. Please refer to Section 18 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 (PCPs) and specialists shall notify GCHP members no less than 120 days prior to terminating their contract. This allows time to assist beneficiaries with a new PCP 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 GCHP's discretion, 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 GCHP has made arrangements for the assumption of such services by another physician and/or provider. The provider will help GCHP 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 GCHP 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:

- An acute 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 California Children's Services (CCS)
- Ventura County Behavioral Health Department (VCBHD)
- Ventura County Health Care Agency (VCHCA)
- Tri-Counties Regional Center (TCRC)
- Women, Infants, and Children (WIC) Program
- Ventura County Public Health Department (VCPHD)
- Local Education Agencies (LEA)
- Healthcare Program for Children in Foster Care (HCPCFC)

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 state Department of Health Care Services (DHCS) and administered by the Ventura County Health Care Agency's (VCHCA) CCS office. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under the age of 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. 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.

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.

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. To assist PCP's in identifying CCS patients, GCHP will send providers a monthly list of members who have been 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 CCS or how to become a CCS provider, contact the local CCS office at 1-805-981-5281 or visit the DHCS CCS **website**.

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

California Immunization Registry (CAIR2)

CAIR2 is a secure, statewide computerized immunization registry and information system. Providers can use CAIR2 to access their patients' immunization information, utilize the integrated vaccine algorithms to determine vaccination due dates, enter vaccine doses administered, manage vaccine inventory, run patient or inventory reports, or generate reminder / recall reports for patients who are due for vaccinations. It is a sophisticated and user-friendly tool to help providers manage their patients' immunizations and keep records up to date.

Per Assembly Bill 1797, starting Jan. 1, 2023, state health care providers who administer vaccines will be required to enter immunization information into CAIR2 or Healthy Futures / RID and include race and ethnicity information for each patient to support assessments of health disparities in immunization coverage. To learn more about these new requirements, view **AB 1797 Immunization Registry FAQs**.

Additionally, per All Plan Letter (APL) 18-004, the state Department of Health Care Services (DHCS) requires that all GCHP providers:

1. Ensure the timely provision of immunizations to members in accordance with the most recent schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP), regardless of a member's age, gender, or medical condition, including pregnancy.
2. Document each member's need for ACIP recommended immunizations as part of all regular health visits, including, but not limited to, the following member encounters:

    - Illness, care management, or follow-up appointments
    - Initial Health Appointments (IHA)
    - Pharmacy services
    - Prenatal and postpartum care
    - Pre-travel visits
    - Sports, school, or work physicals
    - Visits to a Local Health Department (LHD)
    - Well patient checkups

ACIP-recommended immunizations are viewed as preventive services and are not subject to prior authorization.

This immunization information is essential to GCHP, as DHCS requires GCHP to ensure member-specific immunization information is reported to CAIR2. GCHP strongly encourages providers to report immunization information the same day they are administered.

For more information about CAIR2 and how to join, contact 1-800-578-7889 or visit online at **www.CairWeb.org**.

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.

Members with Developmental Disabilities or Developmental Delay

A developmental disability is a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or other conditions similar to intellectual disability 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.

The Initial Health Appointment (IHA) is performed when enrolling new members 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 intellectual disability, 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.

GCHP covers all medically necessary and appropriate developmental screenings, primary preventive care, diagnostic and treatment for all members, including those 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.

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). Tri-Counties Regional Center is 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 work with other agencies to provide the full range of early intervention services to meet the client's needs. Regional centers can provide specific information on the services available in the member's service area. Services may include respite, day programs, supervised living, psychosocial and developmental services, and specialized training.

Members with developmental disabilities are linked to a PCP, who is responsible with providing 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).

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.

For more information, contact Tri-Counties Regional Center at 1-805-485-3177, or visit their **website**.

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 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 of age or older.
- Diagnosed with a significant physical, behavioral, or memory problem that impedes activities of daily living (ADL's).
- 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 to avoid timely filing penalties.
- 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 the GCHP **website**.

Vision Services

Vision care is provided through Vision Service Plan (VSP) providers. All members can have their eyes examined every two years. Members who have been diagnosed with diabetes are allowed an eye exam every year.

The plan covers:

- Routine eye exam once every 24 months; GCHP may pre-approve additional services as medically necessary.
- Eyeglasses (frames and lens) once every 24 months; contact lens when required for medical conditions such as aphakia, aniridia and keratoconus.

The VSP phone number is 1-800-877-7195 (TTY: 1-800-428-4833), or visit the VSP **website** 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.

Palliative Care Benefit - My*Gold*Care Program

In accordance with Senate Bill 1004 and APL 18-020, palliative care is offered through the My*Gold*Care program, to any member that qualifies. Palliative Care provides patient and family-centered care that address the physical, intellectual, emotional, social, and spiritual needs of our population in the most compassionate way possible. This does not result in a reduction in benefits for members and can be provided along with curative treatment.

There is no prior authorization required for palliative care services.
Referring providers may refer directly to a My*Gold*Care palliative care provider to assure timely access. A list of contracted outpatient and in-home palliative care providers can be found in GCHP's Provider Directory.

Eligibility Criteria for Palliative Care
GCHP will provide palliative care services to all members who elect and qualify under all the following general eligibility and disease-specific criteria:

- The beneficiary is likely to or has started to use the hospital or emergency department to manage their advanced disease. This refers to unanticipated decompensation and does not include elective procedures.
- The beneficiary has an advanced illness with appropriate documentation of continued decline in health status and is not eligible for or declines hospice enrollment.
- The beneficiary's death within a year would not be unexpected based on clinical status.
- The beneficiary has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation.
- The beneficiary and, if applicable, the family / patient-designated support person, agrees to attempt, as medically / clinically appropriate, in-home, residential based, or outpatient disease management / palliative care instead of first going to the emergency department; and participates in Advance Care Planning discussions.

Disease-Specific Criteria
A member must qualify for palliative care services in accordance with APL 18-020 or have a serious diagnosis (which is not defined in the APL) and death would not be unexpected within a year.

Qualified conditions include, but are not limited to, the following:

- Congestive Heart Failure (CHF)
- Obstructive Pulmonary Disease (COPD)
- Advanced Cancer
- Liver Disease
- Other: Prognosis of death within a year would not be unexpected based on clinical status. If a beneficiary continues to meet the above eligibility criteria, he or she may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

Billing for Palliative Care Providers:
All My*Gold*Care palliative care providers will need to bill for palliative care services with a diagnosis code of Z51.5 and submit a monthly Palliative Care Patient Encounter Submission Report.

For more information, please visit the GCHP **website**.

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 Medi-Cal Dental 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 assist 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 Customer Service Department to request a 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 of, 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.

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 of age and younger receiving full-scope Medi-Cal (Children / young adults 20 years of age and younger with suspected hearing loss of 30 decibels or greater should be referred to CCS).

Hearing Aids

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 / Carelon Behavioral Health (formerly Beacon Health Options). Behavioral Health services do not require a prior authorization, except for psychological testing and Comprehensive Diagnostic Evaluation (CDE) for autism and developmental delay. Contact Carelon Behavioral Health at 1-855-765-9702 or **click here** for the Carelon Behavioral Health PCP 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 with GCHP through Carelon Behavioral Health. 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).

The following elements apply:

- Any GCHP member with qualifying diagnoses up to the age of 21 will be eligible for ABA / BHT services. Members 21 years of age and older may be eligible for ABA / BHT through TCRC.

- The diagnosis of autism or 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 Carelon Behavioral Health should be made.

Carelon Behavioral Health 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 Carelon Behavioral Health to obtain the diagnosis from a licensed psychologist.

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 Carelon Behavioral Health 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

Gold Coast Health Plan (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, restricted scope, 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.

Restricted Scope or Restricted Medi-Cal

Restricted-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 restricted-scope Medi-Cal with or without an SOC. GCHP currently covers only a few restricted-scope aid codes. Most other restricted-scope aid codes are under fee-for-service (FFS) Medi-Cal, which is administered directly by the state.

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 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 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 delivering 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 Provider 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, contracted providers 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 see the **Member Handbook**.

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 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 GCHP's service areas will not result in a change of responsible county when it involves the placement of foster / adoptive children out of GCHP'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, including member rights, please refer to the **Member Handbook**. If assistance or clarification is required, please call the Customer Service Department at 1-888-301-1228 / TTY 711.

Section 6: Responsibilities of the Primary Care Provider (PCP) and Specialist Provider (SPC)

PRIMARY CARE PROVIDER (PCP) RESPONSIBILITIES

The Primary Care Provider (PCP), also referred to as a member's 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 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, pediatricians and internal medicine. Physician assistants and nurse practitioners also act as PCPs; however, members cannot be assigned to them.

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 and 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 services are medically necessary and that duplicate services are avoided.
- 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 consider severity of medical condition when rescheduling of appointments for unforeseen circumstances.
- General accessibility to the site of care 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 have equity in the delivery of services and must not unlawfully discriminate, exclude members, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation,

claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), 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 English and Spanish and possibly other languages if the provider has a large amount of members that they care for routinely who speak another language.
- The after-hours answering service for the medical home 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:

Telehealth Services

It is imperative that GCHP members have access to timely care. In an effort to continue providing additional access options, and in continuation of the telehealth requirements put into place under the Public Health Emergency, GCHP members will continue to have access to telehealth services with those providers who offer telehealth services. Accordingly, Medi-Cal providers should take steps to allow members to obtain health care via telehealth when medically appropriate "as a means to increase provider capacity."

When billing for telehealth services, providers should bill using Place of Service Code 02 and Modifier 95 for Synchronous telehealth services and Modifier GQ for Asynchronous telehealth services. Providers will be reimbursed at the same rate whether a service is provided in-person or through telehealth if the service is the same regardless of the modality of delivery.

GCHP providers will be reimbursed the same amount for a service rendered via telephone as they would if the service was rendered via video provided that the modality, telephone vs video, is medically appropriate. (DHCS APL 23-007).

Qualified providers are those currently enrolled in Medi-Cal including, but not limited to, physicians, nurses, occupational therapy, physical therapy, mental health practitioners, substance use disorder practitioners, as well as FQHCs and RHCs and Tribal 638 Clinics.

For more information, please click on the hyperlinks below. Providers may also visit the GCHP **website**.

- **For guidance on billing**
- **Frequently Asked Questions (FAQs)**

Routine Appointments

Non-emergency Primary Care appointments must be available within 10 business days of the member's request for an appointment.

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 Appointment (IHA)

As of Jan. 2, 2023, DHCS requires that each PCP complete and administer a comprehensive IHA, in accordance with the Population Health Management (PHM) Policy Guide, for all newly assigned members within 120 days of the member's enrollment with GCHP. The IHA is not necessary if the member's PCP determines that the member's medical record contains complete information that was updated within the previous 12 months. The IHA must be provided in a way that is culturally and linguistically appropriate for the member.

The IHA must be documented in the member's medical record and include the following:

- The history of the member's physical and mental health.
- Identification of risks.
- An assessment of need for preventative screens or services.
- Health education.
- The diagnosis and plan for treatment of any diseases.

PCPs will continue to receive monthly lists of new members to assess the need for an IHA and outreach to members requiring a visit within 120 days of enrollment. PCPs are required to document unsuccessful scheduling attempts within the medical record; three attempts to connect with the member, including at least one telephone attempt and one written attempt will ensure compliance with the IHA requirement if an IHA is not conducted.

Primary care visits will be monitored as a proxy for the IHA leveraging Managed Care Accountability Set (MCAS) measures specific to infant and child / adolescent well-child visits and adult preventive visits. CPT or HCPCS claims within the PCP visit claims that indicate an IHA was conducted will be tracked. For children, primary care visits and childhood screenings, including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and substance use disorder (SUD) will be assessed.

IHA Resources

IHA resources available on GCHP's website include:

- **Bright Futures Periodicity Table**
- **United States Preventative Services Task Force**
- **GCHP IHA Training Presentation**
- **IHA Billing Code List**
- **Language Assistance Services**

PCPs shall offer translation, interpretation, auxiliary aids, and other accommodations to ensure effective communication with members, including the provision of written materials in alternative formats. PCPs and their staff can contact GCHP's Cultural and Linguistic Department at **CulturalLinguistics@goldchp.org**.

Providers and their staff can contact GCHP's Quality Improvement Department for continuing education and training related to the IHA at **QualityImprovement@goldchp.org**.

IHA outreach logs are sent to GCHP Quality Improvement by fax at 805-248-7616 or secure e-mail at **QualityImprovement@goldchp.org**.

Preventive Care

As a PCP, you are required to provide preventive health care according to nationally recognized criteria. 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.

PROVIDER 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:

Primary Care Providers (PCP)

A medical home / PCP's request to transfer the member to another PCP requires GCHP's approval.

The PCP must notify GCHP's Provider Relations Department in writing regarding the desire to reassign a member. Complete documentation regarding the nature of the problem must be included with the request. With documented evidence and justification, requests to reassign a member will be considered based on criteria outlined in this Provider Manual. Examples include, but are not limited to:

- Significant safety concerns, such as threatening the life or wellbeing of personnel or the rendering providers.
- Member drug seeking behavior, such as documented evidence of manipulative attempts to obtain substantially more medication than is warranted.

Unjustified requests for member reassignment, include but are not limited to:

- Requests to reassign a member to another PCP due to the patient's medical condition resulting in high costs or frequent visits will not be granted.
- Requests to reassign a member due to no show will not be granted.

GCHP will use their best efforts to review requests for reassignment, which includes Care Management intervention. Until a member's reassignment becomes effective, it is the medical home / PCPs responsibility to authorize and provide all the medically necessary services. If the member is in active care, the PCP will continue to serve the member according to the PCP's best professional judgment. Members in active treatment will require special review by GCHP's chief medical officer (CMO).

If the request for member reassignment is approved, the PCP will be notified and GCHP's Member Services Department will contact the patient to facilitate assignment with a new PCP.

If the request is not approved, GCHP will notify the PCP. The PCP has the right to appeal the decision by contacting GCHP's Provider Relations Department.

Specialists (SPC)

A specialist can cease providing care for members when the provider / patient relationship becomes unsatisfactory. In these cases, the specialist must notify the PCP and the patient in writing 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 the specialty care is still medically necessary. The specialist must notify the member in writing that they will no longer provide care for the member and email a copy of the letter to the GCHP Provider Relations Department at **ProviderRelations@goldchp.org**.

Administrative Members

A provider can cease providing care for a non-assigned / Administrative 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 and should include the GCHP Customer Service number 1-888-301-1228. The provider will send a copy of the letter to the Provider Relations Department.

SPECIALIST RESPONSIBILITIES

Whenever possible, specialty care will be provided by GCHP providers within GCHP's service area. If a medically necessary specialty service is unavailable within GCHP'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 availability 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's 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 consider the severity of the medical condition when rescheduling appointments for unforeseen circumstances. If possible, patients should have same-day appointments.
- General accessibility to the site of care 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 and must not unlawfully discriminate, exclude members, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), 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.

Routine Appointments

Non-emergency appointments should be available within 10 business days of the request for an appointment.

First Prenatal Visit

The first prenatal visit must be scheduled within 10 business days of the member's request.

PRIMARY CARE AND SPECALTY CARE PROVIDER RESPONSIBILITIES

24/7 Availability

GCHP will ensure that a 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 GCHP Medi-Cal members:

Type of Care	Wait Time
Emergency Services	Immediately.
Urgent Care	Within 48 hours (if no prior authorization is required). Within 96 hours (if prior authorization is required).
Non-Urgent Primary Care Appointment	Within 10 business days of request for appointment.
Non-Urgent Behavioral Health Appointment	Within 10 business days of request for appointment.
Non-Urgent Specialty Care Appointment	Within 15 business days of request for appointment.
Phone Wait Time	Within three to five minutes whenever possible.
Ancillary Services for Diagnosis or Treatment	Within 15 business days of request for appointment.
Long Term Care (LTC)	Within seven business days of request.
Skilled Nursing Facility (SNF)	Within seven business days of request.
Intermediate Care Facility / Developmentally Disabled (ICF-DD)	Within seven business days of request.
Community Based Adult Services (CBS)	Capacity cannot decrease in aggregate statewide below April 2012 level.
Initial Health Appointment (IHA)	Within 120 calendar days of enrollment.

Type of Care	Wait Time
Waiting Time in Office	Not to exceed 45 minutes after time of appointment
Patient Call Back	Within 60 Minutes.
Sensitive Services	Ensure confidentiality and ready access to sensitive services in a timely manner and without barriers – NO AUTHORIZATION REQUIRED.

Language Assistance Services

Specialist (SPC) shall offer translation, interpretation, auxiliary aids, and other accommodations to ensure effective communication with members, including the provision of written materials in alternative formats, for any disability, if necessary. PCPs and their staff can contact GCHP's Cultural and Linguistic Department at **CulturalLinguistics@goldchp.org**.

Medical Records

The medical home is responsible for maintaining complete and comprehensive medical records of patient care for each member. The medical home must also maintain procedures for the content, maintenance, and confidentiality of medical records that meet the requirements established by GCHP, state and federal laws and regulations. GCHP has the right to review the medical records of a covered member for purposes related to treatment, payment, and health care operations (TPO).

Pursuant to the California Welfare and Institutions Code § 14124.1 and in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations, providers of health care services rendered under the Medi-Cal program shall keep and maintain records of each service rendered under the Medi-Cal program for 10 years from whichever is later of the following:

- The final date of the contract period between the plan and the provider.
- The date of completion of any audit.
- The date the service was rendered.

Pursuant to Title 22 CCR § 53861(b), practitioners and providers will retain or cause to be retained all records pertaining to pending or in progress litigations until the litigation is final.

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 reasons related to TPO. Under the HIPAA Privacy Rule, a provider does not require a signed authorization to release a patient's protected health information for TPO, which may include some of the following GCHP activities:

- Quality improvement studies mandated by the state, such as the Managed Care Accountability Set (MCAS) and Healthcare Effectiveness Data and Information Set (HEDIS®) studies, Performance Improvement Projects (PIPS), Potential Quality Issues (PQIs) or the Encounter Data Validation (EDV) Studies.
- Prior authorization requests.
- Claims payments issues.
- Utilization review.
- Assistance with case coordination.

- Possible CCS referrals for CCS-eligible conditions.
- DHCS auditing requests.
- Follow-up to a member complaint.
- Potential Quality Issues.
- Facility site reviews.
- Medical record reviews.

The California Health and Safety Code § 123100 declares that every person having ultimate responsibility for decisions regarding their health care also possess a right to access information about their condition and care provided. Records are not released without a written, signed and dated authorization from the patient or the patient's representative. Pursuant to U.S. Code of Federal Regulations §164.508c a valid authorization request must include:

- Person authorizing release.
- Person / organization authorized to receive the PHI.
- Description of PHI to be disclosed.
- Purpose of the PHI disclosure.
- Date authorization expires.
- Signature and date of person authorizing the release.

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. GCHP requires that you submit encounter data at least once a month, as the information is critical for health plan analytics and HEDIS® studies. Most importantly, this data is used by the state to set future GCHP revenue, which has a direct impact on GCHP's payments to providers.

All providers may transmit their encounter data electronically using the ANSI 837 format as outlined by the Health Insurance Portability and Accountability Act (HIPAA).

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 GCHP's Information Technology (IT) vendor. Please note that if you are already submitting your encounter data electronically using a clearinghouse, you may be able to submit to GCHP using your existing connection. Please contact your existing clearinghouse to confirm.

Encounter Data Validation

The state Department of Health Care Services (DHCS) partners with Health Services Advisory Group, Inc. (HSAG) to conduct Encounter Data Validation (EDV) studies to evaluate the completeness and accuracy of encounter data submitted to DHCS. The studies may involve the evaluation of encounter data compared to medical record documentation for services rendered during the study period.

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.

Records are to be maintained in a protective and confidential manner that are not readily accessible to unauthorized persons or visible to the general public. Electronic record procedures must be established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism to ensure that record input is unalterable, and file recovery systems.

In compliance with the HIPAA regulations and the privacy rules for Protected Health Information (PHI), members are entitled to receive an accounting of disclosures of confidential PHI released by the provider of care.

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.

Member Rights

All providers should be knowledgeable of the Medi-Cal Member Rights listed below.

GCHP members have these rights:

- To be treated with respect, giving due consideration to their right to privacy and the need to maintain confidentiality of their medical information.
- To be provided with information about GCHP and its services, including Covered Services.
- To be able to choose a primary care provider within GCHP's network. Members may change PCP every month.
- To participate in decision making regarding their own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer or limit services or benefits.
- To receive interpretation services from a qualified interpreter 24-hour, seven days a week at no cost. GCHP discourages the use of minors or family members as interpreters.
- To receive free legal help at local legal aid office or other groups.
- To formulate advance directives.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To disenroll upon request. Members that can request expedited disenrollment include, but are not limited to, those receiving services under the Foster Care or Adoption Assistance Programs and those with special health care needs.

- To access Minor Consent Services.
- To receive written member-informing materials, including alternative formats (such as braille, large print and audio format) auxiliary aids, and services to people with disabilities upon request and in a timely fashion.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To have access to and receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by GCHP, your providers or the state.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Service Facilities, midwifery services, Rural Health Centers, sexually transmitted disease services and Emergency Services outside GCHP's network pursuant to the federal law.
- To make suggestions to GCHP about your member rights and responsibilities.
- To have privacy and your medical information kept confidential.
- To timely medical appointments.
- To get a second opinion for your diagnosis or treatment plan.
- To have an adult represent you with GCHP, once the Plan receives and validates the appropriate permissions from you.

Transportation from Provider Office to Hospital

When a provider determines that a member requires immediate hospitalization from his or her office, the provider 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.

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:

- No authorization is required for hospital discharges.
- All NEMT services, except hospital discharges, are subject to GCHP review and the NEMT form verification process.

- A physician or specialist must submit an NEMT form to GCHP which constitutes a prescription and attestation of the medical necessity for transportation service.
- The verification process for the NEMT form takes no longer than five business days.
- NEMT vendor requires at least two business days from the time of appointment is required for non-urgent requests.
- If the transportation request is of an urgent nature and needs to occur in less than 48 hours, call GCHP's Transportation Liaison at 1-805-437-5832.
- 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 current **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 form will be forwarded to the transportation vendor.
6. The NEMT vendor will contact the member and provider to schedule and verify the medical appointment.

What to Include on the NEMT Form

When submitting a NEMT form, these elements must be completed:

1. The medical purpose of the transportation.
2. The frequency of the necessary medical transportation or inclusive dates of the requested medical transportation.
3. When a caregiver will accompany the member 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 (NMT) 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 GCHP's transportation vendor using passenger vehicles at no cost to GCHP members.

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

For questions, call GCHP's Customer Service Department at 1-888-301-1228.

Section 7: Quality Improvement (QI) and Health Equity Transformation Program

Gold Coast Health Plan's (GCHP) Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to support GCHP's mission to improve the health of our members through the provision of high-quality and equitable health care and services through a member-first focus that centers on the delivery of exceptional service to our beneficiaries by enhancing the quality of health care, providing greater access, and improving member choice. The QIHETP also defines the processes for continuous quality improvement of clinical care and services, patient safety, and member experience provided by GCHP and its contracted provider network, and community partnerships. These processes include a commitment to improving and sustaining performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives with a specific focus on health equity.

GCHP's QIHETP aligns its efforts with the state Department of Health Care Services (DHCS) comprehensive Quality Strategy as well as the goals set forth by the California Advancing and Innovating Medi-Cal (CalAIM) Initiative. The scope of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:
    - Preventive service for children and adults
    - Primary care
    - Specialty care, including behavioral health services
    - Emergency services
    - Inpatient services
    - Ancillary services
    - Chronic disease management
    - Care Management
    - Population Health
    - Prenatal / perinatal care
    - Family planning services
    - Medication management
    - Coordination and continuity of care
    - Long-Term Care
2. Quality of nonclinical services including, but not limited to:
    - Accessibility
    - Availability
    - Member and provider satisfaction
    - Grievance and appeals process
    - Culturally and linguistically appropriate services
    - Network adequacy
    - Health equity
3. Member safety initiatives including, but not limited to:
    - Facility site reviews / medical record reviews / physical accessibility review surveys
    - Credentialing of practitioners / organizational providers
    - Peer review
    - Sentinel event monitoring
    - Potential Quality Issues (PQIs)
    - Provider Preventable Condition (PPC) monitoring
    - Health education
    - Utilization and risk management
    - Transitional Care Services

4. A QI focus which represents all categories below:
    - All care settings
    - All types of services
    - All demographic groups
    - Health equity

Quality Improvement and Health Equity Transformation Program (QIHETP) Goals

The QIHETP goals include:

- Objectively and systematically monitoring and evaluating the quality, appropriateness, accessibility and availability of safe and equitable health care and services. Identifying and implementing ongoing and innovative strategies to improve the quality, equity, appropriateness, and accessibility of member health care. Implementing an ongoing evaluation process that lends itself to improving identified opportunities for under / over utilization of services. Facilitating organization-wide integration of quality management and population health principles. Measuring and enhancing member satisfaction with the quality of care and services provided by GCHP's network providers. Promoting engagement in local community, statewide, and national collaborations and initiatives aimed at improving quality and equity of care and services.
- Maintaining compliance with state and federal regulatory requirements. Providing oversight of delegated entities to ensure compliance with GCHP standards as well as state and federal regulatory requirements.

For more information about GCHP's QIHETP, **click here**.

Quality Improvement and Health Equity Committee (QIHEC)

The QIHEC is responsible for the monitoring, evaluating, and reporting of organization wide health equity and quality improvement processes and initiatives that ensure the delivery of and access to quality health care and customer service. The QIHEC is accountable to the Ventura County Medi-Cal Managed Care Commission (VCMMCC) and must submit quarterly and annual QIHEC reports.

The QIHEC's objectives are to:

- Ensure QIHEC members can have candid discussions about barriers to achieve quality goals and objectives, and to facilitate the removal of such barriers.
- Ensure a communication process is in place to adequately track work plan and QIHETP activities and enable system-wide communication and resolve action items on the annual QI Work Plan.
- 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.

The QIHEC's responsibilities include:

- To facilitate data-driven indicator reviews and development for monitoring key quality management activities, including but not limited to: MCAS / HEDIS® / CMH Child and Adult Core Measures for Medicaid, CAHPS®, Access / Availability, Performance Improvement Projects, Service / Clinical Quality measures, UM/CM metrics, Population Health metrics, Behavioral Health metrics, Credentialing performance, and Delegation Oversight.
- To review reports from GCHP committees and departments, including quarterly committee meeting minutes, action item logs, dashboards, key activities and action plans including subcommittee updates, and reports regarding monitoring of health plan functions and activities. To analyze and evaluate the results of quality improvement and health equity activities including annual review of the results of performance measures, Performance Improvement Projects (PIPs) related to clinical

and non-clinical care, utilization data, consumer satisfaction surveys, and the findings and activities of other committees such as the Consumer Advisory Committee.
- To make recommendations for implementation of interventions or corrective actions based on results of quality improvement and health equity activities, including those recommended by network providers, fully delegated subcontractors, and downstream contractors.
- To oversee the annual review, analysis and evaluation of goals set forth by the Quality Improvement and Health Equity Transformation Program as well as GCHP's quality improvement policies and procedures.
- To recommend policy changes or implementation of new policies to GCHP's administration and commission.

Managed Care Accountability Set (MCAS)

The Managed Care Accountability Set (MCAS) is a set of performance measures selected by DHCS that the Medi-Cal Managed Care Plans (MCPs) use to report annual performance measures and to evaluate the quality of care and services delivered to GCHP's members. MCAS consists of standardized measures from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) measure set and the Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Measure Set, which enables DHCS to objectively evaluate GCHP's delivery of care and services.

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 final rates are 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 and allow the comparability of performance rates within the health care industry, GCHP must complete an annual NCQA HEDIS® Compliance Audit™ conducted by the EQRO.

DHCS will publicly report the audited results of each DHCS-required performance measure (HEDIS® / MCAS / CMS Adult and Child Core Measures for Medicaid 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 measures that are held to the MPL. 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 is given an audit result of Not Reportable (NR). The IP must include an analysis of barriers, targeted interventions, and relevant data to support the analysis. Each IP must be completed on a DHCS approved quality improvement tool and include justification for using new or existing interventions, prioritization of barriers and interventions, and a method for evaluating the outcome and effectiveness of the interventions. GCHP must complete and submit each IP by the submission date established by DHCS.

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

The FSR/MRR is conducted by a certified site reviewer (CSR) nurse and/or certified master trainer (CMT) nurse and includes an on-site inspection and interview with office personnel. State-mandated tools and standards are used by the reviewer in conducting the reviews.

An FSR, MRR and PARS is conducted a minimum of every three years for each primary care site. A PARS is performed every three years on designated high-volume ancillary and specialty providers. New PCP sites are not eligible to be assigned members until they pass an initial FSR. GCHP will contact the PCP site to schedule initial and periodic site visits. In accordance with DHCS guidance, GCHP reserves the right to perform unannounced site visits.

The MRR is based on an audit of randomly selected medical records per PCP and is comprised of pediatric, adult, and obstetric records, when applicable. The MRR 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.

The PARS focuses on facility site access including the building / PCP's office, parking, elevators, exam rooms, accessible drinking water, accessible web, and electronic content.

If deficiencies are identified during the FSR/MRR, the reviewer will issue a Corrective Action Plan (CAP). The CAP will include specific time frames for addressing the identified deficiencies. In some cases, assignment of new members will be held until the identified deficiencies have been corrected.

All site reviews / PARs conducted and CAPs completed are reported to DHCS as mandated for evaluation / audit.

For questions or more information regarding FSR, MRRs, or PARs, please contact the QI Facility Site Review Team at **FSR@goldchp.org**.

Performance Improvement Projects (PIP)

GCHP is required to conduct and/or participate in a minimum of two Performance Improvement Projects (PIPs) at a cadence set forth by DHCS. PIP topics are chosen in consultation with DHCS and the EQRO. The PIP topics selected are based on demonstrated areas of poor performance, such as low HEDIS® / MCAS / CMS Core Measure, CAHPS® scores, or DHCS / EQRO recommendations, and must be aligned with the state's Quality Strategy for preserving and improving the health of Californians, as well as the goals set forth in the CalAIM initiative. GCHP will utilize the PIP Modules approved by DHCS / EQRO and complete each module by the submission dates established by DHCS / EQRO. The status of each PIP is reported at the quarterly QIHEC meetings.

Performance Improvement Methodology

GCHP uses the tools and methodology approved by DHCS and the EQRO to implement and document performance improvement projects. Approved tools to implement and study the effectiveness of interventions include the Plan-Do-Study-Act (PDSA) Worksheets, the Performance Improvement Project (PIP) Modules, which are based on the Institute for Healthcare Improvement's (IHI) Models for Improvement, fishbone diagrams, and the Strength, Weakness, Opportunities and Threats (SWOT) analysis.

Member Incentives

To promote the completion of important preventive care screenings, GCHP offers member incentives to qualifying members who complete the following preventive care services within the calendar year.

- Child and Adolescent Well Care Exam: Members 3 to 21 years of age can earn a $25 gift card for completing a yearly well-care exam.
- Cervical Cancer Screening: Members 21 to 64 years of age can earn a $50 gift card for completing a routine screening for cervical cancer.
- Breast Cancer Screening: Members 40 to 74 years of age can earn a $50 gift card for completing a breast cancer screening (mammogram).
- Lead Screening: Members 0 to 2 years of age can earn a $25 gift card for completing a blood lead test on or before their second birthday within the calendar year.
- Human Papilloma Virus (HPV) Vaccine: Members 9 to 13 years of age can earn a $25 gift card for completing the second dose of the HPV vaccine on or before their 13th birthday.

To receive the incentive, members must fill out a member incentive form, including their member ID, service date, and a signature / stamp by the rendering provider. This form can be submitted via fax, mail, or email. Providers can also submit this form to the Quality Improvement (QI) Department on a member's behalf. These forms can be found on GCHP's website in the **Member Resources Section** under the For Members tab.

GCHP also partners with select providers to offer point of care member incentives for Child and Adolescent Well Care Exams, Cervical Cancer Screening, and Breast Cancer Screening. If you are interested in offering point of care member incentives, please contact the QI Department.

For more information about GCHP's member incentive programs you can contact QI at **QualityImprovement@goldchp.org**.

Provider Preventable Conditions (PPC)

Pursuant to Title 42 of the Code of Federal Regulations, states are prohibited from permitting payment to Medicaid providers for treatment of PPCs, except when the condition existed prior to the initiation of treatment for that beneficiary by that provider. PPCs consist of health care-acquired conditions (HCAC), when they occur in acute inpatient hospital settings only, and other provider-preventable conditions (OPPC) when they occur in any health care setting.

GCHP is required to comply with the guidelines established by DHCS by screening claims and encounter data for provider preventable conditions and report each PPC to DHCS.

Providers caring for GCHP members must report each PPC to DHCS and GCHP after discovery of the PPC and confirmation that the patient is a Medi-Cal beneficiary. PPCs can be reported to DHCS via their secure online reporting portal or by fax. PPCs must be reported to GCHP via secure email at **PQIReporting@goldchp.org**.

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 / Recredentialing, Member Rights (MR), Grievances and Appeals, Cultural and Linguistic Services, 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
- C&L: GCHP C&L 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.

Potential Quality Issue (PQI)

To determine opportunities for improvement in the provision of care and services to GCHP members, there is a systematic method in place that identifies, investigates, and reports Potential Quality Issues (PQIs) and directs actions for improvement based upon risk, frequency and severity.

PQIs are identified and referred to the Quality Improvement (QI) Department for further review and investigation. Identification of a PQI is made through the systematic review of a variety of data sources such as information gathered through concurrent, prospective and retrospective utilization review, referrals by health plan staff, health plan providers or provider staff, and referrals by non-health plan contracted staff. A PQI may also be identified through an FSR, claims and encounter data, pharmacy utilization data, MCAS / HEDIS® / CMS Core Measures medical record review and quality audits, and grievances filed by members.

A PQI investigation is conducted by a QI registered nurse and may include the following:

- Contacting the provider's office for medical records and/or other information pertaining to the issue.
- A request for provider response.
- Interviewing provider or facility staff.

PQIs are rated, or leveled, by GCHP's chief medical officer (CMO) or designee for member outcome (O), system issues (S), and provider care (P). A scale of zero to three is used to rate / level the issue and is based on the severity of member outcome and/or level of opportunity for improvement.

Depending on the rating / leveling of a PQI, the case could be sent to Credentials / Peer Review Committee (C/PRC) for consideration in a provider's recredentialing process.

PQI Reporting

PQIs may be reported by any of the following:

- GCHP staff member
- Anonymous
- Any member of the community
- Any contracted or non-contracted provider / staff

A PQI is reported to the QI department by sending a completed **PQI Referral Form** to **PQIReporting@goldchp.org**.

Quality Incentive Provider Pool

The Quality Incentive Provider Pool (QIPP) is a multi-year initiative for improvement in quality performance measures included in the **Managed Care Accountability Set (MCAS)** for measures held to the minimum performance level (MPL) by the state Department of Health Care Services (DHCS).

GCHP designed the QIPP to help identify members due for clinically recommended care and assist PCPs in providing comprehensive high quality health care to members.

Performance and payment methodology for QIPP is determined by a provider's MCAS performance rates. QIPP additionally requires operational integration activities, such as leadership and operational meetings, annual and quarterly provider work plan submissions to GCHP, and data integration activities.

For more information about QIPP, you can contact GCHP's Quality Improvement Team at **QualityImprovement@goldchp.org**.

Section 8: Care Management Program

POPULATION HEALTH

The Population Health Management (PHM) Program at GCHP is being designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Specifically, the PHM Program intends to:

- Build trust with and meaningfully engage members.
- Gather, share, and assess timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes.
- Address upstream drivers of health through integration with public health and social services.
- Support all members in staying healthy.
- Provide care management services for members at higher risk of poor outcomes.
- Provide transitional care services (TCS) for members transferring from one setting or level of care to another.
- Reduce health disparities.
- Identify and mitigates Social Drivers of Health (SDOH).

GCHP is currently in the building phase for its PHM program and will continue to improve the depth and breadth of services available to our members as we learn more about their needs and characteristics through a data-driven approach.

CARE MANAGEMENT PROGRAM

GCHP's Care Management (CM) Program addresses the needs of members with complex and non-complex health needs and assists with coordination of health care to ensure the continuity of quality health care. GCHP's CM Program is a collaborative process that includes telephonic contact with the member and/or their representative and the medical home.

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, and from the review of data and utilization patterns.

The 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 members to address their health care needs by coordinating quality services through appropriate, efficient, and timely interventions.

Care Management Process

Through telephonic interactions with the member, the member's designated representative, and providers, data is collected and analyzed, and potential care needs are identified by CM staff. 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. GCHP's CM guiding principles are 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.

GCHP's primary Care Management staffing model consists of licensed nurses, care management coordinators and licensed clinical social workers (LCSW).

Types of Care Management

CARE COORDINATION / NON-COMPLEX CARE MANAGEMENT

- 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 coordinated through this program?
  1. Appointments
  2. Referrals to community resources
  3. Transportation
  4. Durable Medical Equipment (DME) needs
  5. Pharmacy
  6. PCP selection and information
  7. Member educational materials

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 from complex case management?
  1. Multiple comorbidities and/or chronic conditions
  2. Polypharmacy (multiple medications)
  3. Psychosocial needs
  4. High utilizers of ER / IP services
  5. CCS coordination of care and transitions to adulthood

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

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 evidence-based practice.
- Collaborate and communicate with the member and/or member representative, and providers to develop and implement interventions that are driven by the member's goals for health improvement.
- Facilitate accomplishment of the agreed-upon goals in the member's individualized plan.
- Provide the member and/or member representative with information and education, which promotes self-care.
- 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.

Referrals to GCHP Care Management

The Care Management Referral Form is available on GCHP's **website**.

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

24-Hour Advice Nurse Line

GCHP members have free 24-hour access to a registered nurse who can help them decide what to do if they are sick or hurt. The 24-hour Advice Nurse Line provides access to advice from a licensed registered nurse, who will triage the member's condition and refer to the appropriate level of care, as needed. The 24-hour Advice Nurse Line also helps ensure that GCHP members, providers and staff are receiving and providing care at the appropriate level, time, and place. Calling the 24-hour Advice Nurse Line also gives

members the option to enter GCHP's Health Information Library. This service allows members to listen to pre-recorded health information in English or Spanish.

To reach the 24-hour Advice Nurse Line, please direct members to call:

- 1-805-437-5001
- 1-877-431-1700 (toll free)
- For TTY, call 711

Section 9: California Advancing and Innovating Medi-Cal (CalAIM)

What is CalAIM?

The state Department of Health Care Services (DHCS) designed a program to improve the health and wellbeing of Medi-Cal members beyond traditional medical services, make services work together better, and improve the quality of services. The program is called California Advancing and Innovating Medi-Cal (CalAIM).

1. **Enhanced Care Management (ECM)**
   Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered.

   Gold Coast Health Plan (GCHP) offers the following ECM services to eligible members:

   Adult Population of Focus (POF)
   - Adults and their Families Experiencing Homelessness
   - Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization (formerly "High Utilizers")
   - Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
   - Individuals Transitioning from Incarceration
   - Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization
   - Adult Nursing Facility Residents Transitioning to the Community
   - Birth Equity Population of Focus

   Children and Youth Population of Focus (POF)
   - Homeless Families or Unaccompanied Children / Youth Experiencing Homelessness
   - Transitioning from Incarceration
   - Children and Youth at Risk for Avoidable Hospital or ED Utilization (formerly "High Utilizers")
   - Enrolled in California Children's Services (CCS) / CCS Whole Child Model with Additional needs Beyond the CCS Eligible Condition
   - Children and Youth Involved in Child Welfare

2. **Children and Youth with Serious Mental Health and/or SUD Needs Community Supports (CS)**
   Community Supports (CS) are services or settings that Managed Care Plans (MCPs) may offer in place of services or settings covered under the California Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. CS services are optional for MCPs to offer and for members to utilize. MCPs may not require members to use a CS instead of a service or setting listed in the Medicaid State Plan.

   Gold Coast Health Plan (GCHP) offers the following CS services to eligible members:

   - Asthma Remediation
   - Community Transition Services / Nursing Facility Transition to a Home
   - Day Habilitation Programs
   - Environmental Accessibility Adaptations (EAAs, also known as Home Modifications)
   - Housing Deposits
   - Housing Tenancy and Sustaining Services
   - Housing Transition Navigation Services
   - Medically Supportive Food / Meals / Medically Tailored Meals
   - Nursing Facility Transition / Diversion from Assisted Living Facilities

- Personal Care and Homemaker Services
- Recuperative Care (Medical Respite)
- Respite Care
- Short-Term Post-Hospitalization Housing

To refer a member for CS, please fill out the CS Referral Form and the appropriate authorization request form located on the **GCHP website**.

3. **Doula Services**

Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of members while adhering to evidence-based best practices. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion.

Medi-Cal covers doula services as preventive services pursuant to Title 42 Code of Federal Regulations (CFR) Section 440.130(c) and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. DHCS issued a statewide standing recommendation that all Medi-Cal members who are pregnant or were pregnant within the past year would benefit from receiving doula services from a Medi-Cal enrolled doula provider.

To recommend a member for doula services, please refer to the **GCHP website**.

4. **Community Health Workers (CHW)**

Community Health Worker (CHW) services are preventative health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and provide education services. CHWs may include individuals known by a variety of job titles, including Promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals.

To refer a member for CHW, please complete the forms located on the **GCHP website**.

Section 10: 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 (GCHP) can make decisions about prior authorization requests. Only the chief medical officer (CMO), associate chief medical officer (ACMO), or other physician reviewers have the authority to deny service authorization requests. Authorization decisions are based on evidence base GCHP policies as well as nationally recognized standards including, but not limited to:

- MCG Guidelines
- U.S. Preventive Services Task Force (USPSTF)
- 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:

- MRI and CT scans
- Outpatient surgery
- Dermatology therapy
- Home health services
- Speech therapy
- Physical and occupational therapy for members under 21 years of age, and for adults after 10 visits in a calendar year
- 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)
- Certain physician administered injections and infusions

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 members may access certain services without a referral from a PCP for the following services:

- Emergency services
- Urgent care services
- Emergency hospital admissions

GCHP members may self-refer to any willing Medi-Cal provider for sensitive services (refer to "Family Planning and Sensitive Services" below for more information).

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

GCHP members may self-refer to Behavioral Health providers contracted through the GCHP's Behavioral Health Organization (Carelon Behavioral Health) for therapy, such as counseling.

GCHP members may self-refer to Health Education programs (refer to Section 14: Health Education for more information).

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. For members who exhaust their other coverage, GCHP must be notified to ensure ongoing coverage of services. In some cases, requirements for Continuity of Care may be met.
Call 1-888-301-1228 for more information.

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. Examples of covered services include:

- Routine pregnancy testing
- Elective therapeutic abortions
- Birth Control Pills
- "Morning after Pill" to avoid pregnancy as approved by the FDA
- Routine birth control
- Norplant, including device, insertion and removal
- Inter-uterine device (IUD) including device, insertion and removal
- Diaphragm
- Contraceptive foam, male and female condoms, cervical caps, sponges, etc.
- Elective tubal ligation
- Elective vasectomy
- Office visits for education and instruction for birth control, including Sympto-Thermal method, Billings Ovulation method, Rhythm method, and instruction and education
- STI screening, testing, diagnosis, treatment and education
- HIV/AIDS screening, testing, diagnosis, treatment and education

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.

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

Fax

- Complete the **Prior Authorization Treatment Request Form**.
- Fax the form to GCHP at 1-855-883-1552.
- Please note: All inpatient requests must be submitted via fax only.

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 vendor number, tax ID, NPI and provider and/or facility name.
- 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 Prior Authorization Treatment Request Form for each service request per member. The request 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 GCHP 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 GCHP's in-area network providers.
- The expertise required for consultation is beyond what is available through GCHP'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 Form (DRF)** 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 **Prior Authorization Treatment Request Form (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. GCHP'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, GCHP 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.
- Covered equipment 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 visit 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 some durable medical equipment (DME). Ancillary services requiring prior authorization include, but are not limited to, the following:

- DME (purchase over $500 or rental over $200 per month)
- Physical / occupational therapy for members under 21 years of age and adults after 10 visits per calendar year
- Speech pathology
- Home Health Agency services
- Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (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 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.

Transitional Care Services

GCHP delegates responsibility for transitional care services (TCS) to our contracted facilities (including hospitals and nursing facilities) for high-risk* members. The facility must assign a care manager to each member being discharged, who is the single point of contact responsible for ensuring completion of all TCS in a culturally and linguistically appropriate manner for 30 days post-discharge.

The care manager has the following responsibilities:

- Discharge Risk Assessment
  - The assigned care manager will ensure that the discharge risk assessment is complete.
  - Will be completed prior to discharge to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental condition, and/or substance use disorder (SUD) relapse.
  - The assigned care manager will ensure the member is assessed to determine if they are newly eligible for Community Supports (CS) and/or ongoing care management services, such as Enhanced Care Management (ECM) or Complex Case Management (CCM) and refer member based on the member's needs, preference, and assessment findings.
- Discharge Planning Document
  - The assigned care manager will ensure that the discharge planning document is complete, accurately coordinated, shared with appropriate parties and that the member does not receive two different discharge documents from discharging facility and from the care manager.
  - The assigned care manager must ensure that this document is shared with the member, member's parents or authorized representatives, and the treating providers, including the Primary Care Provider (PCP), GCHP care management, the ECM or CS provider and the receiving facility or provider.
  - The discharge planning document shall use language that is culturally, linguistically, and literacy-level appropriate, and will include:
    - Preadmission status, predischarge support needs, discharge location, barriers to post-discharge plans, and information regarding available care and resources after discharge.
    - The care manager's name and contact information and a description of the TCS.
- Necessary Post-Discharge Service and Follow-Ups
  - Assigned care managers will ensure needed post-discharge services are provided, and follow-ups scheduled, including but not limited to follow-up provider appointments, SUD and mental health treatment initiation, medication reconciliation, referrals to social service organizations, and referrals to necessary at-home services.
  - Assigned care managers will coordinate with behavioral health or county care coordinators and GCHP care management to ensure physical health needs are met and assess for additional care management needs or services such as CCM, ECM, or CS and refer as needs are identified.
  - Members will be offered the direct assistance of the care manager, but members may choose to have limited to no contact with the care manager. In these cases, at a minimum, the care manager will act as a liaison coordinating care among the discharging facility, the PCP and GCHP.

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

High-risk members exclude the following members:

- Those with long-term services and supports (LTSS) needs.
- Those who are in ECM or CCM (TCS must be provided by the ECM or CCM Care Manager).
- Children with Special Health Care Needs (CSHCN).
- Pregnant individuals.
- Seniors and persons with disabilities who meet the definition of "high-risk."
- Any "high risk" Members as identified through the GCHPs' Risk Stratification and Segmentation (RSS) mechanisms or through the Population Health Management (PHM) Service once the statewide RSS and risk tiers are presented therein. Any member who is known to have been served by specialty mental health services (SMHS) and/or as having a specialty mental health need or substance use disorder.
- And member transitioning to or from a skilled nursing facility.
- Any member that the facility identifies as being high risk.

Hospital Observation

Observation stays of up to two days do not require prior authorization. Observations exceeding two days will require authorization.

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)
- Subacute 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. To expedite approvals and claims processing in a timely manner, it is essential that the documents submitted are complete and legible.

All admissions for skilled nursing level of care require prior authorization. For long term care placement, 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.

It is the responsibility of the physician referring the member or ordering the admission (skilled nursing) or the facility (long term care) to provide 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 any limited stay.

Nursing Facility Admission Notification

Nursing facilities must notify GCHP when 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. **Prior 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 1.16.1 Effective 10/1/2018. (Admission)
    - Version 3.0 Nursing Home Quarterly (NQ) Version 1.16.1 Effective 10/1/2018. (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**.
        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. Preadmission Screening / Preadmission Screening and Resident Review (PAS/PASARR)
3. Physical therapy, occupational therapy, and speech therapy clinical notes submitted prior to the end of the authorization period
4. 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.

Bed Hold Days

If a member is residing in a nursing facility and their condition requires them to be admitted to an acute care hospital, the nursing facility may bill for bed hold days. The following rules apply to bed hold days:

- The bed hold is limited to a maximum of seven consecutive days per hospitalization.
- Authorization is required for bed hold days for members residing in a skilled nursing or sub-acute facility.
- No authorization is required for bed hold days for members residing in a long-term care facility.

In addition, if a member is residing in an ICF/DD facility, bed hold days may be billed for members who leave the facility on a temporary pass. Bed hold days are limited to seven consecutive days. Authorization is not required for bed hold days for members residing in an ICF/DD facility.

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.
- 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

- 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 non-contracted provider giving the second opinion recommends a treatment, diagnostic test, or service that is medically necessary and in alignment with the first opinion, the member will be redirected to a contracted provider.

In-area services available with contracted providers will be directed to those providers.

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, GCHP 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, or a copy of the criteria utilized to make the determination, 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 11: 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 claim 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 working 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 GCHP-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 name (when different than billing 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 contact EDI support at **GCHPOnboardingRequests@edifecs.com**.

To submit your EDI claims to GCHP, your clearinghouse must register your NPI. Please refer your clearinghouse to the instructions to learn how to register your NPI with for EDI submissions. If you are a direct submitter of EDI claims, please refer to the instructions on how to register your NPI.

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. Failure to submit required documentation may result in a claim denial.

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 GCHP 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 paper 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.

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. GCHP utilizes the National Correct Coding Initiative (NCCI) CMS policy to promote national correct coding methodologies and to control improper coding.

Providers are responsible for all claims submitted with their national provider identifier (NPI), 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 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 submitted beyond 180 days from the date of service or 180 days beyond the date of discharge for inpatient claims are subject to a timely filing claim payment reduction.

- Claims received in months 7-9 from the date of service / date of discharge will reimburse 75% of allowable covered charges.
- Claims received in months 10-12 from the date of service / date of discharge will reimburse 50% of allowable covered charges.

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 must 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 (replacement of a previously submitted claim, e.g., changes or corrections to charges, clinical codes [provider reviewed clinical documentation and determined the code originally billed was incorrect] or procedure codes, dates of service, member information, etc.) must be submitted within 180 calendar days from the date of last action. A late charge claim (additional charges added to a previous claim submission) must be received within 365 calendar days from the date of service unless the provider's contract specifies a different limitation. Timely filing claim payment reductions apply to all late charge claims. Late charge claims received after 365 calendar days will be denied for timely filing unless circumstances prevented the claim from being filed within 365 calendar days. 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 30 working days of GCHP'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 of age (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

Established Patient	
99394	Adolescent – ages 12 to 17
99395	18 to 39 years of age (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

All pharmacy benefits are now administered by Medi-Cal Rx. Medi-Cal Rx is responsible for processing and paying pharmacy claims billed by pharmacies. Information regarding Medi-Cal Rx can be found on the dedicated Medi-Cal Rx **website**. Please do not submit pharmacy claims to GCHP. More information can also be found on the GCHP Pharmacy Services webpage.

A list of Physician-Administered Drugs (PADs) covered under the medical benefit that require a prior authorization can be found on the GCHP **website**. A Prior Authorization Treatment Request Form will need to be submitted for review by Utilization Management. The Prior Authorization Treatment Request Form can also be found on the GCHP **website**. For additional information, please call 1-888-301-1228.

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 lab services.
CMS-1500	Allied Health Practitioners	All covered services delivered by Allied Health Care Professionals.

Claim Form	Type of Provider	Services Billed on this Form
UB-04	Hospitals / Clinics / FQHCs / SNFs / Surgicenters	All professional or facility services.
CMS-1500	Imaging Centers	Professional X-ray and related services.
UB-04	Long-Term Care (LTC)	All LTC services.

* ***All claims should be submitted no later than 180 calendar days from the date of service or date of discharge on an inpatient claim to avoid a timely filing claim payment reduction, 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 12: 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 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 / 180-calendar-day claim payment reduction will be made with OHC claims based on the date of the EOB. The claim must be submitted to GCHP within 180 calendar days from the date of the primary carriers EOP.

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). The claim must cross over from the BCRC to GCHP within 180 days from the date of the MEOB.

The primary insurance must be billed prior to GCHP. The EOB issued by the primary carrier must be submitted with your claim. Failure to include the primary carrier EOB may result in a claim denial.

You will not receive additional reimbursement for services that are capitated by the primary carrier.

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.

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. If the SOC amount is not reported on the claim form or not collected from the member, GCHP will request a refund for any overpayments resulting from the members SOC not being met.

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 Medicare non-covered, exhausted or denied services when billed to GCHP with the appropriate Medicare denial attached.

Share of Cost (SOC)

Some Medi-Cal members must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). Members are not eligible to receive Medi-Cal benefits until their monthly SOC dollar amount has been certified online. Certifying SOC means that the Medi-Cal eligibility verification system shows the subscriber has paid or become obligated for the entire monthly dollar SOC amount owed. The SOC is comparable to a commercial health insurance out-of-pocket deductible in that the carrier does not pay until the deductible is met.

Providers should access the Medi-Cal eligibility verification system to determine if a member must pay an SOC. The eligibility verification system is accessed through the Automated Eligibility Verification System (AEVS) and the Medi-Cal Provider website at **www.medi-cal.ca.gov**.

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 (including the SOC amount paid directly to the provider from the member) may not exceed the Medi-Cal maximum allowable amount for the services rendered. Claims submitted for members who have not met their SOC requirement for the month of service will be denied.

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, GCHP will facilitate and coordinate their care.

Section 13: Member Services

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

- Choose or change a PCP, which may be a clinic or physician.
- Learn about their eligibility.
- Provide their claim status.
- Understand how to access care within a managed care health plan.
- Understand member benefits and services available.
- 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, which is used to assess each member's individual health needs.

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

Administrative members are mailed a welcome letter, their GCHP ID card, and GCHP's Member Handbook.

Every year, members also receive three newsletters, which include articles on health education topics, service and benefit reminders, and information about how to use GCHP'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: 711 Monday through Friday, from 8 a.m. to 5 p.m. (excluding holidays).

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.

Section 14: Language Assistance Services

Overview of Cultural and Linguistic 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 language assistance services to members who are Limited English Proficient (LEP), non-English speaking, or monolingual.

GCHP is committed to ensuring effective communication with members with visual impairments or other disabilities requiring the provision of written materials in alternative formats, and shall facilitate requests for Braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate at no cost to members.

GCHP is committed to ensuring that all members and potential members, regardless of race, color, religion, ancestry, national origin, ethnic group identification, age, mental or physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or language ability to have equal access to quality health care. If you need language assistance services for your GCHP patients, contact GCHP's Cultural and Linguistic Services at 1-805-437-5603, Monday through Friday from 8 a.m. to 5 p.m. (except holidays) or call GCHP's Member Services Department at 1-888-301-1228 (TTY: 711). Providers can also email **CulturalLinguistics@goldchp.org**.

Language Assistance Services

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 access to interpreters and translation services at all key points of covered services at no cost to GCHP members and potential members. GCHP strongly discourages the use of unqualified interpreters, including bilingual office staff, friends or family members - especially minors. Providers shall offer an interpreter during clinical visits and shall document in the medical record if the member declines the use of an interpreter at the time of the visit.

GCHP's Cultural and Linguistic Services coordinates interpreting and translation services for GCHP's members and providers. GCHP provides training opportunities for providers and their staff on language assistance services, cultural competency, diversity, equity, and inclusion trainings to increase awareness of the diverse health care needs of GCHP's membership at no cost.

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 Department at 1-805-437-5603 Monday through Friday from 8 a.m. to 5 p.m. (except holidays) or email **CulturalLinguistics@goldchp.org**.

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 to be notified at least 49 business hours in advance.

Telephone Interpreting Services

GCHP offers telephonic interpreting services available to providers 24 hours a day, seven days a week for covered services. To access telephonic interpreting services after regular business hours, call 1-866-421-3463. GCHP contracts with a vendor that provides telephone interpreting services in more than 240 languages. Call GCHP's Cultural and Linguistic Services during business hours at 1-805-437-5603 to request a provider access code.

In-Person Interpreting Services

GCHP works with various vendors to provide qualified in-person interpreter services. It is important to submit the **Language Assistance and Auxiliary Services Request Form** to GCHP Cultural and Linguistic Services via fax at 1-805-248-7481 or email at **CulturalLinguistics@goldchp.org** at least five to seven business days in advance of the request for a covered service. To cancel an interpreting request, send an email to GCHP's Cultural and Linguistic Services at **CulturalLinguistics@goldchp.org** 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 need services from a sign language interpreter receive those services. GCHP has contracted with vendors to provide qualified sign language interpreting for members during covered services. The Language Assistance and Auxiliary Services Request Form must be submitted to GCHP at least five to seven business days in advance of the covered service. Submit your request form via fax to 1-805-248-7481 or email at **CulturalLinguistics@goldchp.org**. If you have questions about language assistance services, call Customer Service at 1-888-301-1228 (TTY: 711). You may also call GCHP's Cultural and Linguistic Services at 1-805-437-5603, Monday through Friday from 8 a.m. to 5 p.m. (except holidays).

How to Access Sign Language Interpreter Services:

- For sign language interpreter services, provider(s) and members may call GCHP's Member Services Department at 1-888-301-1228 (TTY: 711), or call GCHP's Cultural and Linguistic Services at 1-805-437-5603, Monday through Friday from 8 a.m. to 5 p.m. (except holidays).
- For emergency, same-day or urgent requests during business hours, call Cultural and Linguistic Services at 1-805-437-5603.

When Requesting Interpreter Services:

- Verify the GCHP member's Medi-Cal eligibility before requesting an interpreter.
- Provide an advanced notice of at least five to seven 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.

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 receives a weekly file from DHCS containing a list of members who requested alternative formats (AF). GCHP informs providers and subcontractors of members requesting member information to be in an alternative format.

GCHP provides alternative formats and appropriate auxiliary aids and services to members with disabilities upon request. Providers and subcontractors shall document member's AF preference in the electronic member record system. Alternative formats include the following, but are not limited to:

- Large print (no less than 20-point Arial font)
- Braille
- Accessible electronic format, such as an audio or data CD, and other auxiliary aids and services that may be appropriate.

Plain Language – 6th Grade Reading Level or Below

Evidence shows that patients often do not understand much of the information given by health care providers. Per DHCS, member informing materials shall be written in a 6th grade reading level or below. If you need assistance with readability reviews, contact GCHP's Health Education Department at **HealthEducation@goldchp.org**.

GCHP recognizes that using simple language is essential for the effective delivery of health care. Plain 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 6th grade reading level.

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**.

For additional questions or resources, please email **CulturalLinguistics@goldchp.org** or call 1-805-437-5603 Monday through Friday, between 8 a.m. and 5 p.m. (except holidays). For provider training opportunities, visit the GCHP **website**.

Bilingual Fluency Assessments

Providers and subcontractors shall ensure that their staff working in the area that requires bilingual fluency are competent in Spanish. Staff working in positions requiring bilingual fluency skills should be assessed in a standard process and providers shall maintain records of bilingual assessments. Policies shall include the frequency of staff being assessed or reassessed for bilingual fluencies.

Diversity, Equity, and Inclusion Training

Contracted network providers, staff and delegated entities are required to complete an annual cultural competency training.

The DEI training is mandated by the state Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) to ensure staff, providers and delegated entities are meeting the unique and diverse needs of all members. All providers and staff shall complete a DEI training. Upon completion of the training, please submit the **Cultural Competency Training Acknowledgment Form** to GCHP's Cultural and Linguistic Services. Visit the GCHP website to access the training modules and acknowledgment form or contact GCHP for more information.

The Think Cultural Health website, features information, continuing education opportunities, additional resources for health care professionals to learn about culturally and linguistically appropriate services (CLAS). Culturally and linguistically appropriate services (CLAS) are increasingly recognized as an important strategy for improving quality of care to diverse populations. For more information, **click here**.

GCHP shall ensure that all contractors, subcontractors, downstream subcontractors, and network provider staff shall receive mandatory diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as noted in the DHCS contract. For information on DEI trainings, visit the **GCHP website**.

Network providers must ensure that cultural competency, sensitivity, health equity, and diversity trainings are provided for employees and staff at key points of contact with members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C (Cultural and Linguistic Programs and Committees). In addition, subcontractor and downstream subcontractors must ensure that cultural competency, sensitivity, health equity, and diversity training is provided for subcontractor's and downstream subcontractor's staff at key points of contact with members.

GCHP's Cultural and Linguistics Department shall collaborate with Provider Network Operations to ensure that the network providers mandatory training includes information on diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in the 2024 DHCS contract, Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training). This process must also include an educational program for network providers regarding health needs to include but not be limited to, the Seniors and Persons with Disabilities (SPD) population, members with chronic conditions, members with specialty mental health service needs, members with substance use disorder needs, members with intellectual and developmental disabilities, and children with special health care needs. Trainings must include social drivers of health and disparity impacts on members' health care. GCHP shall maintain attendance records and shall be reviewed and maintained by GCHP's health equity officer or designee.

Training options on diversity, equity, and inclusion may be found on the GCHP website, under Provider Resources, Cultural Competency Training. The GCHP website offers four training modules to network providers, staff, contractors, subcontractors, and downstream subcontractors to complete. Upon completion of the training, return a completed **Cultural Competency Training Acknowledgement Form** to GCHP, Cultural and Linguistic Services. If a training was provider by another organization or entity, providers shall attest to having received and confirmed that a training was completed. Training must be completed as required by DHCS. GCHP shall track and maintain records of completed training by network providers, all contractors, subcontractors, and downstream subcontractors.

In addition to training modules available on the GCHP website, the U.S. Department of Health and Human Services (HHS) offers free credits on presentations, webinars, and other online training programs for health care providers. The website, Think Cultural Health, features information on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care and other resources for health care professionals to learn about culturally- and linguistically-appropriate services. For more information, **click here**.

For additional questions or resources, please email **CulturalLinguistics@goldchp.org** or call 1-805-437-5603 Monday through Friday between 8 a.m. and 5 p.m. (except holidays) For provider training opportunities, visit the GCHP **website**.

Section 15: Health Education

Overview of Services

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, PCPs, 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 Member Services at 1-888-301-1228 (TTY: 711). To reach GCHP's Health Education Department call 1-805-437-5718, Monday through Friday, from 8 a.m. to 5 p.m. (except holidays) or email **HealthEducation@goldchp.org**.

Health Education Contract Requirements for GCHP Providers

Providers are required to make health education programs and services available to members at no cost. 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 at 1-805-437-5718, Monday through Friday, from 8 a.m. to 5 p.m. (except holidays) or email **HealthEducation@goldchp.org**.

Bright Futures Preventative Care Screening Guidelines

Bright Futures is a national health promotion and prevention initiative led by the American Academy of Pediatrics. The Bright Futures Guidelines provide theory-based and evidence-driven guidance for all preventative care screenings and health supervision visits. Providers may visit the **American Academy of Pediatrics website** or the GCHP **website** for more information and resources.

Staying Healthy Assessment (SHA)

Per DHCS, the Staying Healthy Assessment (SHA) shall no longer be a required component of the Initial Health Assessment (IHA), however, the SHA questionnaires may be found on the website.

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**, call GCHP's Health Education Department at 1-805-437-5718, Monday through Friday between 8 a.m. and 5 p.m. except holidays), or email **HealthEducation@goldchp.org**.

- **Chronic Disease Self-Management Classes** – GCHP offers partners with agencies who offer the Chronic Disease Self-Management Program (CDSMP) classes in English and Spanish. The goal of the classes is to build self-confidence and improve skills needed to manage chronic conditions.

- **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 help member quit smoking, vaping, or using smokeless tobacco and promote tobacco cessation classes throughout the county. For information on free tobacco cessation classes, support groups and nicotine replacement products, contact the Health Education Department or the Kick It California at 1-800-300-8086 or visit **https://kickitca.org**. For information in Spanish, call 1-800-600-8191.
  The Ventura County Health Care Agency (VCHCA) offers free "Call It Quits" classes. The program consists of eight, 1.5-hour sessions. Registration is required. For program information, call 1-805- 201-STOP (7867) or email **CallItQuits@ventura.org**.
- **Urgent Care Brochure** – A brochure on **urgent care service** hours and locations is available for members. Contact GCHP's Health Education Department for copies.
- **Centers for Disease Control and Prevention (CDC)** – Health Education also uses the CDC's website to provide GCHP'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.
- **Healthwise Digital Health Education Member Engagement Tool** – GCHP has partnered with Healthwise, a leader in evidence-based health education and self-management health promotion tools. Healthwise helps empower members through its user-friendly materials, resulting in improved health outcomes and increased satisfaction. Providers and members can visit the **GCHP website** to review the online library of interactive culturally and linguistically appropriate health education resources, available in English and Spanish at no cost. Materials may be downloaded directly from the website. Healthwise also offers tailored health education videos on chronic health conditions to assist members in managing their health conditions.
- **Diabetes Prevention Program** – The Diabetes Prevention Program (DPP) is available to members with pre-diabetes or at high risk for type 2 diabetes. The DPP assist members with lifestyle changes related to healthy eating and physical activity. The DPP provides group support, weekly lessons, personal health coach and tools. The DPP is available in English and Spanish at no cost to members. For more information, call 1-888-305-6008, Monday through Friday, from 6 a.m. to 6 p.m.
- **Well-Child Visit and Immunization Flyers** – GCHP has flyers to promote well-child visits and immunizations available on the GCHP website.

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 GCHP's care management program.

To learn more about the Health Navigator Program, call GCHP's Health Education Department at 1-805-437-5718, Monday through Friday, from 8 a.m. to 5 p.m. (except holidays) or email **HealthEducation@goldchp.org**.

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. This information can also be found on the GCHP **website**.

Health Promotion Materials

GCHP continues to collaborate with local clinics and other agencies to promote support groups and classes for 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
- Disease management
  - Diabetes and prediabetes
  - Asthma
- High blood pressure
- Immunizations and COVID-19 Resources
- Pregnancy and postpartum
- Breastfeeding
- Sexually transmitted infections (STI) and family planning
- Tobacco cessation and vaping
- Well care exams
- Health library

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 GCHP providers to ensure that health promotion materials are available for distribution in English, Spanish, and other languages upon request. Contact GCHP's Health Education Department at **HealthEducation@goldchp.org** for more information.

Health Education Trainings for Providers

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 long and can be scheduled at the provider's convenience. Trainings offered by GCHP include:

- Health Education and Nutrition
  - » MyPlate
  - » ReThink Your Drink
- Health Education program overview
- Tobacco cessation training – The 5 A's

Provider Order Forms / Health Education Materials

GCHP's Health Education Department created a list of approved health education resources for providers. To obtain the list of approved health education materials, call 1-805-437- 5718, Monday through Friday, from 8 a.m. to 5 p.m. (except holidays) or email **HealthEducation@goldchp.org**.

The health education materials and resources that are available in English and Spanish, including but not limited to:

- GCHP Tobacco Education and Quit Smoking Resource Guide
- Kick It California Helpline brochures
- GCHP Winning Health member newsletter
- GCHP Health Education Referral Form
- GCHP Asthma Action Plan
- GCHP My Blood Pressure Check Up Flyer
- GCHP Community Resource Guide
- GCHP Senior Resources Guide
- GCHP Urgent Care brochure
- GCHP Dialysis Transportation brochure
- DHCS – Newborn Referral Form MC 330
- First 5 Kit for New Parents
- California Poison Control Magnet
- Ventura County Women, Infants and Children (WIC)
- Ventura County Public Health Lead Brochure
- Choose My Plate (10 Tips to Build a Healthy Meal) (link provided on form for direct ordering)
- Asthma materials for adults and children
- Dairy Council of California: Health Eating Made Easier

Section 16: Pharmacy

All pharmacy benefits are administered through a statewide program called Medi-Cal Rx. Medi-Cal Rx is responsible for processing and paying pharmacy claims billed by pharmacies. Information regarding Medi-Cal Rx can be found on the dedicated Medi-Cal Rx **website**.

Medi-Cal Rx does not include pharmacy services billed as a medical (professional) or institutional claim. Pharmacy services, including Physician-Administered Drugs (PADs), billed on a medical claim is the responsibility of Gold Coast Health Plan (GCHP). For list of Physician-Administered Drugs that require prior authorization, please use GCHP's **List of Services Requiring Prior Authorizations** (refer to list of Physician Administered Drugs section) for the most updated list.

Information regarding the Medi-Cal Rx formulary (or Contract Drugs List), prior authorization process, and provider portal can be accessed directly from the **DHCS Medi-Cal Rx website**.

Medi-Cal Rx Customer Service Center can be reached directly at 1-800-977-2273, 24 hours a day, seven days a week, to assist with any questions or issues regarding pharmacy claims or prior authorizations.

For more information regarding pharmacy services, please check the GCHP **website**. For additional questions, the GCHP Pharmacy Team can be reached at 1-805-437-5738 or by email at **Pharmacy@ goldchp.org**.

Section 17: Outpatient Clinical Laboratory and Outpatient Imaging Services

Clinical Laboratory Services — Lab Specimens and Drawing Stations

Quest Diagnostic Laboratories is the preferred laboratory provider. For more information, please visit GCHP's **website**. Providers can 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 Laboratory section of the directory. The preferred list of labs, locations and phone numbers is posted on GCHP's **website**.

Outpatient Imaging Centers

There is a wide range of contracted imaging centers located conveniently throughout the county. Providers can 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 GCHP's contracted imaging centers, their locations and phone numbers are posted **here** on 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 GCHP's website. PCPs have some basic laboratory tests included as part of their monthly capitation payment.

List of Laboratory Codes and Descriptions

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 a 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 a 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)
83036	Glycosylated (A1C) hemoglobin analysis by electrophoresis or chromatography
83037	Glycosylated (A1c) hemoglobin analysis by device cleared by FDA
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

CODE	DESCRIPTION
	Influenza Testing (A and B)
87276	Influenza A virus Influenza
87275	B Virus
87400	Influenza, A or B, each
86580	Skin test; Tuberculosis, Intradermal
	Lead Screening
83655	Blood lead screening
	Sexually Transmitted Infections
87491	Chlamydia Screening
87591	Gonorrhea

Section 18: Resolution of Disputes and Grievances

Provider Dispute Resolution (PDR) Process

Gold Coast Health Plan's (GCHP) Provider Dispute Resolution (PDR) mechanism offers providers dissatisfied with the processing or payment of a claim a method for resolving claim related issues. The provider dispute must be filed in writing by completing GCHP's Provider Claim Reconsideration Form within 365 calendar days of the action or inaction date. Do not submit a dispute if the claim is in a pend status. The provider may also include additional information that affect the outcome of the dispute. Providers must exhaust GCHP's internal dispute resolution process before pursuing other available options.

Below are examples of concerns that can be addressed through the GCHP's Provider Dispute Resolution process:

- A claim was underpaid.
- A claim was overpaid due to a payment or billing error.
- A procedure was denied as inclusive to another procedure in error.
- A corrected claim where a previous payment was made.
- A claim payment based on the utilization management decision.

Provider Dispute Resolution (PDR) are submitted by completing the Provider Claim Reconsideration Form.

- By mail:
  Gold Coast Health Plan
  ATTN: Provider Disputes
  P.O. Box 9176
  Oxnard, CA 93031

- By Fax to:
  GCHP's Grievance and Appeal Department 1-805-512-8599

- By Email to:
  Grievances@goldchp.org

Please ensure when completing the Provider Claim Reconsideration Form that the resolution request type option is selected, and all fields are completed based on the request type:

- **DISPUTE Request: Reconsideration of an original claim that has been previously denied or underpaid.**
- **APPEAL Request: Reconsideration of an authorization denial or a notice of action.**
- **GRIEVANCE Request: Reconsideration of a previously disputed claim in which the provider is not satisfied with the resolution.**

It is imperative that all the following information is included on the dispute request:

- 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.
- If the dispute involves a claim or request for reimbursement of overpayment, provide the original claim number and date of service.

- A clear explanation of why it is believed the payment or other action is incorrect.
- The member's full name, date of birth and complete nine-character GCHP ID number.

Claim disputes submitted with incomplete information will be returned to the provider along with a clear identification of the missing information that is necessary for the review and resolution of the dispute. Please note that if the dispute does not include an attached Provider Claim Reconsideration Form, the dispute request will be returned to the provider requesting the completed form. Providers have 30 working days after the receipt of a returned provider dispute to resubmit the amended dispute with the additional information. If the information is not submitted, or not submitted timely, the dispute is closed without further action.

If a provider has multiple disputes addressing the same 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 working days of receipt. GCHP will send a written resolution to the dispute within 45 working 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

Provider Grievance is the final step in the administrative process and a method for GCHP providers to resolve claim issues related to their provider dispute outcome. The request should be submitted only after a Provider Dispute Resolution Process has been submitted and the resolution of the dispute does not meet the provider's satisfaction. Grievances related to claim dispute decisions must be submitted within 180 calendar days from the date of the provider dispute resolution letter. The request for review must be submitted by completing the Provider Claim Reconsideration Form to initiate the process. Failure to submit the request within the timeframe specified will result in the request being denied for past timely to submit. GCHP reviews each case individually using the documents presented by the provider to render a fair decision 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.

All grievances received will be promptly acknowledged, reviewed, and researched by GCHP's Grievance and Appeals team. Research may require the participation of staff from other relevant GCHP departments. Grievances related to medical-necessity decision disputes will be reviewed as an Appeal, only if they are submitted timely within 60 calendar days from the date of the Notice of Action (NOA) letter.

A provider grievance can be filed by completing the **Provider Reconsideration Request Form** and submitting the form as follows:

- By Mail:
  Gold Coast Health Plan
  Attn: Provider Grievance and Appeals
  P.O. Box 9176
  Oxnard, CA 93031

- Via Fax to:
  GCHP's Grievance and Appeal Department 1-805-512-8599

- By Email:
  Grievances@goldchp.org

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 response form, providing pertinent information related to the complaint, and/or speaking with GCHP Grievance and Appeals representatives to assist with resolving the complaint in a reasonable manner. When responding, it is imperative that your response is on the provider's letterhead and not submitted on a blank word document or in the body of an email. Responses received in the body of an email will not be accepted. If you are assisting the member with their complaint, the forms are available in English and Spanish.

Member Grievances

The member, an authorized representative, or a provider acting on behalf of the member 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 at 1-888-301-1228 (TTY: 711).

- In writing, by completing a member grievance form and/or written correspondence mailed to:
  Gold Coast Health Plan
  Attn: Member Grievance and 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 that the grievance has been received, the date of receipt, and includes the provider's name, telephone number and address of the Grievance and 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.

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 the expedited criteria within 72 hours of receipt of the request.

Member Discrimination Grievances

GCHP is required by the state Department of Health Care Services (DHCS) to investigate grievances alleging any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination laws. GCHP has implemented procedures to provide for the prompt equitable resolution of discrimination-related grievances. The discrimination grievances might include – without limitation – sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability,

physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56. This requirement includes language access complaints and complaints alleging failure to make reasonable accommodations under the Americans Disability Act (ADA).

GCHP is required to report all discrimination cases to the DHCS Office of Civil Rights within 10 calendar days of mailing the discrimination grievance resolution letter to the member. GCHP is required to submit detailed information regarding the discrimination grievance, including the provider's or other accused party's response to the grievance and/or any corrective action taken.

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 (TTY: 711).
- 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.

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 and 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: 711)

- In writing, by completing a Member Appeal form and/or written correspondence mailed to:
  Gold Coast Health Plan
  Attn: Grievance and Appeals
  P.O. Box 9176 Oxnard, CA 93031

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

A GCHP Grievance and 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 and 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.

The member can request a timeframe extension for additional time to provide more documentation. GCHP will make reasonable efforts to accommodate the member's request. If GCHP is unable to resolve the appeal in the specified timeframe, the member will be given information on the right to file a Member Grievance for the delay.

Deemed Exhaustion

In the event GCHP fails to adhere to the state and federal notice and timeframe requirements for either an NOA or NAR, including the failure to provide a fully translated notice, the member is deemed to have exhausted GCHP's internal appeal process and may initiate a state hearing.

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 would need to be filed orally and followed up with a written request.

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 resolution. 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 NAR 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

- Online: www.cdss.ca.gov

- Fax: (916) 309-3487 or toll-free at 1-833-281-0903

A State Hearing Form or the request letter should include the member's name, address, telephone number, Social Security Number (SSN) and/or CIN number, and the reason for the requesting a State Hearing. If someone is helping the member request a State Hearing, add their name, address, and telephone number to the form or letter. If the member needs an interpreter, tell the State Hearings Division what language they speak. The member will not have to pay for an interpreter. The State Hearings Division will provide one. If the member has a disability, the State Hearings Division can provide special accommodations free of charge to help the member participate in the hearing. Please include information about the disability and the accommodation required.

Section 19: 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, other licensing, law enforcement, and 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. GCHP members will also be informed via Evidence of Coverage, the GCHP 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 14043143.1(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 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 new associates 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 fraud, waste and abuse 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 Identification Card (BIC), GCHP Identification 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 purposes other than the purposes 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 or prevent 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, FWA toll-free hotline, email, phone or in person to the Compliance Department. 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 **secure.ethicspoint.com** 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 Navex 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 Navex relative to any employee-related allegation that is not related to fraud, waste or abuse, the case will be referred to the executive director of Human Resources. If the report involves a Commission member, the compliance officer will contact general counsel immediately. In the event the report involves the CEO, the compliance officer will contact the Commission 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 regarding a Medicare issue or 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 Navex will be available online. In addition, the reporter will also receive a report number and the reporter can contact Navex 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 established in the tracking software 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 upon the nature of the case 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 merit, there is reason to believe that an incident of fraud and/or abuse has occurred based on preliminary findings, Compliance will utilize the material reviewed by the department(s) in preparation to report and notify DHCS Medi-Cal Managed Care Division / Member Rights / 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 20: 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 GCHP website.

Claims

- **CLAIM CORRECTION FORM** – Use this form to accompany corrected claim(s). Any corrected claim received without the corresponding claim correction form will be rejected.
- **ELECTRONIC CLAIMS SUBMISSION** – Electronic claims submission instruction process.
- **PROVIDER CLAIM RECONSIDERATION FORM** – This form is to be used for disputes related to claim denials, overpayment and underpayment.

HEALTH SERVICES

Authorization and Referral Forms

Authorizations:

- **PRIOR 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.
- **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.

Referrals:

- **DIRECT REFERRAL FORM** – This form is used by Primary Care Providers (PCPs) and specialists to refer a member to another contracted provider located in Ventura County.
- **CARE MANAGEMENT REFERRAL FORM** – This form is used to request assistance with a member with unique or special needs.

Member Services

- **PRIMARY CARE PROVIDER (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 AND 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 CLAIM RECONSIDERATION 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 GCHP's network, please submit a letter of interest by email to **ProviderContracting@goldchp.org**.
- **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 Customer Service Department for assistance at 1-888-301-1228 or email **ProviderRelations@goldchp.org**.

Quality Improvement

- **PQI REFERRAL FORM** – This form is used to report a potential quality issue. Please e-mail completed form to **PQIReporting@goldchp.org**.

Appendix 1: Functions of Committees and Gold Coast Health Plan (GCHP) Staff Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) is responsible for the monitoring and evaluation of the overall effectiveness of quality improvement and health equity activities at GHCP. The Quality Improvement and Health Equity Committee (QIHEC) is chaired by the chief medical officer (CMO) and staffed by the quality improvement director, GCHP management, licensed practitioners from GCHP's provider network, a behavioral health practitioner, and at least one Commissioner. The QIHEC meets quarterly and is responsible for advising GCHP's staff and commissioners on the Quality Improvement and Health Equity Transformation Program (QIHETP).

The QIHEC:

- Oversees annual review, analysis and evaluation of goals set forth by the Quality Improvement and Health Equity Transformation Program, Quality Improvement and Health Equity Transformation Work Plan, as well as GCHP's quality improvement policies and procedures.
- Makes recommendations for implementation of QIHETP interventions or corrective actions based on results of quality improvement and health equity metrics and activities.
- Facilitates data-driven indicator review and development for monitoring key quality management activities, including but not limited to: MCAS / HEDIS®, Access / Availability, Performance Improvement Projects, Service / Clinical Quality measures, UM/CM metrics, Population Health metrics, Behavioral Health metrics, Credentialing performance, and Delegation Oversight. Analyzes and evaluates the results of QI and Health Equity activities, including the annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees, such as the Consumer Advisory Committee.
- Institutes actions to address performance deficiencies, including policy recommendations.
- Ensures appropriate follow-up of identified performance deficiencies.
- Reviews reports from GCHP committees and departments, including quarterly dashboards, key activities and action plans and reports regarding monitoring of health plan functions and activities, and makes recommendations.

Utilization Management Committee (UMC)

The UMC is established as a standing sub-committee of the QIHEC of GCHP. The committee structures and processes are clearly defined in the Quality Improvement and Health Equity Transformation Program Description.

The UMC oversees the implementation of the program and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multi-disciplinary and monitors continuity and coordination of care as well as under- and over-utilization of services. Any perceived or actual utilization management problems are reviewed by the UMC. The committee meets quarterly. The QIHEC and UMC work together on overlapping issues.

Pharmacy & Therapeutics (P&T) Committee

The Pharmacy and Therapeutics (P&T) committee is chaired by the Director of Pharmacy Services and comprised of local physicians and pharmacists. The committee meets quarterly with the primary responsibility of ensuring cost effective and quality drug management for GCHP members. The committee will also discuss retrospective Drug Utilization Reviews (DURs), review the policies and procedures for Pharmacy Services, review and update the Physician Administered Drug (PAD) list covered under the

medical benefit, and provide recommendations on educational materials and programs regarding drug products and appropriate utilization for Providers. P&T committee members are appointed by the CMO and/or the Director of Pharmacy Services. The P&T committee reports to the board through the CMO and the QIHEC.

Credentials / Peer Review Committee (C/PRC)

The Credentials / Peer Review Committee (C/PRC) oversees GCHP's credentialing and practitioner peer review process, including guidance and peer input. The C/PRC is chaired by the CMO and attended by GCHP management and licensed practitioners from GCHP's contracted provider network, which includes primary care and specialty practices.

The committee meets quarterly and supports GCHP's efforts to ensure its contracted providers deliver the highest quality of care to its members by:

- Providing guidance and comments on the credentialing process.
- Reviewing and making decisions for initial credentialing and recredentialing.
- Reviewing credentialing policies annually.
- Reviewing potential quality issues involving the quality of care and services.
- Determining corrective action when necessary.

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, non-discrimination, and conflict of interest rules.

Medical Advisory Committee (MAC)

The Medical Advisory Committee (MAC) is chaired by the CMO, and attended by GCHP management, and licensed practitioners from GCHP's contracted provider network. The MAC meets quarterly to provide feedback and advice to the health plan on any aspect of health plan policy or operations affecting network providers or members. . The meetings also provide a forum for ongoing collaboration between GCHP and the physician community. Feedback from the MAC is relayed to the QIHEC and other committees and/or departments where data may be relevant to process improvements.

Examples of topics discussed include, but are not limited to:

- The delivery of medical care to GCHP's membership.
- Issues of concern to the physician community.
- Quality of care concerns.
- GCHP clinical programs.
- Local medical care practices that may affect health plan operations.

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

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

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 renewable one-year term. 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, 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 of the CMO include:

1. Fulfillment of and adherence to QIHETP 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, Quality Improvement and Health Equity Committee, and Medical Advisory 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 180 days from the date of the primary carrier's Explanation of Benefits.

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 "encounter 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 contact **GCHPOnboardingRequests@edifecs.com**. 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. For most practices, the appropriate timeframe for follow up would be 45 calendar days after the claim was originally mailed or transmitted electronically. GCHP 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 view claims via the web?

Providers can use GCHP's Provider Web Portal to search for claims that were submitted by paper or electronically. If your office has not registered and is not using the Provider Web Portal, please contact the Customer Service Department at 1-888-301-1228 or email **ProviderRelations@goldchp.org**. Detailed instructions on how to use the Provider Web Portal can be located on the **GCHP Provider Portal** web page.

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. Please refer to the

Child Health Disability Prevention (CHDP) Claims Submission under section 10 of this provider manual for additional billing instructions.

9. How should claims for newborns be submitted?

Services rendered to a newborn 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 newborns, the claim must be billed using the newborns Medi-Cal 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. CCS-covered conditions that have been denied by Medi-Cal FFS due to services being rendered by a non-CCS paneled provider are not the financial responsibility of GCHP.

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, the member 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 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 GCHP 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 was 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 GCHP'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 Claim Reconsideration Form.

For further information, please see the dispute resolution process section 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 contracted 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 GCHP 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.

GCHP 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, GCHP 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 GCHP 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, GCHP 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 GCHP partners shall facilitate access to the records necessary to complete the audit.

Appendix 4: FAQs for Member's Grievances and/or Appeals

NOTE: This guide is provided to give basic assistance to provider offices in dealing with questions received from Gold Coast Health Plan (GCHP) members related to grievances. For more complicated matters, please refer members to GCHP at 1-888-301-1228 / TTY 711.

1. What is the GCHP grievance and/or appeal process?

GCHP has a process for evaluation of grievances and appeals. It provides a method for the member to voice their grievances or settle any concerns they may have about the services they receive as GCHP members.

2. What is a grievance?

A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievance 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.

3. When can a member file a grievance?

A member can file a grievance at any time.

Some examples of grievances include, but are not limited to, the following:

- Member experiences a problem getting services they feel are needed, such as medication, medical equipment, or an appointment with a doctor.
- Member is unhappy with the services received from a health care provider.
- Member is unhappy with their health care treatment.

In most cases, filing of complaint / grievance must be done within 180 days of the event that caused dissatisfaction. If a complaint is filed because GCHP has denied or modified a request for Prior Authorization, an appeal must be filed within 60 days of GCHP's Notice of Action.

4. What is an Appeal?

An Appeal is review of GCHP of an Adverse Benefit Determination, which means the denial, deferral or limited authorization of a requested covered service, including:

- Determinations on the level of service.
- 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.
- The denial of a member's request to dispute a financial liability including cost sharing, deductibles, and other financial liabilities.

5. When can a member file an Appeal?

A member can file an appeal within 60 calendar days from the Notice of Action.

6. Who can file a grievance and/or an appeal?

- Member
- Authorized Representative
- Provider on behalf of the member

7. How can the grievance or appeal be submitted?

- **Phone:**
  1-888-301-1228

- **Mail:**
  GCHP Grievances & Appeals
  P.O. Box 9176
  Oxnard, CA 93031

- **In-person:**
  Gold Coast Health Plan
  711 Daily Dr., Suite 106
  Camarillo, CA 93010

- **Email**:
  Grievances@goldchp.org

- **Fax:**
  1-805-512-8599

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For more information, call Gold Coast Health Plan at 1-888-301-1228. If you use a TTY, call 711.

www.goldcoasthealthplan.org