CCA Health Plans of California, Inc.

Medicare Advantage Plan Provider Manual | 2024

In California:
CCA Medicare Excel (HMO) Plan in Santa Clara and San Joaquin Counties

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Welcome Letter

Dear CCA Health California Provider:

Welcome to CCA Health California ("CCA Health" or the "plan")! As a plan provider, you play a crucial role in the delivery of healthcare services to our members and for this CCA Health would like to thank you.

This provider manual is intended to be a guideline for the provision of covered services to CCA Health Medicare beneficiaries. The manual contains applicable policies, procedures, references and resources, and general information, including minimum standards of care that are required of plan providers.

It is important that you have access to the most up-to-date version of the manual, which can be viewed or downloaded at any time by visiting our website at commonwealthcarealliance.org/ca/. To avoid confusion, please discard any versions you may have previously received.

We hope this information will help you better understand CCA Health's operations. Should you or your staff have any questions about the information contained in this manual or anything else pertaining to CCA Health, please do not hesitate to contact our Provider Services Department at 833-847-7323.

At CCA Health we value our relationships and work closely with our contracted primary care providers (PCPs), specialists, and all other providers. We look forward to working with you to meet our high quality of care standards, as well as to provide and manage cost-effective healthcare for our members.

Thank you,

CCA Health California

SECTION 1: Key Contact Information

Contact	Telephone	Fax	Email	Website/Portal
Claims				
General questions • Claim status • Payment dispute and appeal	866-333-3530			
Member Services				
General questions Member benefits • Medical • Dental • Hearing • Drug/Pharmacy • Vision • Member enrollment • Dental (*Customer service calls are delegated to Delta Dental)*	866-333-3530	866-207-6539	memberservicesCA@commonwealthcare.org	
Member Appeals & Grievances				
Member appeals Member grievances **All dental-related appeals and grievances are managed by Delta Dental. **All pharmacy related appeals are delegated to MedImpact	866-333-3530 800-330-2732 888-254-9907	866-207-6672	appealsCA@commonwealthcare.org grievances@mydeltadental.com	
Nurse/Clinician Line – 24 Hour				
• Available 24 hours a day • 7 days a week	833-378-4406 (TTY 711)			

Contact	Telephone	Fax	Email	Website/Portal
Clinical Operations				
Prior authorization and status – please contact member's assigned IPA. • AllCare IPA • Physician Partners IPA • Premiere Care Northern CA • Santa Clara County IPA • Seoul Medical Group Clinical issues and escalations	209-572-6900 657-206-8700 818-461-5000 800-977-7478 800-611-9862 877-370-2737			
Provider Services				
Provider Services • General questions • Dispute resolution • Access to care issues • Training and orientation	833-847-7323		providerservicesCA@commmonwealthcare.org	
Provider Network				
New provider enrollment and provider demographic updates. Provider contracting • Requests to become a Commonwealth Care Alliance provider, medical or behavioral health	833-847-7323		providerservicesCA@commmonwealthcare.org	
Compliance				
Concerns and reporting • Fraud, waste, and abuse and compliance concerns	844-333-2225 Compliance Hotline **anonymous**			CCA electronic submission form

Contact	Telephone	Fax	Email	Website/Portal
Hearing Benefit Administrator: Nations Hearing				
• Claims processing • Member eligibility • Provider Relations • Hearing Provider Manual NationsBenefits Attention: Claims 1801 NW 66th Avenue, Suite 100 Plantation, FL 33313	800-921-4559			Portal: https://providers.nationshearing.com
Fitness Benefit Administrator: Silver & Fit				
• Claims processing • Member eligibility • Provider Relations • Gym Assignment	877-329-2746		fitness@ashn.com (Claims)	
Vision Benefit Administrator: VSP				
• Claims processing • Member eligibility • Covered services • Provider Services • Appeals and grievances • Vision Provider Manual **In-network providers** Vision Service Plan Attention: Claim Services PO Box 385020 Birmingham, AL 35238-50	855-492-9028			www.vspproviderhub.com **Out-of-network providers** Vision Service Plan Attention: Claim Services PO Box 385018 Birmingham, AL 35238-50

Contact	Telephone	Fax	Email	Website/Portal
Pharmacy Benefit Administrator: MedImpact Healthcare Systems, Inc.				
• General questions • Prescription benefits • Prior authorization • Pharmacy redeterminations (appeals) • Mail order prescriptions	888-254-9907			
Interpreter Services				
Providers may contact the CCA Member Services department, along with the member, and they will be connected to the appropriate interpreter telephonically. • Please have the member's name and ID number available. Member Services is available during the hours of 8 am to 8 pm PST (Monday–Friday) and 8 am to 6 pm PST (Saturday and Sunday) to assist members with interpreter services.	Member Services: 866-333-3530			
Acupuncture and Chiropractic Benefit Administrator: American Specialty Health (ASH)				
• Claims processing • Member eligibility • Prior authorization submission • Provider Relations • Provider Manual American Specialty Health P.O. Box 509001 San Diego, CA 92150-9001	800-972-4226			https://www.ashlink.com/

Contact	Telephone	Fax	Email	Website/Portal
Dental Benefit Administrator: Delta Dental				
• Claims processing • Member eligibility • Prior authorization submission • Provider Relations	800-330-2732			https://www.deltadentalmi.com/Dentist Dental Provider Manual located on the Delta Dental Portal

SECTION 2: Introduction to CCA Health California

This section introduces CCA Health California and describes its mission, vision, and core values aimed toward providing the highest-quality healthcare to its members.

About CCA Health California

CCA Health California operates a Medicare Advantage plan in San Joaquin and Santa Clara Counties, offering benefits and services designed for high-need populations. The plan works closely with independent practice associations (IPAs) and community organizations to coordinate high-quality, patient-centered care that addresses the social factors that impact health and empowers individuals to make choices that align with their preferences and values.

Our Mission

Our mission is to improve the health and well-being of people with the most significant needs by innovating, coordinating, and providing the highest-quality, individualized care.

Our Vision

Our vision is to lead the way in transforming the nation's healthcare for individuals with the most significant needs.

Our Core Values

Our core values are:

- Integrity — Honor our commitment to our mission and values, holding ourselves to the highest ethical standards of behavior.
- Dignity – Respect the inherent value and personal choices of all stakeholders, including patients, members, families, colleagues, providers, advocates, and others.
- Compassion – Engage all stakeholders with empathy, caring, and understanding.
- Excellence – Exceed expectations through teamwork and innovation to deliver best-in-class service to the people we care for and the customers and providers we work with.
- Stewardship – Manage people and resources responsibly to maximize our contribution to the health of our members, patients, customers, and providers.
- Community – Advocate and support social change to promote a culture of collaboration, diversity, and inclusiveness.
- Partnership – Collaborate actively with patients, members, and providers to design and improve our care.
- Innovation – Invest in creative solutions that improve outcomes for patients, members, and providers.

SECTION 3: Definitions and Acronyms

Advance Directive:

Refers to a document(s) signed by a member that explains the member's wishes concerning a given course of medical care should a situation arise where he/she is unable to make these wishes known. Advance directives must be documented in a prominent place in the medical record for all members 18 years and older. May also be referred to as a durable power of attorney.

Agreement:

Refers to the professional services agreement provider executed with CCA Health to provide certain covered services. If there is an inconsistency between the agreement and this plan provider manual, the agreement controls.

Appeal:

The procedures that deal with the review of adverse initial determinations made by CCA Health, on health care services or benefits under Part C or D the member believes he or she is entitled to receive. This includes a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the member) or decision on any amounts the member must pay for a service or drug These appeal procedures include CCA Health's reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

Balanced Billing:

When a provider bills a member for the difference between billed charges and the CCA Health allowable charge after CCA Health pays a claim. Balanced billing is prohibited by the Medicare program.

Benefit Plan(s):

A health benefit policy or other health benefit contract or coverage document a) issued by CCA Health or b) administered by CCA Health pursuant to a government contract. Coverage is defined by and subject to the limitations and exclusions set forth in the applicable Evidence of Coverage and/or Medicare coverage rules.

Capitation:

Prepaid monthly fee paid to a Participating Physician Group (PPG)/Independent Physician Association (IPA)and in some cases, a Health Delivery Organization (HDO,) for a plan member in exchange for the provision of comprehensive healthcare services.

Centers for Medicare and Medicaid Services (CMS):

The United States federal agency that administers Medicare, Medicaid, and other government healthcare programs.

Continuous Quality Improvement:

A process that continually monitors program performance. When a quality problem is identified, a continuous quality improvement develops a revised approach to that problem and monitors the implementation and success of the revised approach. The process includes involvement at all stages by all organizations, which are affected by the problem or involved in implementing the revised approach.

Coordination of Benefits:

Allows plans that provide health or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., to determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

Corrective Action Plan:

Means a step-by-step plan of action that is developed to achieve targeted outcomes for resolution of identified errors to:

- Identify the most cost-effective actions that can be implemented to correct error causes;
- Develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient;
- Achieve measurable improvement in the highest priority areas;

- Eliminate repeated deficient practices.

Covered Services:
Medically necessary healthcare items and services covered under a benefit plan.

Downstream Entity:
A party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage (MA) benefit or Part D benefit, below the level of the arrangement between an MA Organization or applicant or a Part D plan sponsor or applicant and a first-tier entity.

Emergency Medical Condition:
As defined by CMS, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 any bodily organ or part.

Emergency medical condition status is not affected if a later medical review found no actual emergency present.

Encounter Data:
Encounter information, data, and reports for covered services provided to a member that meets the requirements for a clean claim.

Evidence of Coverage (EOC):
The document that the plan issues to members describing the coverage to which they are entitled and other applicable information. Also refers to other similar documents, including the Summary of Benefits and Disclosure form .

Grievance:
Any complaint or dispute, oral or written, other than one that involves a plan or plan-delegate adverse determination, expressing dissatisfaction by a member or authorized representative on behalf of a member, with any aspect of the operations, activities, or behavior of CCA Health or its providers and delegates, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of covered services.

Health Employer Data and Information Set (HEDIS®):
Refers to a set of standard performance measures that provides information about the quality of care provided by a health plan.

Health Maintenance Organization (HMO):
A healthcare service plan that requires its members to use the services of designated physicians, hospitals, or other providers of medical care except in a medical emergency. HMOs have a greater control of utilization and typically use a capitation payment system.

Independent Practice Association (IPA):
A provider that is a contracted independent practice association.

Medically Necessary or Medical Necessity:
Those covered services that are:

- Necessary for the diagnosis or treatment of a medical condition;
- Provided in a manner consistent with professionally recognized standards of healthcare;
- Requested and authorized in accordance with applicable CCA Health Medical Policy and other administrative requirements of the DMHC, the DHCS, the CMS or other regulatory agencies
- The most appropriate supply or level of service, that can be safely provided

- Not provided primarily for the convenience of a member, the member's family, a hospital, or the member's hospital provider.

If this definition conflicts with a definition of medically necessary services required by any regulatory agency that oversees contracted CCA Health operations, that regulatory definition shall supersede the above definition.

National Committee for Quality Assurance (NCQA):

An independent non-profit organization in the United States that works to improve healthcare quality through the administration of evidence-based standards, measures, programs, and accreditation.

Non-covered Service:

A service that 1) does not meet the requirements of a Medicare benefit category, 2) is statutorily excluded from coverage on grounds other than Section 1862(a)(1), or 3) is not reasonable or medically necessary under Section 1862(a)(1).

Out-of-Network Provider:

A non-network healthcare services provider that does not have an agreement with the plan. Also referred to as a "non-network" or "non-contracted" provider.

Plan:

CCA Health California ("CCA Health" or the "Plan").

Provider Manual: This document sets forth the operational rules applicable to plan providers and which is updated by the plan at least annually. The manual also provides guidelines for the provision of covered services to the plan's members. The manual contains applicable policies, procedures, references and resources, and information regarding the standards of care that are required of plan providers.

Primary Care Provider (PCP):

A physician chosen by or assigned to a member and who both provides primary care and acts as a gatekeeper to control access to other medical services. Other care providers may be included as primary care providers such as those in General and Family Medicine, Internal Medicine, Obstetrics/Gynecology, Geriatricians, and Pediatricians. Also includes nurse practitioners and physician assistants, as allowed by state scope of practice regulations.

Prior Authorization (PA):

Approval that a provider must obtain from a MA plan or delegated entity of an MA plan for coverage of certain covered services. Also referred to as "authorization" or "precertification".

Provider:

Professional individuals and entities, including PPGs/IPAs and HDOs, contracted, directly or indirectly, with CCA Health, to provide or arrange for the provision of covered services to members under a benefit plan.

Provider Dispute Resolution (PDR): A formal process for receiving, resolving, and reporting provider disputes (appeals) for MA claims relating to payment of non-contracted provider claims. PDRs must include clear identification of the disputed item(s), the date(s) of service, and a clear explanation of the basis upon which the provider believes the payment amount is incorrect. A non-contracted PDR must be adjudicated within 30 calendar days from the earliest date received.

Referral:

The process by which a provider refers a member to another provider for covered services.

Referred Services:

A covered service, performed by a referred-to provider, that is: 1) authorized in advance by a PCP, the plan, or a PPG/IPA and 2) limited in scope, duration or number of services, as authorized. Also refers to any specialty, inpatient, outpatient, or laboratory services that are ordered or arranged, but not furnished directly. Referred services depend on the agreement regarding who is at financial risk.

Service Area:

A geographic area where the plan is licensed to market, enroll members, and provide covered services through its benefit plans.

Special Enrollment Period (SEP):

Under Medicare law, a Special Enrollment Period (SEP) allows you to enroll in Medicare Part B outside of your Initial Enrollment Period (IEP) and the General Enrollment Period (GEP).

Specialist Physician (Specialist):

Refers to a contracted physician who is professionally qualified to practice his/her designated specialty and delivers specialized services and supplies to a member.

Standing Referral:

Members with certain life-threatening, degenerative, or disabling conditions or a disease requiring specialized medical care over a prolonged period of time, which may be allowed a standing referral, upon approval. A standing referral allows a member access to a specialist and/or specialty care services from a provider with expertise in treating the medical condition or disease that requires ongoing monitoring.

Urgent Services:

Those covered services rendered outside of the PCP's service area (other than emergency services), which are medically necessary to prevent serious deterioration of a member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the member returns to the PCP's service area. Also referred to as "urgent care".

Utilization Management (UM):

The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a provider or member in cooperation with other parties, to help ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning, and case management.

SECTION 4: Provider Rights and Responsibilities

Provider Rights

As a plan provider, you have a right to:

- Receive payment in accordance with applicable laws and applicable provisions of your agreement.
- File a provider dispute or appeal.
- Rely on eligibility information provided by CCA Health about any particular member.

Provider Responsibilities

As a plan provider, you must comply with the following Medicare requirements, in addition to other plan requirements, when providing services to our members.

- You may not discriminate against members in any way based on health status.
- You must allow members to directly access screening mammography and influenza vaccination services.
- You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services. For more information, see the member's benefits plan.
- You may not bill a Medicare member for the difference between billed charges and the CCA Health allowable charge after CCA Health pays a claim. This is known as balance billing, and it is prohibited by Medicare.
- You must provide female members with direct access to a women's health specialist for routine and preventive healthcare services.
- You must make sure that members have adequate access to covered services.
- You must make sure that your hours of operation are convenient to members and do not discriminate against members.
- You must make sure that medically necessary services are available to members 24 hours a day, 7 days a week.
- PCPs must have backup for absences.
- You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
- You must provide services to members in a culturally competent manner, taking into account Limited English Proficiency or reading skills, hearing or vision impairment, and diverse cultural and ethnic backgrounds.
- You must cooperate with plan procedures to inform members of healthcare needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member's medical record whether they have executed an advance directive.
- You must provide covered services in a manner consistent with professionally recognized standards of healthcare.
- You must make sure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must comply with all applicable federal and Medicare laws, regulations, and CMS instructions. These include, but are not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse e.g. applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.
- The payments that you receive from us or on behalf of us are, in whole or in part, from federal funds and you are therefore subject to certain laws applicable to individuals and entities receiving federal funds.

- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the MA program, and all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- You must cooperate with our processes for notifying members of network participation agreement terminations.
- You must submit to us all risk adjustment data as defined in 42 CFR 422.310(a), and other MA program-related information as we may request, within the timeframes specified and in a form that meets MA program requirements. By submitting data to us, you represent to us, (and upon our request you shall certify in writing) that the data is accurate, complete, and truthful, based on your best knowledge, information, and belief.
- You must comply with our MA medical policies, Quality Improvement Programs, and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance, and other indicators as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals, and expedited appeals. This includes, but is not limited to, providing requested medical records within 2 hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.

SECTION 5: Provider Network Operations

The CCA Health Provider Network Operations department is dedicated to educating, training, and ensuring all participating providers and PPGs/IPAs have a resource to voice any concern they may have.

As an active liaison between CCA Health and the external provider network, the CCA Health Provider Network department will promote positive communication, facilitate the exchange of information, and seek efficient resolution of provider issues.

CCA Health encourages you to make recommendations and suggestions to better serve our members and to improve the processes within our organization through open discussions and meetings.

Orientation

Providers

Where applicable, the plan's PPGs and IPAs are responsible for conducting provider training and orientation to their contracted providers with regard to CCA Health within 30 calendar days of contracting with the PPG or IPA regardless of effective status with CCA Health. All CCA Health direct contract providers will receive directly from by CCA Health.

CCA Health Provider Network Operations staff will also conduct provider training to PPG and IPA contracted providers as needed for various items. These training will be coordinated and scheduled in advance with the provider and provider staff. Depending on the nature of the training and education, prior notification will be given to the PPGs and IPAs.

PPGs and IPAs

The CCA Health Provider Network Operations staff will conduct orientations to educate new PPGs and IPAs on plan operations, policies, and procedures.

Communication and Outreach

The fastest and preferred way for CCA Health to communicate with you is electronically. Any news or updates regarding policy, product, or reimbursement changes are posted on the Provider Portal at https://vhpprovider.prod.healthaxis.net. We also use multiple other channels, including mail, email, phone, and fax to alert you to new, changed, or updated protocols, policies, programs, and administrative procedures. In the event a protocol changes or is modified, if possible, we notify you prior to implementation in accordance with your agreement with CCA Health, and in accordance with state and federal law.

Joint Operation Committee Meetings (PPG/IPA only)

Joint Operation Committee meetings are conducted by CCA Health Provider Network Operations department at least annually or as needed. This allows monitoring and oversight of delegated responsibilities, assists in maintaining ongoing communication, and ensures effective problem resolution between CCA Health and the PPGs and IPAs. Documentation of attendees and issues discussed will be maintained by CCA Health and shared with the PPGs and IPAs.

Participating Providers

Primary Care Provider (PCP)

The member's chosen or assigned PCP is required to provide and coordinate all routine healthcare services and preventive care. The PCP is also responsible for making referrals to specialists, HDOs, and other providers in the CCA Health network, as medically necessary.

Specialist

The CCA Health network provides a comprehensive range of specialists in multiple locations. As part of CCA Health pre-contractual process, a complete specialist network deemed by state and federal regulatory is required to cover the PPGs/IPAs service area. In order to identify and communicate any deficiencies to the PPG or IPA CCA Health will monitor the specialty network.

Specialist as PCP

For women, an OB/GYN may serve as the designated PCP if the OB/GYN agrees to serve in that capacity.

Ancillary Providers and Hospitals

Ancillary providers and hospitals may become affiliated with CCA Health through a contracted PPG/IPA or through a direct contract. The affiliation will depend on the contractual agreement and delegation of services between CCA Health and the PPG or IPA.

Referrals

Plan PCPs may refer members for specialist services when medically necessary. Referrals must be entered into the authorization system or via the designated process set forth by the PPG/IPA and CCA Health, with the exception of services established as no prior authorization required under the direct referral process. Please refer to CCA Health provider forms and referrals link for Authorization Requirements, for the listing of these services.

Referring providers are responsible for ensuring all relevant medical information is sent to the referred to provider. The referral, as well as denial or acceptance of the referral, must be documented in the member's medical record by both the referring provider and the referred to provider. The specialist is required to send, in a timely manner, a completed consultation report to the members PCP. After the PCP reviews the results of the consultation and the specialist recommendations, the PCP may request additional treatment authorization if clinically indicated by the specialist.

Ancillary Referrals

As appropriate and medically necessary, providers should refer members to plan and/or PPG/IPA preferred ancillary providers, including but not limited to, ambulatory surgery centers, skilled nursing facilities (SNF), dialysis centers, durable medical equipment (DME), ambulance providers, and home infusion providers.

Except for those covered services provided in the home, please keep in mind that to ensure appropriate access and availability for our members, referred providers should be located within 15 miles, or 30 minutes, of the member's home or work and have the capacity to render such service(s). If none of the providers meet these geographic and capacity requirements, PPGs/IPAs may refer to non-contracted ancillary providers; however, prior authorization must be sought and received before covered services are rendered.

Credentialing and Re-credentialing

CCA Health and/or its delegated entities, credentials and recredentials providers who have an independent relationship with the plan and provide care under CCA Health's PPGs/IPAs. Credentialing and recredentialing requirements are applied to all licensed practitioners contracted with CCA Health and its delegated entities, including non-physician medical practitioners, where applicable.

CCA Health requires every applicable provider, including applicable HDOs, to be credentialed according to the appropriate standards before delivering care to plan members. Credentialing and recredentialing standards used by CCA Health and its delegates are compliant with applicable federal and state requirements, the CCA Health's contract with CMS, and applicable accreditation standards.

Provider Information and Changes

Providers and/or the PPGs/IPAs must provide CCA Health with provider information and status changes in accordance to the timelines and with the information listed below.

Demographic/Administrative Changes

Demographic or administrative changes, such as office location, hours, email, telephone and fax numbers, billing address, tax identification number, board status, key contact person, etc., must be reported to CCA Health at least 60 days

before the change takes effect. This will ensure CCA Health is compliant with the CMS policy of 30-day prior notice to affected members. An updated provider profile must be submitted with your formal request for change.

Once the new office address is updated members will be transferred from the existing site to the new site. If the new office address is located outside the geographic service area, CCA Health will coordinate with the PPG/IPA to reassign the member(s) to a new PCP within the service area. In transferring members, the provider's location, specialty, and language are taken into consideration. If the PPG/IPA is unable to meet this requirement, members will be transferred to a PCP in the geographical area of the former office location.

Provider Additions

New providers must be reported to CCA Health at least 30 days prior to the date that a new provider is added to the PPG/IPA or other plan delegate. In order to move forward with a provider, and add them to the CCA Health network, the provider credentialing packet that includes all required information (which may vary depending on whether the credentialing is delegated) must also be sent to CCA Health at least 30 days in advance. This will include the provider profile, W9, and first page and signature page of the contract.

PCP Terminations

Per CMS requirement, CCA Health will provide affected members at least 30 calendar days' advance written notice of their PCP's termination. CMS considers "enrollees who are patients seen on a regular basis by the provider whose contract is terminating" to be "affected enrollees." An "affected enrollee" is an enrollee who is assigned to, currently receiving care from, or has received care within the past three months from a provider or facility being terminated. The following are requirements for a PCP termination notification:

- The PPG/IPA must provide at least 90 days' advance written notice of a termination in accordance with CCA Health agreement and the 1997 Balanced Budget Act. Notification should include the termination date, reason for termination, terminating PCP's information and National Provider Identifier ("NPI") or California license number, and the name and ID number of the PCP that the PPG/IPA wishes the member(s) to be transferred to, if applicable. If the PPG/IPA wants the impacted member(s) reassigned to specific PCPs, they should provide CCA Health with that information at the time of the notification of termination. CCA Health will strive to accommodate such requests subject to the member's right to make a final PCP selection. Incomplete requests may be returned to the PPG/IPA.
- In instances where a PCP joins a new PPG/IPA without terminating from their present PPG/IPA, member transfers can only be initiated by the member, even if requested by the PCP. CCA Health cannot transfer members, at the PCP's request, when the PCP belongs to more than one PPG/IPA. Per the above, CCA Health will transfer the PCP's current membership to a new PPG/IPA in cases where the PCP terminates from one PPG/IPA and is affiliated with or joins another plan PPG/IPA within the same geographic location. A member may choose to stay with their current PPG/IPA for any number of reasons, including choice of specialists, location, preference for the PPG/IPA, preference for the affiliated hospital, etc.
- In very limited circumstances (see below), the PPG/IPA may be unable to provide advance notice of a PCP termination. In such circumstances, CCA Health must notify the impacted members to expedite a transfer to a new PCP.
- The limited circumstances or exceptions referenced above include:
    - Death
    - Revocation of medical license or Medicare sanction and debarment
    - "Grossly unprofessional conduct", which includes any criminal or fraudulent acts (e.g., allegations of molestation or abuse).
    - PCP relocation out of the area without adequate notice.
    - The PCP is an employee of a PPG/IPA and quits effective immediately. As a result, the PCP does not have an office available where he or she may treat members.

- The PCP is an employee of a PPG/IPA and their employment is terminated effective immediately.
- In instances when a PCP terminates immediately, CCA Health will attempt to contact each affected member via telephone (if possible) and/or via a member letter, using a CMS approved letter template explaining the situation and facilitating the member's assignment to a new PCP. CCA Health will also facilitate members when continuity of care issues are identified, such as pending referrals, hospitalization, needed immediate visits.
- If the PPG/IPA does not provide CCA Health with 90 days written notice and the termination reason does not qualify as one of the limited circumstances listed above, notification will be given to the PPG/IPA indicating they are not complying with the 90-day advance notice requirement. CCA Health will reiterate in the letter that the member transfers will not become effective until the first of the month following 90 days notification to CCA Health. Until that time, the PPG/IPA is responsible for making arrangements with the terminating provider to continue rendering medical services to members.

Specialist Provider Termination

The PPG/IPA and CCA Health direct contracts are required to send written notification for all provider terminations to the CCA Health Provider Network department upon knowledge of the termination and at a minimum of 60 days in advance of the proposed date of termination. The change shall become effective the first of the next consecutive month from the date of receipt in order to comply with the 30-day prior notification to affected members. CMS considers "enrollees who are patients seen on a regular basis by the provider whose contract is terminating" to be "affected enrollees." An "affected enrollee" is an enrollee who is assigned to, is currently receiving care from, or has received care within the past three months from a provider or facility being terminated. For continuity of care purposes, CCA Health retains the right to obligat e the PPG/IPA to provide medical services for existing members until the effective date of termination according to the terms of its contract with the PPG/IPA. The PPG/IPA is responsible for transition of care for all members of terminated providers.

If the PPG/IPA group does not provide CCA Health's affected members with 60 days advance written notice, the PPG/IPA is responsible for ensuring the specialists continues to provide covered services to affected members until a 60-day advance notice of the termination is given.

Provider Panel Status Changes

Providers are required to notify CCA Health of any provider panel status changes within five business days of:

- Any provider who is no longer accepting new patients or existing patients (closed panel)
- Any provider who is no longer accepting new patient and only accepting existing patients
- Any provider who was previously not accepting new/existing patients and is now open to new/existing patients (open panel)
- A provider who is now available by referral only
- A provider who is available only through a hospital or facility
- Any provider who has a reduction, suspension, or termination of privileges

A PPG/IPA plan physician who is not accepting new patients and is contacted by a CCA Health member or potential CCA Health member seeking to be assigned shall direct the CCA Health member or potential member to CCA Health to find a PPG/IPA plan physician who is accepting new patients.

Changes in PPG/IPA and Other Delegate Management Services Organizations (MSO)

PPGs/IPAs and other plan delegates must provide a 90 day advance written notification of a change in their MSO along with a copy of the executed contract between the PPGs/IPAs and other plan delegate and the new MSO to CCA Health Provider Network Operation department.

The new MSO must meet the CCA Health's pre-contractual criteria, which include on-site audits, MSO's policies and procedures for claims, credentialing, health education, and utilization management functions. If the new MSO does not meet the criteria, the MSO is responsible for submitting a corrective action plan. Failure of the PPG/IPA and other plan delegate to comply will result in panel closure of all providers.

Change in Provider's PPG Affiliation

In contracted counties where CCA Health is contracted with multiple PPGs/IPAs a PCP may change their PPG/IPA affiliation by submitting written notification of their change request to the PPG/IPA that the PCP wishes to change from in accordance with their contractual agreement. A separate request is also sent by the PCP to CCA Health along with a copy of the notification sent to the PPG/IPA.

CCA Health Provider Network department will validate the information with the PPG/IPA the PCP wishes to change from in writing via certified mail. If the PPG/IPA provides no response, CCA Health will process the request in accordance with the member notification policy. The PPG/IPA that is terming will be notified of the effective date of the change and will be financially responsible for any covered services provided through the effective date of the transfer.

After Hours, Back-up Coverage, Leave of Absence, and Vacation

PCP's and the PPGs/IPAs must provide adequate coverage for providers on leave of absence or on vacation. All PCP's or their covering providers must provide telephone access 24 hours a day, 7 days a week so that they can appropriately respond to members and other providers concerning after-hours care.

When PCPs are not available to provide service to members, effective coverage must be arranged through another practitioner who is a PCP in the CCA Health network. A coverage plan must be submitted to the CCA Health Provider Network Operations department for any absences greater than four weeks. Absences over 90 days may require the transferring of members to another CCA Health PCP.

Provider Directory

CCA Health is required to maintain and provide an accurate provider directory. To comply with this requirement, we must rely on our provider partners to give us real-time provider roster information. We are required to audit and validate our provider network data and directory on a routine basis. CCA Health encourages all providers to review their information in the directory and to report/submit any changes to their contracted PPG/IPA or directly to the CCA Health Provider Network Operations department.

CCA Health conducts a quarterly roster verification process that ensures the provider network and contact information is accurately reflected in our provider data system.

Additionally, our validation efforts may include reaching out to our provider partners using a vendor partner. Outreach to network providers may include the use of fax, email, mail, or phone calls. Providers are required to provide timely responses to these communications.

Access and Availability Standards

CCA Health has established access and availability standards for its delivery network that meet the applicable regulatory and/or accreditation requirements. These standards ensure that the CCA Health provider network has adequate capacity and availability of providers to meet our member's healthcare needs.

CCA Health assesses organization-wide and practice-specific performance against the network access and availability standards. The findings are evaluated and reported to the Quality Management Committee. Corrective action plans are developed, implemented, and monitored as needed.

CCA Health's access and availability standards are provided to all providers and members through various media sources including, but not limited to the Provider Manual, Provider Newsletter, plan website, and EOC.

Geographic Access

CCA Health has established a process and standards for assessing and ensuring that its healthcare delivery network has available professional, hospital, emergency, and ancillary services providers that provide primary care, specialty care and behavioral health (BH) care, in sufficient numbers and in an adequate geographic distribution to meet the needs of its members.

CCA Health's access to care standards provide that no member be required to travel any unreasonable distance or for any unreasonable period of time in order to receive covered services. For the purposes of these standards, "reasonable" is determined by analysis of the following factors:

- The population density of the geographic area traveled.
- Typical patterns of traffic congestion throughout the day.
- Established travel patterns in the community.
- Established patterns of medical practice in the community.
- Natural boundaries and geographic barriers to travel.
- Any other relevant factors.

Timely Access

Timely access standards reflect the timeliness with which a member can obtain covered services for routine/regular care, routine specialty care for non-urgent conditions, emergency care, urgent care, after-hours care, behavioral health care, and ancillary services. The standards also define appropriate waiting times for a member to speak with a plan and provider representative.

Applicable providers are required to be available to render emergency care to members 24 hours a day, 7 days a week, either directly or through arrangements for after-hours coverage with an appropriately qualified provider. Providers may provide care in their offices or based on the medical necessity of the case, refer the member to an urgent or emergency care facility. CCA Health or their delegates have a nurse on call to arrange for care if a provider is unavailable. If a member contacts CCA Health about an emergency situation, CCA Health will direct the member to an appropriate urgent or emergency care center for immediate assessment and treatment. After-hours access issues will be referred to Quality Management as a potential quality issue and handled in accordance with applicable policies and procedures.

These standards help ensure that the hours of operation of our providers are convenient to and do not discriminate against the member. Hours of operation should be no less available than hours offered to other patients; and plan services should be available 24 hours a day, 7 days a week, when medically necessary.

Primary Care* Timely Access Standards			
Appointment Type	**Access Standard****	**Additional Information**	**Goal Rate of Compliance**
Emergency Care	Immediate	When a member calls the provider's office with an emergency medical condition, the provider must arrange for the member to be seen immediately (preferably by directing the member to the emergency room or calling 911). If the condition is a non-life-threatening emergency, it is the still preferable for the member to be given access to care immediately but no later than within six hours.	100%
Urgent Care: No PA Required	Within 48 hours	When a member contacts the provider's office with an urgent medical condition, we require that the member be seen within these timeframes. We strongly encourage the provider to work the member in on a walk-in basis the same day. If a situation arises where a provider is not available (e.g., the practitioner is attending to an emergency or the member calls late on a Friday), the member should be seen by a covering provider or directed to an urgent care, covering office, or emergency room, as medically necessary.	90%
Urgent Care: PA Required	Within 96 hours	See information in "Urgent Care: No PA Required" section above.	90%
Sensitive Services	Preferably within 24 hours, but not to exceed 48 hours	Sensitive services are those related to: • Sexual assault • Drug or alcohol abuse for minors 12 years of age or older • Pregnancy • Family planning • Sexually transmitted diseases, for minors 12 year of age or older • Outpatient mental health treatment and counseling, for minors 12 years of age or older, who are mature enough to participate intelligently and where either 1) there is a danger of serious physical or mental harm to the minor or others, or 2) the children are the alleged victims of incest or child abuse. Minors, as noted by the age restrictions above, may receive these services without parental consent. Confidentiality must be maintained in a manner that respects the privacy and dignity of the individual. See your PPG/IPS's privacy and confidentiality policies for guidance.	90%

Primary Care* Timely Access Standards			
Appointment Type	**Access Standard****	**Additional Information**	**Goal Rate of Compliance**
Routine PCP, Non-urgent Exam	Within10 days	When a member requests an appointment for a routine, non-urgent condition (e.g., routine follow-up of blood pressure, diabetes, or other condition), they must be given an appointment within 10 business days.	85%
Initial Pre-natal Visit to OB/GYN	Within 14 calendar days	Access to OB/GYN providers is available without prior authorization.	85%
Well-Child Visits (for child under two years of age)	Within 14 calendar days	When a parent of a member requests an appointment for a well-child visit, they must be given the appointment within 14 calendar days. It is acceptable for the member to be scheduled with a covering provider.	85%
Preventive Care and Physical Exam	Within 3 calendar days		90%
Initial Health Assessment	Within 30 calendar days	Must be completed within 90 calendar days from when member becomes eligible	100%
Provider Business and After-Hours Telephone Screening	Available 24 hours a day, 7 days a week Call must be returned within 30 minutes.	The plan and its PPGs/IPAs also have 24/7 Nurse Advice Lines available through a toll-free phone line to support and assure compliance with coverage and access. Urgent and emergent calls must be handled by the provider or their on-call coverage within 30 minutes. Clinical advice can only be provided by appropriately qualified staff (e.g., physician, physician assistant, nurse practitioner, or registered nurse). Any provider that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.	100%

Primary Care* Timely Access Standards			
Appointment Type	**Access Standard****	**Additional Information**	**Goal Rate of Compliance**
Nurse Advice Line	Available 24 hours a day, 7 days a week Call must be returned within 30 minutes.	Clinical advice can only be provided by appropriately qualified staff (e.g., physician, physician assistant, nurse practitioner, or registered nurse).	100%
Plan Business Hours Telephone Access	During normal business hours, call wait time not to exceed 10 minutes. Call backs not to exceed 30 minutes.		85%
Provider Office Waiting Time	Not to exceed 15 minutes		85%
Missed appointments	Reschedule attempt no greater than 48 hours after missed appointment	Missed appointments must be documented in the medical record the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours. Repeated missed appointments could result in referral for case management. Providers' offices are responsible for counseling such members.	90%

* For purposes of these standards, primary care providers are all practitioners providing primary care to our members, which includes, General Practice, Internal Medicine, Family Practice, Pediatrics, NPs, PAs, select OB/GYNs, and other specialists, as assigned.

** Exceptions: The applicable waiting time for a particular appointment may be extended if the referring or treating provider when providing triage, or screening services, acting within the scope of their practice and consistent with recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

Specialist/Ancillary Care* Timely Access Standards			
Appointment Type	**Access Standard****	**Additional Information**	**Goal Rate of Compliance**
Emergency Care	Immediate	When a member calls the provider's office with an emergency medical condition, the provider must arrange for the member to be seen immediately (preferably by directing the member to the emergency room or calling 911). If the condition is a non-life-threatening emergency, it is the still preferable for the member to be given access to care immediately but no later than six (6) hours.	100%
Urgent Care: No PA Required	Within 48 hours	When a member contacts the provider's office with an urgent medical condition, we require the member to be seen within these timeframes. We strongly encourage the provider to see the member on a walk-in basis the same day. If a situation arises where a provider is not available (e.g., the practitioner is attending to an emergency or the member calls late on a Friday), the member should be seen by a covering provider or directed to an urgent care, covering office, or emergency room, as medically necessary.	90%
Urgent Specialist Care: PA Required	Within 96 hours	See information in Urgent care: No PA Required section above.	90%
Routine Specialist Care, Non-urgent	Within 15 days	When a member requests an appointment for a routine, non-urgent condition, they must be given an appointment within 15 business days.	85%

Routine Ancillary Care, Non-urgent	Within 15 days	When a member requests an appointment for a routine, non-urgent condition, they must be given an appointment within 15 business days.	85%
Provider Business and After-Hours Telephone Screening	Available 24 hours a day, 7 days a week Calls must be returned within 30 minutes	The plan and its PPGs/IPAs also have 24/7 Nurse Advice Lines available through a toll-free phone line to support and assure compliance with coverage and access. Urgent and emergent calls must be handled by the provider or the “on-call” coverage within 30 minutes. Clinical advice can only be provided by appropriately qualified staff (e.g., physician, physician assistant, nurse practitioner, or registered nurse). Any provider who has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.	100%
Provider Office Waiting Time	Not to exceed 15 minutes		85%
Missed Appointments	Reschedule attempts no greater than 48 hours after missed appointment	Missed appointments must be documented in the medical record the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours. Repeated missed appointments could result in referral for case management. Providers’ offices are responsible for counseling such members.	90%

*Includes behavioral and mental health providers.

** Exceptions: The applicable waiting time for particular appointment may be extended if the referring or training provider, when providing triage or screening services, acting within the scope of their practice and consistent with recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

SECTION 6: Member Services and Appeals and Grievances

Covered Benefits

The benefit designs associated with the CCA Health Medicare Advantage plan that is offered to our members are described and can be located in the Summary of Benefits and the Evidence of Coverage. These documents are available on the CCA Health website at commonwealthcarealliance.org/ca/.

Member Rights

Plan members have the right to:

- Receive understandable information about CCA Health, its services and covered benefits (including member cost-sharing), its network of providers and their rights and responsibilities;
- Be treated with respect and recognition of their dignity;
- Participate with their providers in making decisions about their healthcare;
- Have a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit plan coverage;
- Refuse treatment, including any experimental treatment, and be advised of any probable consequences of their decision;
- Have their provider or other healthcare professional request their consent for all treatment unless there is an emergency, they are unable to sign a consent form, and their health is in serious danger;
- Receive Medicare covered services in an emergency;
- Be protected from discrimination;
- Voice a complaint or appeal about CCA Health, its providers, or the care they are provided and initiate a grievance procedure if they are not satisfied with a decision regarding their complaint or appeal;
- Make recommendations regarding CCA Health's member rights and responsibilities policy;
- Receive assistance in a prompt, courteous, responsible and culturally competent manner;
- Choose an available contracted PCP;
- Receive timely access to the records and information that pertain to them;
- Have their personal and health information kept private;
- Know how their providers are paid;
- Have an advance directive to designate the kind of care they wish to receive should they become unable to express their wishes

Member Responsibilities

Plan members have the responsibility to:

- Pay premiums in a timely manner;
- Know their benefits prior to receiving treatment and follow the policies and procedures regarding obtaining services;
- Notify CCA Health if they have additional health insurance coverage;
- Notify providers when seeking care that they are MA plan members, show their ID card before receiving services, and protect against the wrongful use of their identity for use by another person;
- Keep scheduled appointments and pay any necessary cost-share at the time they receive treatment or promptly when billed;

- Treat their provider and their staff and plan staff with respect and dignity and not be disruptive in their provider's office;
- Express their questions, opinions, concerns, and complaints to CCA Health or its providers;
- Supply information (to the extent possible) that CCA Health or providers need in order to provide their care;
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;
- Follow plans and instructions for care that they have agreed to with their providers.

Advance Directives and Physician Orders for Life-Sustaining Treatment (POLST)

Advanced Directives

An advance directive is a written instruction recognized under California and/or federal law, such as a living will or a durable power of attorney for healthcare. An advance directive allows members to appoint a representative to make healthcare decisions on their behalf. Contact your PPG's/IPA's compliance or legal departments for more detailed and complete information on advance directives.

Providers and members may find more information about advance directives at the California Secretary of State's website here: https://www.sos.ca.gov/registries/advance-health-care-directive-registry/.

They may use the form available from the California Attorney General's office at https://oag.ca.gov/system/files/media/ProbateCodeAdvanceHealthCareDirectiveForm-fillable.pdf, and learn more information from CMS here: https://www.medicare.gov/manage-your-health/advance-directives-long-term-care.

POLST

A POLST form is a document that the member's provider completes with the input of the member or their decision-maker. It documents the member's choices about resuscitation, medical interventions, the use of antibiotics, and the use of artificially administered fluids and nutrition.

The POLST is a physician's order form that outlines a plan of care that reflects the member's wishes concerning end-of-life care. It is voluntary and is intended only for people who are seriously ill. It can be revoked by the member at any time. The form can assist physicians, nurses, HDOs, and emergency personnel in honoring the member's wishes for life-sustaining treatment.

The POLST form complements the advance directive and is not intended to replace that document. Information on the POLST form should be incorporated into the member's medical record. For more information on the POLST, visit: https://capolst.org/.

Complaints, Grievances, and Appeals

CMS requires that all MA plans establish and maintain meaningful procedures for timely resolution of member and provider appeals and grievances, on both an expedited and standard basis. The following chart describes appeals, grievances, and a summary of the applicable turn-around-times.

MA Appeals

An appeal is a formal written request to CCA Health for reconsideration of a medical or contractual adverse decision. Examples include but are not limited to reconsideration of a pre-service denial, determination of a copayment amount, or, in the case of Part D benefits, a redetermination of a drug denial based on medically accepted off-label use.

Members and their authorized representatives may file an appeal. Under Part C, the right of appeal of an organization determination belongs solely to the member. However, CMS allows a provider who is providing treatment to a member, upon providing notice to the member, to request reconsideration on the member's behalf. In such a case, the provider is not required to submit proof that they are the member's representative.

With respect to Part D coverage determinations, the member's prescribing provider may request a redetermination of a coverage determination on behalf of the member. Notice to the member may be required, depending on the circumstances.

To file a request for reconsideration/redetermination on behalf of a member under either Part C or D, contact CCA Health Member Services at 866-333-3530.

Standard Appeal

An appeal must be submitted in letter form on your office letterhead describing the reason(s) for the appeal and the clinical justification/rationale.

Please be sure to include:

- Member name and identification number
- Claim number
- Admission and discharge dates (if applicable) or date(s) of service
- A copy of the original claim or Explanation of Benefits ("EOB") denial information and/or denial letter/notice
- Supporting clinical notes or medical records including lab reports, X-rays, treatment plans, progress notes, etc.

Written Appeals should be mailed or faxed to:

CCA Health California
Appeals & Grievance Department
18000 Studebaker Road, Suite 150
Cerritos, CA 90703

Fax: 866-207-6672

An appeal must be submitted within 180 days from the date of the Explanation of Benefits (EOB) or Adverse Decision Notice. All appeal decisions are answered in writing. Please allow the following turn-around-times for a response to a standard appeal:

- Pre-service reconsideration (appeal): 30 days (a 14-day extension may be allowed)
- Post-service payment reconsideration (appeal): Within 60 days
- Part D redetermination (appeal): Within 7 days

Expedited or Fast Appeal

An expedited or fast appeal is a request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a provider with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

- We will answer an expedited or fast appeal within 24 to 72 hours from the date the appeal is received, depending on the type of expedited appeal.
- Retrospective or post-service denials are not eligible for expedited appeal review.

An expedited appeal may be requested in writing, or by calling or faxing, CCA Health Member Services department at 866-333-3530 or Fax to 866-207-6672.

If you, as the member's provider, provide a written or oral supporting statement explaining that the member requires an expedited appeal, then it is automatically granted to the member. If the member or their authorized representative requests an expedited appeal without support from their provider, CCA Health will determine if the member's health requires an expedited decision. If a request for an expedited appeal is denied, the standard appeal process applies.

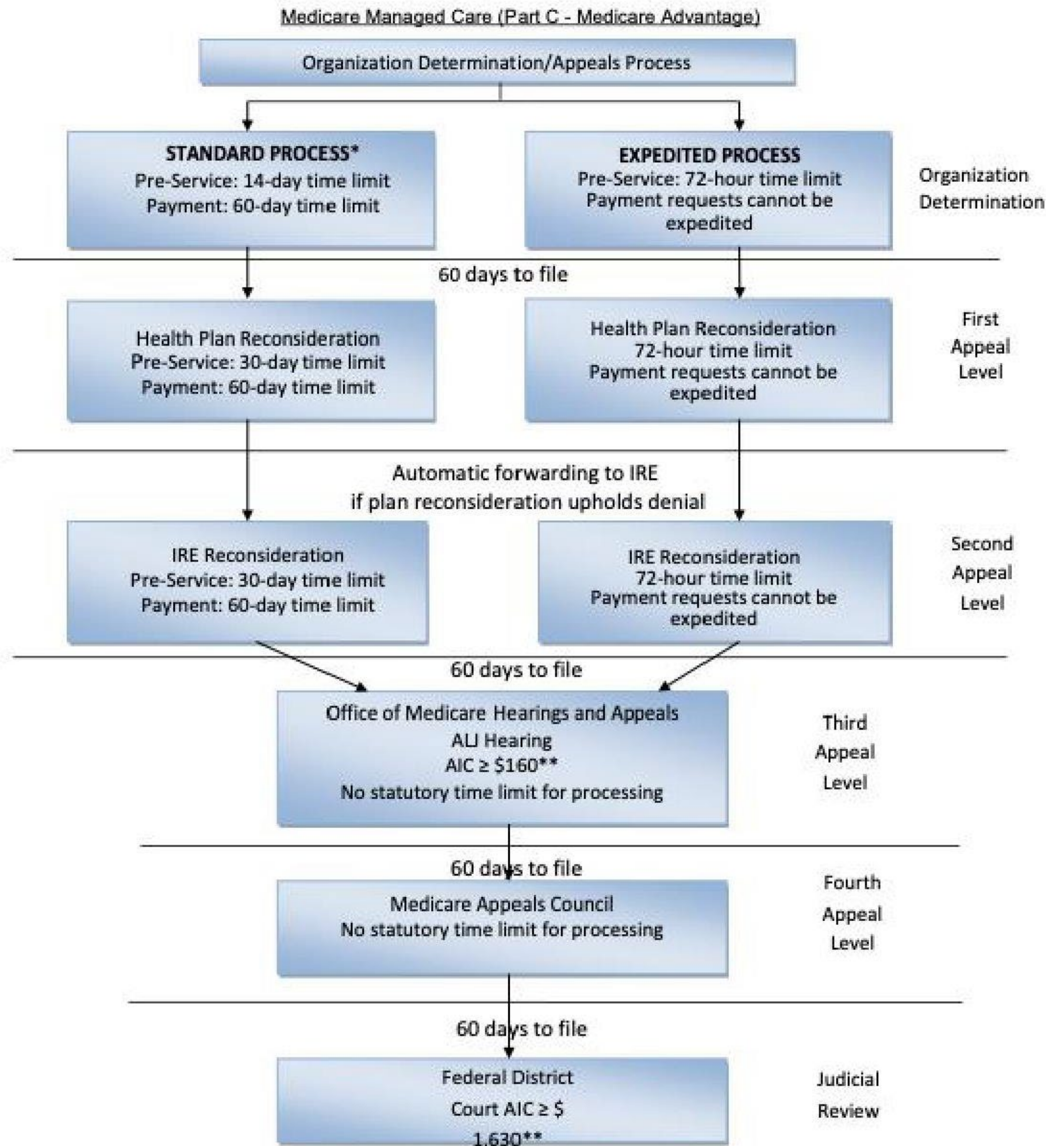
Appeal Resolution

Once the internal appeal process is complete, you will receive a written decision that will include the following information:

- The specific reason for the appeal decision;
- A reference to the specific benefit provision, guideline protocol or other criteria on which the decision was based;
- A statement regarding the availability of all documents, records or other information relevant to the appeal decision that is available free of charge, including copies of the benefit provision, guideline, or protocol on which the decision was based;
- Notification that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided free of charge upon request;
- Contact information regarding a state consumer assistance program;
- Information regarding the next level of appeal, as appropriate

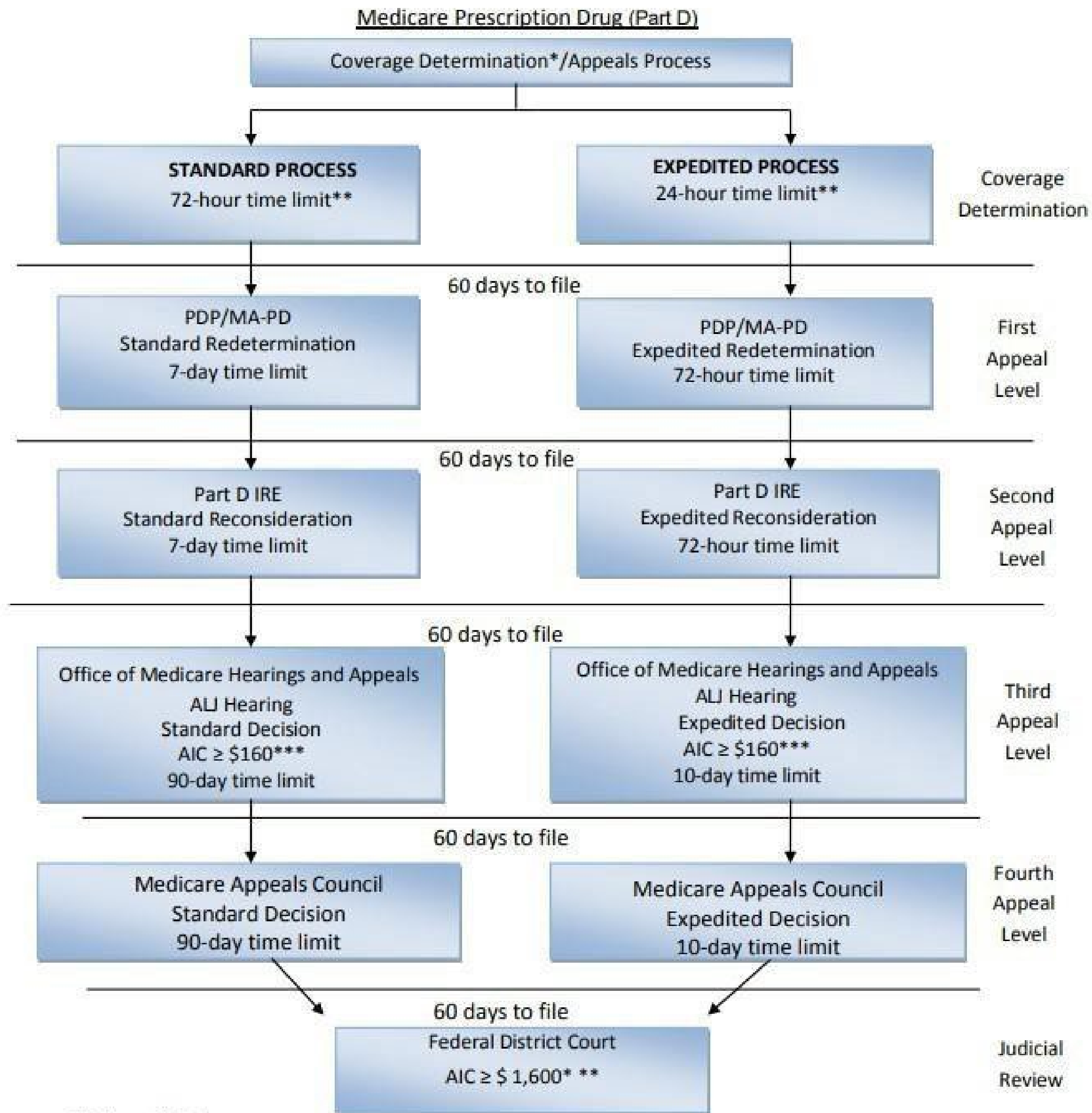
Part C Determination and Appeals Process

Below is a chart demonstrating the determination and appeals process and applicable timelines for Part C:



Part D Appeals

Below is a chart demonstrating the determination and appeals process and applicable timelines for Part D:



Member Complaints and Grievances

The CCA Health Appeals and Grievances and Quality Management departments investigate member complaints related to quality of care and service of providers in our network and takes action when appropriate.

When CCA Health receives a complaint from a member, the applicable plan department will contact the provider in question for additional information, as needed. At the conclusion of our investigation, CCA Health will advise the provider and member of the findings and resolution. We are required to resolve member complaints within 30 days or 24 hours, depending on whether they are standard or expedited. Your timely responses to plan requests for information help us meet that goal.

Providers may also register a complaint on behalf of a member regarding the quality of care or service provided to the member by another provider. Providers may submit the complaint by contacting the CCA Health Member Services department at 866-333-3530, or by fax at 866-207-6539. They may also contact the Appeals and Grievances department directly by fax at 866-207-6672.If the member asks their provider about filing a complaint, they should be referred to the CCA Health Member Services department at 866-333-3530 or the website at commonwealthcarealliance.org/ca/ and/or they should be provided the Appeal and Grievance Form (sample provided in Appendix B).

If a provider receives a written complaint from a member, the complaint should be immediately forwarded to:

CCA Health California
Attn: Appeals & Grievance Department
Member Services Department
18000 Studebaker Road, Suite 150
Cerritos, CA 90703

Member Services Fax: 866-207-6539

Appeals and Grievance Fax: 866-207-6672

The CCA Health appeals and grievances system is outlined in the Member Grievance Policy and Procedure, which can be obtained by calling the CCA Health Member Services department at 866-333-3530.

ADA and Cultural Competency, Hearing/Visually Impaired Interpreter, and Sign Language

The Language Assistance Program

CCA Health is committed to delivering culturally and linguistically appropriate services to all members, particularly those with Limited English Proficiency (LEP) or sensory impairment. CCA Health and its providers must be sensitive to the cultural and linguistic differences of their members, including cultural variation in the management of disease.

All plan providers must comply with the Language Assistance Program by assisting any members with LEP or sensory impaired members with access to Language Assistance Program services. CCA Health Language Assistance Program complies with federal and state requirements and the accreditation standards of the National Committee for Quality Assurance.

Using Bilingual Staff

Providers and members should first use the interpreter staff and other language assistance services offered by the PPG/IPA/HDO. Bilingual staff must meet the regulatory standards for interpreters, including but not limited to documented and demonstrated proficiency in both English and the other language(s), fundamental knowledge in both languages of healthcare terminology and concepts, and education and training in interpreting ethics, conduct, privacy, and confidentiality. For more information about these requirements, please contact CCA Health Member Services department at 866-333-3530.

Using Family, Friends, and Minors to Interpret

CCA Health does not prohibit adult family members and friends from serving as interpreters for members; however, it is discouraged. Members must first be offered professional language assistance and informed of the benefits of using professional interpreter assistance including those listed below. If the member refuses the offer of using a professional and prefers to use a family member or friend, that refusal must be documented in the member's medical or other record.

Be aware that family and friends may be unfamiliar with medical terminology, which may lead to misunderstandings and errors. They may provide unsolicited advice; they may have personal agendas; and the member's privacy and confidentiality is at risk.

Minor children should never be used as interpreters, except in extraordinary situations such as medical emergencies where any delay could result in harm to a member, and only until a qualified interpreter is available. If a member insists on utilizing a minor child for interpretation, this must be documented in the member's medical or other record.

Documentation

The use of interpreter services and the type of service utilized (e.g., in-person, video, or telephonic) must be documented in the member's medical or other record. Alternatively, refusal by the member to use professional interpreter services must also be documented in the member's medical or other record.

Guide to Using Language Services

Providers should first use the interpreter staff and other language assistance services provided by their PPG/IPA/HDO; however, if these services are not available, CCA Health offers interpretation services for all member with LEP, or who are deaf, hard of hearing, or speech impaired. Interpreting services are available to all members with LEP in more than 150 different languages and are provided at no cost to the member.

Members must not be subjected to unreasonable delays in receiving appropriate interpreting services including when scheduling and at the time of appointments. CCA Health's 24-hour phone interpretation services may be used in the event that on-site bilingual staff or the PPG/IPA/HDO's telephone interpreters are not available.

Accessing Interpretation for Members

CCA Health contracts with the telephonic language vendors listed below to provide interpretation services for member with LEP. Telephonic interpretation services are available 24 hours a day, 7 days a week.

CCA Health ensures equal access to healthcare services for members with hearing, speech, or visual loss or impairment through the coordination of interpreting services and the provision of auxiliary aids at no cost to members.

Providers and members should first use the interpreter staff and other language and sensory assistance services offered by their PPG/IPA/HDO. American Sign Language ("ASL") interpreters must meet the regulatory standards for interpreters, including but not limited to documented and demonstrated proficiency, fundamental knowledge of healthcare terminology and concepts, and education and training in interpreting ethics, conduct, privacy, and confidentiality. For more information about these requirements, please contact CCA Health Member Services department at 1-866-333-3530.

- American Sign Language Interpreting: To request ASL services, please contact CCA Health Member Services at 1-866-333-3530. At least 72 hours is needed to arrange an interpreter through these vendors. At this time, CCA Health can only provide ASL services in English and Spanish.
- The California Relay Service (CRS) is an exchange service that enables a person using a teletypewriter "TTY or TDD) to communicate by phone with a person who does not use a TTY and vice-versa. There is no additional charge for this service. Providers may utilize the CRS directly for members with hearing or speech loss. TDD/TTY service is available Monday through Friday from 8 a.m. to 5 p.m. PST in either English or Spanish.
- For CRS assistance, please contact CCA Health at 866-333-3530.

Accessing Translation Services for Members

Pre-translated Documents:

- All written materials intended for members falling under the category of Vital and Significant documents are automatically translated and made available in Spanish, Chinese, Vietnamese, and Korean, the plan's threshold languages. Vital and Significant documents include, but are not limited to:
  - Enrollment applications
  - Evidence of Coverage and Summary of Benefits
  - Consent forms
  - Letters containing eligibility information and participation criteria
  - Prior authorization criteria
  - Grievance and appeal rights and forms
  - Notices about the availability of free language assistance and how to access it
  - Explanation of benefits or other claim processing information if the document requires a response from the member

Translation Requests:

- Documents can also be translated in up to 150 different languages. A member may request translation of a document from their provider. Providers and members should first use the translation assistance services offered by their PPG/IPA/HDO. By law, providers initiating a document translation request on behalf of a member must keep a log of the date the member request was received and when the document was provided to CCA Health.
- Requests for translation of non-urgent documents from a provider must be sent to CCA Health within two (2) business days of the member's request as they must be translated and sent to the enrollee within twenty-one (21) days of request by law.
- Urgent documents must be provided to CCA Health within one business day of the request as they must be translated and sent to the member within three calendar days by law. In urgent situations, CCA Health recommends oral interpretation of the document, in person or telephonically.

Materials in Alternative Formats:

- CCA Health contracts with vendors that develop written and audible materials in alternate formats for our members with visual loss or impairment, such as: Braille, Large Print, Audio (CD or MP3), or AccessOne pdfs (a pdf document in large print that can be read, listened to or printed).
- Providers and members should first use the language and sensory assistance services offered by their PPG/IPA/HDO. CCA Health provides these services upon request at no charge to members. Members may request materials in alternative formats from their provider or by contacting the CCA Health Member Services Department at 866-333-3530. By law, providers initiating a document alternative format request on behalf of a member must keep a log of the date the member request was received and when the document was provided to CCA Health.
- Provider requests for alternate formats of non-urgent documents must be sent to CCA Health within two (2) business days of the member's request, as they must be provided within 21 days of request by law. Urgent document requests must be provided to CCA Health within one business day of the request, as they must be provided within three calendar days by law.

Nurse Advice Line

The CCA Health Nurse Advice Line is available 365 days per year, 24 hours per day to provide triage and other health care advice to plan members. The CCA Health Nurse Advice Line can be reached at 833-378-4406.

SECTION 7: Enrollment

To enroll in a CCA Health product, individuals must meet eligibility requirements and complete the CCA Health application process during a valid enrollment election period.

Effective Date of Coverage

CCA Health processes all eligible Individual Enrollment Request forms. Forms received by the end of the month are processed for eligibility on the first of the following month. The effective date may result in delay if the enrollment request form is incomplete, needs additional information, or lacks documentation of proof of entitlement to Medicare Parts A and B.

Medicare Eligibility Requirements

To enroll, an individual must:

- Have Medicare Parts A & B and continue to pay Part A and Part B premiums This includes those under age 65 and qualified by Social Security as disabled
- Reside in the plan's service area. The individual must continuously reside within the service area for 6 months or more.
- Not have permanent kidney failure at the time of enrollment

Open Enrollment, Lock-in, SEP and Disenrollment

CMS requires MA organizations to have an open enrollment period, also referred to as the Annual Enrollment Period (AEP) which currently runs from October 15 to December 7 of each year. The AEP is also referred to as the Fall Open Enrollment season and the Open Enrollment Period for Medicare Advantage and Medicare prescription drug coverage.

Additionally, MA organizations have a MA OEP which runs from January 1 to March 31. MA plan members may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals enrolled in either MAPD or MA-only plans can switch to:

- MA- PD
- MA-only
- Original Medicare (with or without a stand-alone Part D plan).

The MA OEP does not provide an opportunity for an individual enrolled in Original Medicare to join an MA plan.

MA organizations members are locked-in meaning they can only switch Medicare plans during the open enrollment period or MA OEP unless they qualify for a special election enrollment or switch to a five-star plan. Examples of special election periods (SEP) are when a beneficiary moves outside the plan's service area, moved to the area, is turning, or recently turned 65, has Medicaid and or qualifies for the Low-Income Subsidy, lost retiree health coverage, or is diagnosed with a qualifying disability.

Other special enrollment periods exist, as determined by CMS. This Special Enrollment Period (SEP) is for individuals who have Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program. This includes both full benefit dual-eligible individuals as well as individuals often referred to as partial duals who receive cost sharing assistance under Medicaid (e.g., QMB-only, SLMB-only, etc.) and individuals who qualify for LIS (but who do not receive Medicaid benefits). This SEP allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods: January – March, April – June, and July – September. It may not be used in the 4th quarter of the year (October – December).

CCA Health may involuntarily disenroll a member when the member does not retain Medicare Part A and B coverage, commits fraud, permanently moves out of the CCA Health service area, or is disruptive, abusive, unruly, or uncooperative. These conditions are subject to change at the discretion of CCA Health.

All efforts should be made to resolve issues at the practice level first. If you are unable to resolve the situation or if the member has threatened violence, notify CCA Health immediately, who will work collaboratively with you and the member to arrive at a solution. If you are concerned about you or your staff's safety, please exercise caution and contact law enforcement as appropriate.

Before escalating a matter to CCA Health (unless the member is violent or threatening violence, in which case CCA Health should be notified immediately), providers must:

- Ensure incidents and concerns are documented appropriately (including an evaluation of underlying causes);
- Develop a written action plan and institute to address any access to care issues, other concerns and needs, and how the other concerns and needs are met (providers should conduct an interdisciplinary case conference to consider options);
- If warranted, and with prior approval from CCA Health, send a certified letter to the member describing the behavior and advising that the continued disruptive behavior may result in the member being moved to another provider (send a copy of any relevant communication with the member to the CCA Health Provider Services department).

Under no circumstances, however, will a member who otherwise meets all eligibility requirements be involuntarily disenrolled due to health status. Regardless of the circumstances of disenrollment, covered services must be provided until the effective transfer or disenrollment date.

SECTION 8: Eligibility

Verifying Eligibility

Each member is provided with a CCA Health branded individual healthcare identification card (ID Card). See the Member ID Cards Section below for more detailed information.

Eligibility and other changes frequently occur. Possession of an ID card is not a guarantee of eligibility. If the member cannot present an active ID card or does not appear on your current eligibility list, you must verify eligibility with CCA Health prior to providing services.

Eligibility Reports

CCA Health sends PPGs/IPAs a monthly eligibility list of all its assigned members, on or about the 10th day of each month. Providers participating with CCA Health through a PPG/IPA will receive eligibility within the format and timeframe established by the PPG, which may contain information such as the following:

- Month of eligibility
- Provider name and address
- Member ID number
- Member last name
- Member first name
- Member address
- Member telephone number
- Member sex
- Social Security number
- Date of Birth
- Age
- PPG/IPA effective date
- Special remarks

Member ID Cards

Each CCA Health member will receive a healthcare identification card (ID card). Information may vary in appearance or location on the card due to payer or other unique requirements. It is important to check the member's ID card at each visit and to keep a copy of both sides of the card for your records. Possession of an ID card is not a guarantee of eligibility. If the member cannot present an active ID card or does not appear on your current month's eligibility list, you must verify eligibility with CCA Health by contacting the CCA Health Member Services at 866-333-3530.

Member PCP Selection, Assignment, and Change

PCP Assignment

The patient provider relationship is very important. Members are required to be assigned to a PCP to coordinate all their healthcare. Members may choose a PCP upon enrollment through their application, or, if no PCP is indicated on the application, CCA Health will assign one to them. In assigning PCPs, CCA Health tries to take into consideration their geographic location, linguistic needs, and other relevant variables. CCA Health encourages but cannot require, members to choose a PCP within 15 miles or 30 minutes of their home or work.

In general, if the member's chosen PCP is confirmed as active in the system and has open panel status, then the chosen provider will be honored.

If the chosen PCP is not active or has closed panel status, the member will be contacted by CCA Health to inform him or her that the PCP chosen is not available and asked to make another choice.

Member-Initiated PCP Changes

Members may request a PCP change during any given month. A member may request a PCP transfer by calling CCA Health Member Services at 866-333-3530. All transfer requests received by Member Services will be effective on the first of that same month if the member has not utilized any medical services. If services were rendered, the transfer will not take place until the first of the following month.

Note: All exceptions to this policy must be pre-authorized by Member Services management prior to approving and processing the transfer request. Each retroactive transfer request is reviewed and approved on an individual per case basis pending circumstances involved, access, and urgency of care. Prior to any change, inquiries will be made to assure there was no prior utilization of services during the month.

When the PCP change is processed and completed, CCA Health will mail a new ID Card to the member.

Provider Request to Transfer Member

Occasionally, circumstances may arise in which a PCP or other provider wishes to transfer an assigned member to another PCP or provider. In such cases, the provider must complete and submit a written Transfer Request form and any related documentation to CCA Health for approval. The provider must note the reason for the transfer request and provide written documentation to support the removal of a member from their panel or care.

Upon receipt of a transfer request form, the CCA Health Chief Medical Officer/Medical Director or their delegate will evaluate the information presented and make a determination. The following are not acceptable grounds for a provider to seek the transfer of a member:

- The medical condition of a member
- Amount, variety, or cost of covered services required by a member
- Demographic or cultural characteristics of a member

By law, CCA Health must ensure that there is no member discrimination for the above or any other reasons in requesting a transfer. If the transfer request is approved, the provider will be asked to send an approved notification letter to the member giving them 30 days to transfer to another provider. CCA Health will also contact and reassign the member according to their choice considering geographic location, linguistic needs, and other relevant variables.

Lawsuit Against Provider:

- The filing of a lawsuit by a member against a provider does not by itself automatically provide sufficient cause to transfer a member to another provider. A request for the transfer of a member from a provider will not be considered unless the member's complaint alleges deficiencies in the general practices and procedures of the provider. Lawsuits not involving allegations related to the general practices and procedures of the provider will not be considered sufficient grounds to transfer the member from the provider and/or the PPG/IPA. Note: If you receive notification of a member's intent to sue, please notify CCA Health as soon as possible and provide copies of all notifications.

CCA Health must take into consideration concerns regarding quality-of-care deficiencies, inappropriate professional conduct, and whether the member is in active care and treatment and the continuity of care requirements.

SECTION 9: Pharmacy

Prescription Benefits

CCA Health provides prescription benefits both through its MA benefits and Part D benefits. All drugs covered under the Medicare Parts A (inpatient) and B (outpatient) program are considered covered benefits for CCA Health members. CCA Health provides outpatient prescription drugs through its pharmacy benefits manager, MedImpact Healthcare Systems, Inc. (MedImpact), who can be contacted at 888-254-9907.

A Part D Covered drug is available only: 1) by prescription, 2) as approved by the Food and Drug Administration (FDA) (or is a drug described under Section 1927(k) (2) (A) (ii) or (iii) of the Social Security Act), and 3) if used and sold in the United States and used for a medically accepted indication (as defined in Section 1927(k) (6) of the Social Security Act).

Covered Part D drugs include prescription drugs, biological products, insulin (as described in specified paragraphs of Section 1927(k) of the Social Security Act), and vaccines (licensed under Section 351 of the Public Health Service Act).

Formulary

CCA Health's formulary is a list of covered drugs reviewed and approved by the clinicians and pharmacists who are voting members of CCA Health's pharmacy benefit manager's Pharmacy and Therapeutics Committee, then approved by CMS. Decisions are based on sound clinical evidence published in peer-reviewed journals, supported by national treatment guidelines, and informed by the clinical expertise of the P&T Committee members.

The most up to date plan formulary may be found online: CCA Health California Formulary. The formulary may be updated from time to time to add or remove drugs or coverage limitations and it may vary depending on the benefit plan. For example, some plans may include coverage of some drugs that are excluded per CMS regulations because the plan has chosen to include that benefit as part of their additional coverage. CCA Health strongly recommends that providers ensure they have the most recent and applicable formulary available when making prescription decisions.

Other Formulary Information

Specialty Medications:

- Some specialty drugs have limited distribution and are only available by certain pharmacies as mandated by the manufacturer. These drugs are identified in the formulary. CCA Health has contracted with MedImpact Direct Specialty program to ensure access to these drugs and support of our members.

Over-the-Counter (OTC) Medications:

- CCA Health provides coverage for some OTC medications, drugs, and supplies. Please refer to members' Summary of Benefits for additional OTC limitations: Information for CCA Medicare Advantage Plan Members | CCA Health CA (commonwealthcarealliance.org) CCA Excel Plan Benefits | CCA Health CA (commonwealthcarealliance.org).

Part D Utilization Management (UM), Coverage Exclusions, and Coverage Determinations

UM Tools

Pharmaceutical UM tools are used to encourage appropriate and cost-effective use of prescription benefits. The CCA Health Pharmacy and Therapeutics Committee developed these requirements and limits to help provide quality coverage to our members. These tools include, but are not limited to:

- Age limits: Some drugs may require a prior authorization (PA) if the member's age does not meet the manufacturer, FDA, or Clinical Practice Guidelines.
- Quantity limits (QL): For certain drugs, we limit the amount of the drug we will cover per prescription or for a defined period of time. Similar to the age limit, the quantity limit threshold is based on manufacturer, FDA, and Clinical Practice Guidelines.

- Prior authorization (PA): A PA is required for certain drugs to ensure appropriate utilization.
- Step therapy (ST): In some cases, CCA Health requires that the member have a trial of a first-line medication prior to approving a second-line medication.
- Generic substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically dispense the generic version, unless the prescription indicates brand only. In this case, if an FDA-approved generic alternative is available on the CCA Health formulary, the prescribing provider will need to submit medical justification for the use of the brand product.

The CCA Health formulary is available on the CCA Health website: CCA Health California Formulary. Mior authorization procedures. To ensure members receive high quality, cost-effective and appropriate drug therapy, CCA Health will maintain drug formularies consistent with the required pharmacy benefit design and Medicare regulations.

Request Prior Authorization/Coverage Determination

To request exceptions from the UM tools or request PA, prescribers should submit persuasive evidence in the form of studies, records, or documents to support the request to MedImpact, who can be contacted at 888-254-9907.

Members, members' representatives, or members' prescribing physicians or other prescribers may submit an oral or written request to MedImpact to request a coverage determination, tiering exception, or formulary exception.

If providers prescribe non-formulary drugs or formulary drugs with UM criteria, the provider is required to complete the prior authorization form and submit with medical justification, at no cost to the member.

Prior Authorizations (PA) and Coverage Determination Exceptions (CDE) Policy

The CCA Health–contracted pharmacy benefit manager MedImpact will ensure a timely and accurate review of all medication authorization requests.

- Prior authorization/CDE requests will be determined within 72 hours after receipt of complete information from the provider for standard determinations.
- Expedited reviews will be determined within 24 hours after receipt of complete information from the provider.
- CCA Health shall provide an expedited determination if it determines that applying the standard timeframe for making a determination may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Medication authorizations requests may be submitted by the member, member's representative, member's prescribing physician, or other physicians.

Medications requiring authorization include (but are not limited to):

- Medications on the CCA Health formularies requiring a PA
- Non-formulary medications
- Part B versus Part D determinations.

MedImpact will provide written communication of the prior authorization determination to the member and provider. The provider and member or members representative have the right to appeal any adverse determinations. Appeal requests will be processed by MedImpact, who can be contacted at 888-254-9907.

Outreach for Coverage Decisions

If complete information is not provided upon initial request for a coverage determination or exceptions request, outreach attempts will be made to obtain necessary information to make an informed coverage decision. This is applicable to all CDE requests as outlined below.

- Reasonable and diligent efforts to obtain information include a minimum of three attempts.
- The methods for requesting information will be a mix of faxes or telephone calls. All outreach attempts will be documented with the date and time of the fax/call in the prior authorization database.
- The first request for information will be made within 24 hours of receipt of a standard coverage request, and as soon as possible for expedited requests.
- Although every effort will be made to perform outreach attempts during normal business hours, some attempts may need to be made outside of those hours, particularly for expedited requests which have a shortened timeframe.

Tiering Exceptions

Request for tier exceptions, must include documented evidence of clinical trial and failure of all drugs on the lower tier that can be used to treat the members diagnosis. The process will follow the PA/CDE procedures.

Tier Exceptions cannot be requested for certain situations, including but not limited to:

- Drugs on tier 5 (specialty)
- Drugs approved through the CDE process
- Drugs already positioned on the preferred tier

Request for Payment – Coverage Determination

In the event a member pays out of pocket for a Part D eligible medication:

- Members and member representatives may submit requests for payment to MedImpact on an approved non-electronic claim form.
- Upon receipt of a request for payment from a member or a member representative, MedImpact will process the claim according to the member's benefit plan and the amount agreed to by the plan for payment.

Processing Direct Member Reimbursements

- If the request is for a non-formulary drug or formulary drug with UM edits:
    - A request for medical justification will be required.
    - If the prescriber does not provide sufficient information, a request for the required information will be sent to the prescribing provider and follow the PA/CDE Process.
- If the reimbursement decision is unfavorable, MedImpact makes the decision and provides notice of the decision not later than 14 calendar days after receiving the reimbursement request.
- If the reimbursement decision is favorable, MedImpact makes the decision, provides notice of the decision, and makes payment no later than 14 calendar days after receiving the reimbursement request.
- If MedImpact is not able to obtain all of the information it needs to reach a favorable decision on the merits of the case and has made reasonable and diligent efforts to obtain the missing information within the 14 calendar-day timeframe, MedImpact will issue an unfavorable decision.
- When MedImpact issues a denial, it clearly explains in the decision letter the reason for the denial and how member might be able to receive reimbursement using the CMS Model Denial Notification form in language the member can understand.

Dismissals/Withdrawals

Only in very rare instances would a coverage determination or exception request be withdrawn or dismissed. In both cases, the reason for withdrawal or dismissal will be clearly documented in the prior authorization database and the case will be closed.

Generally, a dismissal would occur when the procedural requirements for a valid request are not met and MedImpact is unable to correct the defect. For example, a coverage determination request is received from a purported representative of the member. MedImpact is not able to obtain the required documentation (Appointment of Representative form) within a reasonable amount of time and therefore the case needs to be dismissed. In this case, the request will be closed with a status of "Dismissed."

A withdrawal would occur when the requestor withdraws his or her request for coverage. For example, a coverage determination is requested by a member for a drug that requires step therapy. But before MedImpact issues a decision, the member speaks to her prescriber and learns that she can take the covered alternative, then calls MedImpact and asks to not process her coverage request.

- If the requester is the prescriber, and he or she withdraws the request, the case will be closed with a denial reason of "Withdrawal".
- If the requestor is the member, and he or she withdraws the request, the case will be closed with the status of "Withdrawal."
-

MedImpact will send a written confirmation of that withdrawal to the party within 3 calendar days of receipt of the withdrawal request. **Reopening and Revising Determinations and Decisions**

A reopening is a remedial action taken to change a binding determination or decision even though the binding determination or decision may have been correct at the time it was made based on the evidence of record. Although cases will very rarely be reopened, a possible reason for reopening a previous determination includes clerical errors such as:

- Mathematical or computational mistakes
- Inaccurate data entry
- Denials of claims as duplicates

A request for reopening must:

- Be made verbally or in writing
- Be clearly stated
- Include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening)
    - At any time if there exists reliable evidence that the coverage determination or appeal was procured by fraud or similar fault.
    - At any time if the coverage determination appeal is unfavorable, but only for the purpose of correcting a clerical error on which the determination was based

Prescription Coverage Exclusions

The following exclusions apply to CCA Health's prescription covered benefits plan:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Drugs purchased outside the United States and its territories are not covered.
- Off-label use of prescription drugs is usually not covered. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the FDA. Generally, coverage for off-label use is allowed only when the use is supported by the CMS-approved references, such as the American Hospital Formulary Service Drug Information or the DRUGDEX Information System.
- By law, the following categories of drugs are not covered by Medicare drug plans, unless specifically indicated as covered by the benefits plan in which the member is enrolled:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction (ED)
- Drugs that are prescribed for medically accepted indications other than sexual or ED (such as pulmonary hypertension) are eligible for Part D coverage
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Transition Policy

A new or continuing member may be taking drugs that are not on our formulary or, on our formulary, but have prior authorization, step therapy, or quantity and other UM limits. Members should discuss this with their providers to decide it they should switch to an appropriate drug that is covered or request a formulary exception (a type of coverage determination).

For new members, during the first 90 days of coverage, we may cover one temporary 30-day transition supply of drugs that are either not on our formulary or, are on our formulary, but have prior authorization, step therapy, and/or quantity and other UM limits. If the prescription is written for fewer days, multiple fills up to a maximum of 30-day supply of medication are allowed. Providers are encouraged to review for formulary alternatives or submit for formulary exceptions.

If a member has a level-of-care change, we may cover a temporary 31-day transition supply for those members who are moving from home, or a hospital stay to a long-term care facility. We may cover a temporary 31-day supply for those members who are moving from a long-term care facility, or a hospital stay to home. A transition supply notice will be sent to the member and prescriber within three business days of the transition fill. Providers are encouraged to review formulary alternatives or submit for formulary exception.

For members who have been in the plan for more than 90 days, reside in a long-term care facility, and need a supply right away, we may cover a 31-day emergency supply of a non-formulary drug or a drug subject to other edits while the member pursues a formulary exception.

For members being admitted to or discharged from a long-term care facility, early refill restrictions are not used to limit appropriate and necessary access to the formulary, and such members can access a refill upon admission or discharge.

Prescribers should submit persuasive evidence in the form of studies, records, or documents to support the existence of the situations listed above. To request prior authorization, please reach out to our pharmacy benefits manager MedImpact, who can be contacted at 888-254-9907.

If providers prescribe non-formulary drugs or formulary drugs that have UM criteria, the provider is required to complete the prior authorization form and submit it with medical justification, at no cost to the members. Once all required supporting information is received, a coverage decision based upon medical necessity is provided within 24 hours for an expedited review and 72 hours for standard requests.

Drug Utilization Review Program

MedImpact establishes a system to conduct Drug Utilization Reviews (DUR) for all members to ensure that they are getting safe and appropriate care. The programs include real-time and historic review of prescriptions claims to reduce medication

errors and adverse drug interactions. These reviews are especially important for members who have more than one doctor who prescribe their medications, use more than one drug, or have more than one pharmacy.

MedImpact conducts DURs when the pharmacy fills a prescription at the point-of-sale. The claim may be electronically reviewed for the following:

- Duplicate drugs that are unnecessary because the member is taking another drug to treat the same medical condition
- Age-related contraindications
- Gender-related contraindications
- Drug-drug interactions
- Incorrect drug dosage
- Drug-disease contraindications
- Drug-pregnancy precautions
- Clinical abuse or misuse

In addition, retrospective DURs identify inappropriate or medically unnecessary care. Ongoing, periodic review of claims data is performed to evaluate prescribing patterns and drug utilization that may suggest potentially inappropriate use.

Opiate Safety Program

CCA Health has a robust opiate program to ensure appropriate use of opiate drugs. The program includes concurrent reviews at the point of sale, retrospective reviews, and case management reviews as necessary. Prescribers are encouraged to work with the plan to reduce dependence on opiates and provide safer alternative therapies.

Concurrent review edits involve but are not limited to:

- Calculation of Morphine Equivalent Dose (MED). MED greater than 90mg will require intervention by the pharmacist. Dosage greater than 200mg will require the provider to submit medical justification.
- Review for multiple prescribers of opiate drugs
- Review for multiple pharmacies
- Review for combination of opiate and benzodiazepines
- Limit dispensing to 7-day supply for acute, opiate-naive patient.
- These edits are subject to change per further program development and Medicare regulations.

Medication Therapy Management (MTM)

CMS requires Part D sponsors to implement a Medication Therapy Management (MTM) program for members with multiple chronic medical conditions, those who are taking multiple medications, and that are likely to incur annual costs for Covered Part D prescriptions at a specified threshold.

The purpose of the MTM program is to reduce the risk of adverse events (including adverse drug interactions) and improve the quality and cost effectiveness of the pharmacy benefit. Improved therapeutic outcomes can be achieved through better medication use by providing the Comprehensive Medication Review Program (CMR) and recommendations to targeted members and providers. Members in the MTM program have indications of high potential for medication-related issues. Thus, through the CMR, a clinical pharmacist reviews the member's information and generates a medication action plan and personal medication list. Recommendations for drug therapy changes, if any, are sent to the member's prescriber(s). The MTM is provided at no additional cost and is a voluntary program. The CCA Health MTM program is provided by its contracted provider SinfoniaRx.

Pharmacy Network

Retail Pharmacies

The CCA Health pharmacy network consists of over 60,000 pharmacies with a nationwide coverage. Members are required to use contracted pharmacies to receive their pharmacy benefit.

Mail Order

We encourage members to use the CCA Health mail-order pharmacy program, administered by its MedImpact Direct mail-order service, which allows members to receive up to a 90day supply for certain medications delivered to their address of choice. To order a mail order prescription, please contact MedImpact Direct at: 888-254-9907.

Members can also receive 90-day supplies of maintenance medications from certain retail pharmacies. The copayment/coinsurance is the same as for the mail-order benefit. These pharmacies are identified in the pharmacy provider directory and on CCA Health website at commonwealthcarealliance.org/ca/.

SECTION 10: Claims

CCA Health applies the appropriate regulatory requirements related to claims processing and payments.

Member Balance Billing

Providers shall not bill members for any covered/authorized or approved service except for their plan allowed cost-sharing (copay/coinsurance).

Beneficiaries that are dually eligible are individuals who are enrolled in both Medicare and Medicaid. The Qualified Medicare Beneficiary (QMB) program is for individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost-sharing. Providers are prohibited from billing QMB individuals for all Medicare cost share (except Part D). All Medicare and Medicaid payments received for services rendered to QMB individuals are considered payment in full. Providers are subject to sanctions if they bill a QMB individual for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing).

For more information visit: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1128.pdf

Collection of Copayments and Charges for Non-covered Services

Providers shall not collect payments from members for non-covered services unless the member has been advised in advance and in writing that such services may not be covered and CCA Health has confirmed that the services are not covered.

Claim Submission Formats and Time Frames

Submission Time Frame

- Non-contracted providers must submit claims within 12 months from the date of service.
- Contracted providers must submit claims in accordance with their contractual agreement with CCA Health or 12 months from the date of service if timely filing is not established in the agreement.

Submission Formats

Providers must submit claims using the current paper or electronic format.

Electronic Claims:

- Electronic claims must be submitted in HIPAA compliant format and meet all requirements for Electronic Data Interchange transactions.
- CCA Health encourages each provider to submit claims electronically. Electronic claims submission has substantial benefits including decreased submission cost, faster processing and reimbursement, and timely filing documentation.
- CCA Health has contracted with TransUnion to accept electronic claims. TransUnion offers a robust portal to submit, correct and manage transactions.
- CCA Health is now accepting electronic claims submitted via Office Ally. Payer ID: TU127; Payer name: CCA Health of CA FFS.
- You may also submit electronic claims directly via TransUnion. TransUnion Contact information:
- Email: pdl_dddcsr@transunion.com (preferred)
  Phone number: 310-337-8530
  Payer ID: TU127

- Transactions supported:

  ANSI X12 837P (professional)
  ANSI X12 837I (i
  ANSI X12 999
  ANSI X12 277

Paper Claims:

- Providers must submit paper claims using the current versions of CMS-1450 (UB) for all facility claims (excluding ambulatory surgery centers) and CMS- 1500 forms for professional claims.
  - Ambulatory surgery centers must submit claims using CMS-1500 form.
- Claims that require submission of supporting documents must be submitted in paper. In order to avoid delays in claims processing, submit the appropriate supporting documentation which includes but is not limited to:
  - Medical/emergency records
  - Invoices
  - Explanation of benefits from other health insurance or primary payer
- When submitting paper claims, all required/mandatory fields in the current CMS- 1450 or UB format adopted by the National Uniform Billing Committee and CMS- 1500 adopted by the National Uniform Claim Committee (NUCC), as applicable to the service, must be included.
- Providers must ensure all claims submitted to CCA Health are clean and accurate. A clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment. Claims submitted in paper must be legible in order for CCA Health to accurately process claims. Claims that are not legible or contain invalid or incomplete information may be returned as un-processable.
- Beginning 1/1/2020, paper claims must be submitted to the following address:

  CCA Health California
  Attn: Claims Dept.
  PO Box 21063
  Eagan, MN 55121

Prior Authorization:

Include the authorization number on claims that have received prior authorization, as well as the ordering or referring provider, to avoid delay in processing claims.

Claims Processing and Payment

Payment Timelines

CCA Health will make every effort to ensure clean claims that are the financial responsibility of CCA Health are processed (paid or denied) within 30 calendar days of receipt from non- contracted providers. All other claims are processed (paid or denied) within 60 calendar days of receipt.

Reimbursement:

- Contracted providers will be reimbursed in accordance with the agreement they have with CCA Health.
- Non-contracted providers will be reimbursed according to prevailing the Medicare fee schedule and prospective payment systems (PPS). Two percent (2%) or current mandatory sequestration payment reduction will be deducted from non-contracted provider’s payment.

- Medicare fee schedules and PPS prices will be updated quarterly or as CMS post updates. Facilities and providers who will be reimbursed based on Medicare PPS must submit their Medicare ID.
- Reimbursements of non-contracted providers will be based on the latest Medicare Advantage Payment Guide for Out-of-Network Payments. A summary of this guide is noted below:
  - Acute care hospital (inpatient) – services will be paid using the Medicare inpatient prospective payment system (IPPS) even when the submitted charge is lower. Exceptions include those hospitals in the PPS waiver state such as Maryland, cancer hospitals, children's hospitals and hospitals approved in demonstration project. Payment is based on diagnosis related groups.
  - Ambulance services that are covered are paid using the lesser of the ambulance fee schedule or submitted charges.
  - Ambulatory surgical centers (ASC) are paid based on ASC payment rates. ASC procedures and payment amounts are grouped by the core-based statistical area (CBSA) code.
  - Anesthesiologist payments depend on base and time units. Base units are sourced from the CMS Anesthesiologists Center. Anesthesia time units are computed by dividing the reported anesthesia time by 15 minutes.
  - Cancer hospitals' services are excluded from the hospital PPS and will be paid based on a per diem rate for inpatient services and percent of their cost. Hospitals will be required to submit a copy of their most recent interim rate letter from the Medicare Administrative Contractor.
  - Clinical lab services are paid using the Medicare Clinical Laboratory fee schedule.
  - Critical access hospital services will be paid based on reasonable cost basis. For outpatient services, the payment amount is calculated by multiplying the billed charges by the cost-to-charge ratio for each hospital. Inpatient services are paid a per diem cost. Hospitals will be required to submit copy of their most recent interim rate letter from CMS or Medicare Administrative Contractor.
  - Durable medical equipment, prosthetics and orthotics, parenteral and enteral nutrition, surgical dressings and therapeutic shoes and inserts are paid based on the lesser of the actual charge or the Medicare fee schedule amount.
  - End-stage renal disease (ESRD) facilities are paid, for routine services, an amount called a composite rate. Composite rates are geographically adjusted and vary depending on whether a facility is hospital based or independent. Non- routine services maybe billed separately by provider. ESRD payment is calculated using the Medicare ESRD calculator. Patient's height and weight must be included in the bill to calculate payments.
  - Hospital outpatient services will be paid using the Medicare outpatient prospective payment system (OPPS), even when the submitted charge is lower. Other services such as laboratory and radiology are usually paid based on Medicare allowable rates. Hospitals exempt from outpatient PPS include those in Maryland, Indian Health Service, and critical access hospitals.
  - Home health services will be paid based on home health prospective payment system groups using one of the home health resource groups for five or more visits in 60-day period, even when the submitted charge is lower. This payment covers episodes of care of up to 60 days. Low utilization payment adjustments may be made in the case of an episode with four or fewer visits. Durable medical equipment is excluded from PPS and instead paid on a fee schedule. PPS payments are made even if they are greater than the submitted charge.
  - Part B drugs reimbursement will be based on average sale price (ASP) plus 6% for services that are not paid on cost basis or PPS. Most drugs for hospital inpatient PPS are not billable since they are assumed to be included in the diagnosis-related group payments. When the outpatient department of a hospital bills for drugs, the cost is generally included in the hospital outpatient payments.
  - Physician services are paid using the lesser of billed charges or the Medicare physician fee schedule participating amount. Applicable payment reduction will apply for non-physician practitioners. If the

physician does not participate with Medicare, payment will be the lesser of billed charges or the Medicare physician fee schedule non-participating amount.

- Skilled nursing facility services will be paid using the Medicare prospective payment system, based on the Resource Utilization Group code, even when the submitted charge is lower.
- Swing beds are paid on the skilled nursing facility PPS. Critical access hospital swing beds are excluded from PPS.
- Inpatient rehabilitation are paid using the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS).
- Psychiatric hospitals (freestanding psychiatric hospitals and certified psychiatric units of general acute care hospitals) will be paid according to the inpatient psychiatric facility prospective payment system and is referred to as either IPF PPS or IPFPPS. Psychiatric patients in regular beds in acute care hospitals are paid under the acute care hospital PPS.

Interest Payment:

- Interest payments will be applied to clean claims from non-contracted providers that are not paid within 30 calendar days. Interest will be paid for the period of the time that the payment is late. Interest rate is based on the rate published by the Treasury department.

Medicare Opt-Out Providers

- Medicare opt-out providers will only be reimbursed for emergent/urgent claims until the member is stabilized. Provider must submit claims with the appropriate HCPCS code and HCPCS modifier “GJ” (Opt-out physician/practitioner EMERGENCY OR URGENT SERVICES). This modifier is used only when emergent or urgent services are rendered, and the member has not signed a private contract with the physician or practitioner. Claims that are billed without this modifier or billed for services or items not covered by Medicare will be denied.

Misdirected Claims

Claims that are the financial responsibility of the medical group or IPA will be forwarded to the appropriate medical group or IPA within 10 working days. Billing providers receive notices from CCA Health identifying the responsible payers.

Emergency Claims

Emergency claims do not require prior authorization.

Inpatient Hospital Claims – Emergency Admission

In the event emergency admission is not authorized prior to member’s discharge, medical records must be submitted with the claims in order to determine medical necessity and avoid delay on payments. Claims with medical records are forwarded by the Claims department to Utilization Management (UM) to determine the appropriate level of care and medical necessity. Upon completion of the UM review, claims are processed and paid according to approved and authorized services.

Inpatient Hospital Claims – Elective Admission

All elective inpatient admissions require prior authorization.

Outpatient and Other Services

Ambulatory services, outpatient surgeries, and ancillary and specialty services require prior authorization. Claims for these services without prior authorization will result in payment denials with the exception of services established as not requiring prior authorization under the direct referral process. Please refer to CCA Health provider forms and referrals link for Authorization Requirements, for the listing of services.

Medicare Secondary Payer/Coordination of Benefits

CCA Health will coordinate payments for covered services. Providers must bill members' primary insurance prior to billing CCA Health. In order for CCA Health to coordinate payments, providers must submit copy of primary insurance evidence of payment. CCA Health may recoup previous payments if the member is identified to have other health insurance.

CCA Health is the secondary payer when the following conditions occur:

- The member is 65 years or older and is covered by a group health plan (GHP) because of either the member's current employment or the current employment of a spouse of any age and the employer that sponsors or contributes to the GHP plan employs 20 or more employees
- The member is disabled and is covered by a large group health plan (LGHP) because of either the member's current employment or a family member's current employment, and the employer that sponsors or contributes to the LGHP employs 100 or more employees
- The member has end-stage renal disease and is in the first 30 months of eligibility with GHP coverage or under COBRA, regardless of the number of GHP's employee's and the member's employment status
- The member is covered under workers' compensation because of job-related illness or injury. Workers' compensation pays for healthcare items or services related to job-related illness or injury
- The member has been in accident or other situation where no-fault or liability insurance is involved. No-fault or liability insurance pays for items or services related to an accident
- The member is entitled to Medicare and the Federal Black Lung Program

Overpayment Recovery

CCA Health will provide appropriate notification to ensure that recoveries or recoupments of overpaid claims made to all providers are processed according to the applicable health plans and regulatory requirements.

Non-contracted providers: CCA Health will follow the process used by Medicare contractors for fee-for-service program.

Contracted providers: CCA Health will process overpayment recoveries according to the contractual agreement. Otherwise, CCA Health will follow the process used by Medicare contractors for fee for service program.

All providers will be notified in writing when CCA Health determines that overpayment(s) have been made.

Timelines for Overpayment Recoveries

As outlined in CMS Guidance 42 CFR § 405.980 overpayment recoveries can occur:

- Within one year from the date of the initial determination or redetermination for any reason.
- Within four years from the date of the initial determination or redetermination for good cause as defined in §405.986.
- At any time if there exists reliable evidence as defined in §405.902 that the initial determination was procured by fraud or similar fault as defined in §405.902.

Overpayments May Occur Due to the Following:

- Payment for provider, supplier, or physician services after benefits have been exhausted, or where the individual was not entitled to benefits

- Incorrect application of the deductible or coinsurance
- Payment for non-covered items and services, including medically unnecessary services or custodial care furnished an individual
- Payment based on a charge that exceeds the reasonable charge
- Duplicate processing of payments
- Payment made to wrong payee
- Payment error due to incorrectly configured fee schedule
- Primary payment for items or services for which another entity is the primary payer
- Payment for items or services rendered during a period of non-entitlement

Overpayment Recovery Notification

- An overpayment demand letter will be mailed to the providers.
- The providers will have 15 calendar days from the demand letter's mail date to send a refund to CCA Health.
    - If provider submits a request to recoup the overpaid amount against future claim payments, CCA Health will start the recoupment process on the 16th day from the date of the letter
    - If provider agrees with overpayment demand, the provider must submit full refund within 30 calendar days from mail date to avoid accruing interest. Interest will start to accrue on calendar day 31, from date of letter.
    - Provider will be given up to 40 calendar days from the date of first demand letter to pay in full.
- CCA Health will start recoupment if no refund is received within 41 calendar days from the date of first demand letter unless a valid request for a redetermination is received. To limit recoupment, the provider must file the request for redetermination by the 30th day following the first demand letter as outlined in Section 200.2.2 Recoupment after the First Demand.
- Other options
    - Rebuttal: The rebuttal process is not an appeal. A rebuttal permits the provider a vehicle to indicate why the proposed recoupment should not take place. The contractor may, based on the rebuttal statement, determine to stop recoupment, or proceed with recoupment. The provider can submit a statement that includes any pertinent information as to why recoupment should not be put into effect on the date specified in the notice/demand letter within 15 calendar days. In contrast, the limitation on recoupment provision mandates that no recoupment begins when a valid and timely request for a first level or second level appeal is received.
    - Appeal: The provider can submit an appeal if he or she disagrees with an overpayment decision.

Overpayment – Voluntary Identification

If a provider identifies an overpayment, the provider may submit a request to arrange recoupment against future claim payments or send a refund and explanation of the overpayment to the address below. The request must include the following information: member name, claim number, date of service, overpaid amount, and explanation of the overpayment.

CCA Health California
Attn: Claims Recovery
Department PO Box 21063
Eagan, MN 55121

Claims Status Inquiry

Providers may verify a claims status within 15 days of submission to CCA Health by calling 866-333-3530 or by checking the CCA Health web portal at https://vhpprovider.prod.healthaxis.net.

Provider Notification of Payment Dispute and Appeals Rights

Contracted Providers

Contracted providers do not have appeal rights under the Medicare Advantage program. If providers disagree with our payment decision, providers may submit their dispute requests in writing to the following:

CCA Health California
Attn: Provider Appeals/Dispute Department
18000 Studebaker Rd, Ste 150
Cerritos, CA 90703

Non-Contracted Providers

Non-contracted providers may submit a formal request disputing the amount paid by CCA Health for covered services. Examples of items that can be disputed include the following:

- Underpayment (the amount paid by CCA Health for covered services is less than the amount that would have been paid under original Medicare)
- Disagreement between a non-contracting provider and CCA Health about the decision to make payment on a more appropriate code (down coding)

Non-contracted providers may submit payment appeals or reconsideration if they do not agree with our payment denial. Examples of appealable claims decision include but not limited to:

- Services that did not receive prior authorization and were determined not to be urgent/emergent
- Services that were determined to be not covered either in the member's Evidence of Coverage or by Medicare

Filing a Payment Dispute and Reconsideration (Non-contracted providers)

- Payment dispute time frame: Submit your payment dispute within 120 calendar days after the date of the initial payment determination
- Payment appeals/reconsideration timeframe: Submit your payment appeals/reconsideration within 60 calendar days after the date of the initial determination.
- Information required to file a payment dispute and reconsideration:
  - Provider's name
  - Provider's identification number (NPI/Tax ID number)
  - Contract information
  - A clear explanation of the disputed item, which should include:
    - The date of service
    - A clear identification of the basis upon which the provider believes the payment amount is incorrect
    - Copy of the provider's submitted claim with disputed portion identified
    - Request for reimbursement for the overpayment of a claim (if item being disputed is for overpayment request)

- Waiver of Liability:
    - Non-contract provider must submit a signed Waiver of Liability form releasing our member from any financial obligation (other than their cost-sharing responsibility). An appeal will not be processed without the signed Waiver of Liability form. The case will be dismissed if the non-contracted provider does not submit the signed Waiver of Liability within the appeal time frame.
- Non-contracted provider's payment dispute/appeals can be mailed or faxed to the following address:

  CCA Health California
  Attn: Provider Appeals/Dispute Department 18000 Studebaker Rd, Ste 150
  Cerritos, CA 90703
  Fax Number: 866-207-6682
- Contact information
    - If you need information or need help in submitting your request, call us at 866-333-3530.
    - You may also check our website at: commonwealthcarealliance.org/ca/ for information.

Claims Oversight and Monitoring – Participating Provider Groups (PPGs)

CCA Health is dedicated to ensuring that claim functions delegated to PPGs/IPAs are processed in accordance with regulatory requirements and contractual provisions. CCA Health monitors PPGs/IPAs monthly claims processing timeliness, and performs at the minimum, annual claims audits. CCA Health audits include a review of PPGs/IPAs claims processing timelines and accuracy.

SECTION 11: Encounter Data

Encounters include all services for which a medical group is responsible. Medical groups shall submit encounter data weekly. Data must be complete and accurate. Submitted data must include national standard codes acceptable by CCA Health. The medical group must meet all data quality measurements related to encounter data submission, as established by CCA Health. The medical group will be responsible to correct any rejections and submit the corrections to CCA Health within 10 days of notice received.

Providers who are contracted with CCA Health through a delegated PPG/IPA must submit encounter data to their affiliated PPG/IPA in the format and within the timeframes established by the PPG/IPA.

A detailed error report will be provided to all encounter files submitted in 837P file formats. CCA Health will provide a report card to the medical group on a regular basis and will use this report card to evaluate the encounter data quality performance.

The CMS MA payment methodology is a risk-adjusted payment rate based on the reporting of encounter data. CMS utilizes hierarchical condition categories to calculate an annual member risk score that represents an individual member's disease burden. In order to perform the calculation, CMS and HHS require information from CCA Health annually about the demographic and health status of our members. Therefore, the clinical documentation and diagnosis code information you submit must be accurate and complete.

All claims or encounters submitted to CCA Health for risk adjustment consideration are subject to a federal internal audit. Audits may come from CMS, HHS, other regulatory or accreditation entities, or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please provide any medical records requested in a timely manner and provide all available medical documentation for the services rendered to the member.

CCA Health offers a cost-free encounter submission process via Trans Union. For information on how to submit encounter data, please contact Trans Union. Trans Union offers a robust portal to submit, correct, and manage transactions.

- TransUnion contact information:

  Email: pdl_dddcsr@transunion.com (preferred)
  Phone number: 310-337-8530
  Payer ID: TU122

- Transactions supported:

  ANSI X12 837P (professional)

  ANSI X12 837I (institutional)

  ANSI X12 999

  ANSI X12 277

SECTION 12: Accounting

Financial Ratio Analysis (PPG Only)

The Accounting department is responsible for all facets of financial reporting and data generation, timely payment of capitation, and claims. A random financial audit will be conducted by CCA Health consultants at least once a year.

PPG/IPAs must submit year-end financial statements audited by an independent certified public accountant firm within 120 calendar days after the close of the fiscal year. On a quarterly basis, financial statements must be submitted to DMHC (regulator) and CCA Health within 45 calendar days after the quarter ends.

PPG/IPA must estimate and document, on a quarterly basis, the organization's liability for incurred but not reported claims using a lag study, an actuarial estimate or other actuarial firm certified methodology and calculation.

PPG/IPA shall maintain at all times:

- A positive working capital (current assets net of related party receivables less current liability)
- A positive tangible net equity as defined in regulation 1300.76(e)
- A cash to claims ratio as defined in regulation 1300.75(f)

Capitation

The Accounting department is responsible for sending the monthly capitation payments to its contracted PPGs/IPAs. Capitation payments are made on or about the 15th day of each month or the next business day if the 15th falls on a Saturday, Sunday, or a holiday.

Capitation and eligibility reports will be posted on a secured site or what is widely known as a Secure File Transfer Protocol (SFTP) server. These reports are available to the PPGs/IPAs on the 10th of each month. Each PPG/IPA is responsible for coordinating with CCA Health on how to access the SFTP server. For security measures, only one individual per PPG/IPA is issued a username and password to access this site. Any changes to the PPG/ IPA contact person will require a new password for the PGP key. PPGs/IPAs must fill out a new PGP Key form and submit to the CCA Health IT department.

SECTION 13: Utilization Management

Purpose

The purpose of the CCA Health Utilization Management (UM) program is to determine if medical services are:

- Covered under the member's benefit plan
- Medically necessary and appropriate Performed at the most appropriate setting for the member
- CCA Health seeks to incorporate both provider and member feedback into the development of its utilization policies, practices, and guidelines.

Affirmative Statement and Non-interference

CCA Health affirms that it encourages appropriate utilization of medically necessary member care and discourages over- and under-utilization of services by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- CCA Health does not specifically reward providers or other individuals for issuing denials of coverage or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in over- or under-utilization.
- Providers are not prohibited from acting on behalf of the member.
- Providers cannot be penalized in any manner for requesting or authorizing appropriate medical care.
- Providers are ensured independence and impartiality in making referral decisions that will not influence hiring, compensation, termination, promotion, or any other similar matters.

Nothing contained in the agreement, this manual, or CCA Health's Policy and Procedures is intended or shall be construed to interfere with the professional relationship between a member and their physician(s), including the physician's ability to discuss treatment options with the member or an advocate for the member. Providers are encouraged to reach out to the CCA Health Medical Director to discuss any inquiries regarding utilization practices and or determinations. CCA Health also seeks provider feedback through its annual provider satisfaction survey. Providers likewise may not prohibit members from completing surveys and/or otherwise expressing their opinion regarding services received from providers.

Medical Necessity

"Medically necessary or medical necessity" means those covered services that are:

- Necessary for the diagnosis or treatment of a medical condition
- Provided in a manner consistent with professionally recognized standards of healthcare
- Requested and authorized in accordance with applicable CCA Health medical policy and other administrative requirements of the DMHC, the DHCS, the CMS or other regulatory agencies
- The most appropriate supply or level of service, that can be safely provided
- Not provided primarily for the convenience of a member, or for the convenience to a family member on behalf of the member, the PPG, the hospital, or the member's hospital provider

If this definition is in conflict with a definition of medically necessary services required by any regulatory agency that oversees contracted CCA Health operations, that regulatory definition shall supersede the above definition.

UM Criteria and Guidelines

Clinical Practice Guidelines (CPGs) Development and Review

Clinical Practice Guidelines are clinical references used to educate and support clinical decisions by providers at the point of care in the provision of acute, chronic, and behavioral health services. CPGs assist providers in providing members with evidence-based care that is consistent with professionally recognized standards of care.

Providers are involved in the identification of CPGs as well as their development, review, and revision, as appropriate. CPGs are reviewed and updated at least every two years or whenever new evidence emerges.

Covered Services Guidelines

CCA Health and its providers must use the following hierarchy when making coverage determinations:

1. Medicare Benefit Policy Manual
2. Medicare Claims Processing Manual
3. Medicare Managed Care Manual
4. CMS Drug Compendia
5. CMS national coverage determinations. Coverage decisions by local Medicare Administrative Contractors (MACs) with jurisdiction for claims in California. Noridian Healthcare Solutions, LLC is the designated MAC for Part A, Part B, and DME claims and National Government Services, Inc. is designated for home health and hospice claims.
    - Local coverage determinations
    - Local policy articles
    - Other MAC-based coverage bulletins
7. CCA Health or its delegates medical policies, which are based on an objective, evidence- based process
8. Other coverage policies of other Medicare Advantage Organizations in the service area, including Medicare Learning Network Matters and Articles

If there is a conflict between our policies and the CMS Medicare Coverage Center guidance, the CMS Medicare Coverage Center guidance takes precedent.

Providers that are delegated for all UM activities may also use care guidelines such as InterQual Criteria or MCG Care Guidelines to assist in UM decision-making. These guidelines should not be used as the rationale in a denial letter; rather, the denial reason must be specific to each individual case and written in a manner that a member can understand. In the absence of guidance from Medicare manuals, national coverage determination (NCD), local coverage determinations (LCD), and CCA Health policies, the delegated entity should request coverage guidance from CCA Health by contacting the CCA Health UM department at 866-333-3530.

Organization determinations (ODs) must be made by healthcare professionals who have appropriate clinical expertise in treating the member’s condition or disease and in accordance with currently accepted medical or healthcare practices, taking into account any special circumstances that may require deviation from the criteria listed above. ODs are always based on member eligibility and appropriateness of care and service. CCA Health does not reward providers or other individuals for approving or issuing denials of authorizations.

Maintenance and monitoring of timeliness for OD’s is based on the most recent CMS ODAG Record Layouts and Regulations.

UM Tools

Prior Authorization (PA)

PA is required to verify whether certain services are medically necessary and covered. Most PA decisions are delegated to CCA Health's contracted PPGs/IPAs; however, the following services may require PA from CCA Health:

- Inpatient out-of-area services that are unplanned or were not initiated within the network (always).
- Transplant procedures where CCA Health maintains the entire or partial financial risk (pursuant to the contract).
- Other services CCA Health may define, from time to time, as requiring PA or as outlined in the contract.

PA is never required for emergency services, including behavioral health services necessary to screen and stabilize members.

Requiring PA for specific services does not indicate or imply the service is a covered service. Coverage is determined by the member's benefit plan. You can access a list of services that require prior authorization and the prior authorization form for CCA Health at CCA Health provider forms and referrals link.

Health delivery organizations are responsible, prior to the date of service(s), for confirming PA approval is on file. Health delivery organizations are also responsible for admission notification for inpatient services even if the PA is on file.

Concurrent and Retrospective Review

CCA Health typically delegates responsibility for concurrent review to PPGs/IPAs and/or to other health plans; however, when not delegated, CCA Health performs inpatient (including continued stay review, discharge planning, and discharge review) and outpatient concurrent reviews. For inpatient stays, CCA Health performs concurrent review from the day of notification of admission through discharge to assure the medical necessity of each day, that services are provided at the appropriate level of care, and that necessary arrangements for discharge and/or transition of care have been made.

CCA Health also typically delegates retrospective review to PPGs/IPAs and other health plans. When not delegated, CCA Health conducts retrospective medical record review as may be required for healthcare services that were provided without formal PA and medical necessity screening. The provider should submit supporting clinical information for review along with its claim medical records to support the service.

Regardless of delegation, a retrospective review can be triggered by claims or encounter data where services are denied for failure to obtain PA, such as diagnosis-related group validation, short stay, or readmission reviews.

CCA Health may request to engage in collaborative review with its delegated entities on complex cases for the purposes of utilization management, care coordination and quality of care.

Notice Requirements

All plan providers delegated for UM management functions must use plan approved notices. Plan notice templates have been designed to meet CMS and other regulatory requirements and are available online at CCA Health provider forms and referrals link commonwealthcarealliance.org/ca/. Notification of denial must include a citation of the criteria used, rationale, and the recommendations for alternatives and/or follow-up with the provider. Notices must not use acronyms or technical/clinical terms unless an explanation or definition is provided.

Member Notice

Contracted acute care facilities of CMS are required to issue the Medicare Outpatient Observation Notice (MOON), Form CMS10611-MOON to CCA Health members who receive hospital outpatient observation services.

- Cost share may apply, please refer to the members benefit plan for cost share amounts for any observation or inpatient billing.

Providers may access instructions and the MOON forms (English and Spanish) on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.

Decision Time Frames

Part C Benefits Organizational Determinations (OD)

A member and/or their provider may seek pre-service ODs from CCA Health or its delegate, where applicable. The member and/or their provider may request that the OD be expedited when they believe that waiting for a decision under the standard time frame could please the member's life, health, or ability to regain maximum function in serious jeopardy.

Under the direction of the CCA Health Medical Director, CCA Health may downgrade an expedited request if it does not meet the criteria expressed above. However, CCA Health will not downgrade an expedited request if it includes a written physician order (MD or DO only). CCA Health may initiate a 14-day extension at the member's request or if CCA Health determines a 14-day extension is necessary to make a determination in the best interest of the member. If initiated, CCA Health will provide the member and the provider notification of the extension with grievance/appeal rights.

Part C Organization Determination and Part B Drug	Turnaround Time to Render decision and notify members and providers
Category of Utilization Management Decision	**Review and Determination Time Frame**
Standard	Determination and notification within 14 calendar days after receipt of request, and as quickly as needed based on the member's health condition
Standard extension	Up to 14 additional calendar days (not to exceed 28 calendar days) after receipt of the original request
Expedited	Determination and notification as quickly as the member's health condition requires, but no later than 72 hours after receipt of the request
Expedited extension	Up to 14 additional calendar days (not to exceed 17 calendar days) after receipt of the original request
Concurrent	Determination and notification as soon as medically indicated; usually within one business day of request
Medicare Part B Standard request	Determinations are made no later than 72 hours of request
Medicare Part B Expedited request	Determinations are made within 24 hours of request

Part D Prescription Benefits Coverage Determinations

Part D Coverage Determination TurnaAround Times to Render Decision and Notify Member and Provider	
Type	**Turnaround Time (From Receipt of Request)**
Standard	72 hours
Expedited	24 hours If a provider requests an expedited decision, the decision is automatically expedited. If the provider is not the one to make the request, CCA Health or its delegate will determine whether the request qualifies for an expedited decision.

Coordination of Care: Medical and Mental Health/Substance Use

Many members with serious medical illnesses also have mental health or substance use health conditions. Continuity and coordination of care take on greater importance for members with these comorbidities.

Please discuss with members the benefits of sharing essential clinical information with their providers, particularly their PCP and mental health providers. When applicable, we encourage you to obtain a signed release from the member that allows you to share appropriate treatment information with their other providers.

Case Management/Complex Management

Case management is the process that proactively assesses, plans, implements, and coordinates care across the continuum of care needs, as well as monitors and evaluates options and services to meet a member's needs to promote quality cost-effective outcomes. Members with highly complex needs may be transitioned to Complex Case Management when appropriate.

Providers unaffiliated with a PPG/IPA may refer members to the CCA Health Case Management program by calling the CCA Case Management Department at 866-333-3530. Providers with PPGs/IPA may refer members to their Case Management Services department.

Disease Management

CCA Health California actively works to improve the health status of our members with chronic conditions. While multiple approaches are used to identify such members, we also encourage network providers to alert us to members who would benefit from participating in a disease management program for diabetes, COPD or congestive heart failure. You can contact the CCA Case Management department at 866-333-3530 to refer a member for disease management support.

Population Health Management

The CCA Health Population Health Management Program utilizes data and health assessment information to direct interventions to members or practitioners to improve management of a condition(s) for health maintenance. Interventions are based on stratification of severity or other clinical criteria. Program content is consistent with evidence-based clinical practice guidelines. The content of the CCA Health Population Health Programs addresses the following for each condition:

- Condition monitoring (including self-monitoring and medical testing).
- Adherence to treatment plans (including medication adherence, as appropriate).
- Medical and behavioral comorbidities and other health conditions (e.g., cognitive deficits, physical limitations).
- Health behaviors.
- Psychosocial issues.
- Behavioral health screening e.g., for depression, and anxiety.
- Providing information about the patient's condition to caregivers who have the patient's consent.
- Encouraging patients to communicate with their practitioners about their health conditions and treatment.
- Additional resources external to the organization, as appropriate.

SECTION 14: Quality Improvement (QI) Program

Purpose

The purpose of the QI Program is to ensure the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The requirements for the QI Program are based on the standards of federal and state regulatory requirements, as well as NCQA standards. The QI Program provides the infrastructure and formal process needed to continuously and systematically monitor, evaluate, and improve the care and service delivered to our members. This multidimensional approach allows us to focus on opportunities to improve health outcomes and satisfaction of both members and providers, as well as improve operational processes. The QI Program promotes the accountability of all employees, delegates, providers, and any downstream and related entities for the care and service provided to our members.

QI activities are coordinated with other performance monitoring activities and management functions including, but not limited to, compliance, utilization management, case management, disease management, grievances and appeals, risk management, patient safety, credentialing, claims, customer services, and network management.

CCA Health does not delegate quality improvement activities to any other entities, other than when a corrective action plan may be requested from a provider.

Goals of the QI Program

The goals of the QI Program are to:

- Provide a clearly defined, coordinated, and centralized infrastructure that links together key departments to provide a forum to monitor performance, discuss quality initiatives, facilitate decision-making, coordinate program activities across functional areas, and make effective and efficient use of organization resources.
- Continuously monitor, assess, and improve the quality of the care, patient safety, and service members receive.
- Ensure that care and service are delivered in a culturally competent manner.

The QI Program objectives that support attainment of these goals include:

- Complying with regulatory requirements regarding QI Program activities
- Measuring and reporting performance using measurement tools, such as those required by CMS and those that are standard in the managed care industry
- Continuously monitoring and evaluating clinical and service quality indicators that reflect important aspects of care and service using benchmarks and performance goals
- Administering a Chronic Care Improvement Program to meet the needs of a defined population.
- Conducting Quality Improvement Projects (QIPs) to improve specific aspects of care or service to members, as appropriate or as mandated by CMS
- Correcting all problems that come to its attention through internal surveillance, complaints, or other mechanisms.
- Developing an annual QI Work Plan
- Implementing a program review process for formal evaluation of the impact and effectiveness of the QI Program and Work Plan at least annually
- Assessing each member's cultural, linguistic, and health literacy needs and delivering care and services in a culturally and linguistically appropriate manner to meet each member's needs

- Providing timely access and availability of care via a comprehensive provider network that is credentialed and recredentialed in a timely manner and that complies with regulatory requirements
- Ensuring the provider network complies with plan medical record standards and evidence-based clinical practice guidelines
- Implementing corrective actions when care or services delivered are identified to be of questionable quality and monitoring of the effectiveness of the corrective actions
- Ensuring the participation of contracted providers in the planning, design, implementation, and review of QI Program activities
- Overseeing all functions and implementing corrective action when oversight performance does not meet plan expectations, including termination of agreements if appropriate
- Ensuring the QI Program addresses plan issued corrective action plans when performance does not meet program expectations.

CCA Health affirms that it encourages appropriate utilization of medically necessary member care and discourages over- and under-utilization of services. CCA Health acts in the following ways to address this:

- Reviews UM statistics and information as presented by the Chief Medical Officer to identify any potential over or under utilization.
- Analyzes information and reports to determine trends or problems related to over or under utilization, medical necessity determinations, determination timeframes, provider practice or referral patterns, and develop recommendations for improvement as appropriate.

Components of the QI Program

The CCA Health QI Program is broad in scope and includes all aspects of healthcare, including both clinical care and service provided to external and internal stakeholders. The components of the QI Program include:

- A health information system to collect, analyze, and report accurate and complete data
- Plan-determined internal quality improvement activities
- A Chronic Care Improvement Program
- A Quality Improvement Project, as appropriate
- Collection and reporting of Healthcare Effectiveness Data and Information Set measures
- Participation in Health Outcomes Survey if enrollment meets threshold
- Participation in Consumer Assessment of Healthcare Providers and Systems (CAHPS®) if enrollment meets threshold
- Collection and reporting of Part C reporting elements
- Collection and reporting of Part D reporting elements

Role of Contracted Providers

CCA Health does not delegate quality improvement activities to the IPAs. However, CCA Health providers are required to meet quality standards and comply with the CCA Health Quality Improvement Programs to ensure the necessary infrastructure to coordinate care, promote quality, optimize performance and efficiency on an ongoing basis. Providers are expected to participate in the following activities, among others:

- Quality improvement activities to satisfy regulatory requirements such as a Chronic Care Improvement Program Quality and Improvement

- Data exchange by routinely reporting data to the Plan for HEDIS, CMS or NCQA requirements and data reconciliation to identify clinical gaps and data gaps
- Timely submission of claims and encounters, including member level results (e.g. laboratory tests, eye exam, BP values)
- Medical record review process to ensure adequate capture of diagnosis and services
- Demonstrated efforts to achieve compliance with industry-wide standards and benchmarks
- Facilitation of member outreach to improve the quality of care or services and enhance member experience
- Support of the plan's Stars strategy designed to improve health outcomes
- Promotion of health equity and provide culturally and linguistically appropriate services to members
- Identification of and address social determinants of health
- Corrective action plan may be requested from a provider to remediate identified deficiencies

Medical Records

Medical records are an important component of delivering high quality care to members. Providers are required to maintain accurate and complete paper or electronic medical records for each of the CCA Health members for whom they provide care. CCA Health conducts medical record reviews for multiple purposes to support the quality management program, contractual obligations, and regulatory reporting requirements.

Requirements

Medical records should include all information as required by applicable state and federal laws. CCA Health reviews medical data for HEDIS® at certain times of the year for quality improvement initiatives. Medical record reviews may require data collection on services obtained over multiple years. Archived medical records or data may be required to complete data collection.

For HEDIS® reporting, medical records are reviewed to validate if services were rendered but may not have been captured as claims data, such as blood pressure readings, HbA1c lab results, eye exams, historical information on breast cancer or colorectal cancer screenings. This information helps enhance member quality improvement initiatives. A CCA Health employee or designated vendor(s) will perform the HEDIS reviews and will contact your office to establish a date for an onsite visit or the option to fax, mail or send the information via secure file transfer protocol. Provider offices are responsible for responding to medical record requests and providing the documentation requested in a timely manner. If your office is selected for an onsite visit, please have the medical records available ahead of time. If a chart for a patient is being requested and not available at your practice location, you should notify the CCA Health employee or the designated vendor immediately. CCA Health requests that providers allow CCA Health employees or its designated vendor(s) to scan the medical records during an onsite visit. HEDIS requires proof of service for any data that is collected from a medical record.

Documentation

All medical record documentation must be legible, detailed, organized in a consistent and logical matter, and in adherence with each provider's internal practice protocols. All entries into the medical record should be dated and signed or initialed by the author and must include the author's credentials (e.g., medical doctor or advanced registered nurse practitioner. Providers are also responsible for maintaining the confidentiality of medical records and the information contained within them.

Reviews

If medical records are found to contain significant deficiencies during the review process, the provider will be provider's notified by CCA Health of the deficiency as well as remediation plans.

Chronic Care Improvement Program

CCA Health will establish a Chronic Care Improvement Program (CCIP) that will be in full compliance with CMS requirements, using the Plan/Do/Study/Act quality improvement cycle. Following the disease management model, the CCIP will be designed to support physician/patient plan of care, emphasize prevention, and evaluate outcomes on a continuous basis.

As required by CMS, the plan will await CMS approval of its CCIP design prior to implementation. Summary reports of CCIP activities will be submitted to CMS, upon request, using the CMS mandated QIP submission Plan/Do/Study/Act template.

CCA Health will identify members who would benefit from participation in the CCIP through its various data sources, such as claims, encounters, pharmacy, lab, or health risk assessments. Using clearly defined technical specifications or predictive modeling software plan will data mine these sources to identify members who meet defined eligibility criteria.

Members who participate in the CCIP will be monitored using the above data sources and metrics specific to the CCIP. Plan will evaluate the health outcomes, quality indices, and/or improved operational systems following interventions to assess the effectiveness of its CCIP. This will be done through the QIC. As described above under QI Methodology, once the project has been implemented, the QIC monitors appropriate indicators to assess the effectiveness of the interventio ns. The QI department is charged with providing regular reports to the QIC on the progress of all QI initiatives, including the CCIP.

Quality Improvement Projects

CCA Health will conduct Quality Improvement Projects (QIPs) that are in full compliance with CMS requirements, using the Plan/Do/Study/Act quality improvement cycle as appropriate. QIPs may be clinical or nonclinical in focus.

As required by CMS, plan will await CMS approval of its QIP design prior to implementation. Summary reports of QIP activities will be submitted to CMS, upon request, using the CMS mandated QIP submission Plan/Do/Study/Act template.

CCA Health systematically and periodically follows up on QIPs to assure improvements are sustained by ongoing monitoring of the metrics related to the project. This is accomplished by carrying forward previously identified projects on the annual QI Work Plan. As scheduled on the QI Work Plan, updated status reports are provided to the QIC periodically.

Data Collection and Reporting Activities

HEDIS® Reporting

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures for managed care organizations. When data are available, CCA Health will collect and report HEDIS data for the plan membership, including patient-level data as required by CMS, using certified HEDIS software.

CCA Health will contract with a HEDIS auditor firm that is licensed by NCQA to conduct HEDIS Compliance Audits. The auditors will certify all final results before submission of CCA Health data is allowed.

The CCA Health HEDIS software vendor will use the plan's source healthcare data to calculate preliminary results. It will then draw samples, assign chase logic and produce detailed lists to be used in obtaining data for the hybrid measures, which use both administrative and medical record data. The plan will use either internal staff or external vendors to conduct medical record abstractions for these hybrid measures. After the medical records have been collected, they will be reviewed by a qualified medical record reviewer for compliance with HEDIS technical specifications and the findings incorporated into a final database in order to calculate final indicators to be submitted to NCQA. A patient level file containing patient-level results will also be created and submitted to CMS.

Health Outcomes Survey Reporting

The Medicare Health Outcomes Survey (HOS) is a survey designed for the Medicare population in managed care settings. It assesses a health plan’s ability to maintain or improve the physical and mental health of its Medicare members over time. When CCA Health has achieved the threshold enrollment required to conduct the HOS, it will contract with an NCQA certified HOS survey vendor to administer the survey and report the results according to CMS protocol and timeline.

. Using the methodology defined in the QI Methodology section above, plan will use the HOS results to identify and prioritize opportunities for improvement and take action.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Reporting

The Consumer Assessment of Healthcare Providers and Systems Health Plan Survey is a tool for collecting standardized information on members’ experiences with health plans and their services. Since its launch in 1997, this survey has become the national standard for measuring and reporting on the experiences of consumers with their health plans. When CCA Health has achieved the threshold enrollment required to conduct the CAHPS survey, it will contract with an NCQA-certified CAHPS survey vendor to administer the survey and report the results according to CMS protocol and timeline.

Using the methodology defined in the QI Methodology section above, the plan will use the CAHPS results to identify and prioritize opportunities for improvement and take action.

Part C Reporting Elements

Part C Reporting is required by CMS on an annual basis for all Medicare Advantage plans. This reporting consists of various measures related to general utilization and benefits, provider network and payment, organizational determinations, reconsiderations and grievances, agent oversight, enrollment, and management. The reporting calendar is specific by measure but in general is required once a year, and reporting can be required at plan or PBP level. Due to the complexity of the reporting, each measure is assigned to a specific area (or areas) within the company. These may include IT, Provider Network, Compliance, Enrollment, QI, Grievances, and Appeals, UM, Sales, etc. Each area in turn has specific policies and procedures detailing the methodology used to collect, analyze, validate, and report each measure using data found in various electronic systems. The information is compiled and entered into HPMS, the CMS reporting portal, in order to comply with established due dates.

Using the methodology defined in the QI Methodology section above, CCA Health uses the Part C Reporting Elements to identify and prioritize opportunities for improvement and take action.

Part D Medication Management Therapy Reporting

CMS has established Part D Medication Therapy Management Reporting requirements for MA Organizations.

The Medication Therapy Management program is designed to optimize therapeutic outcomes, improve medication use, reduce health risks, and improve compliance with medication therapy for appropriately selected members. Using the methodology defined in the QI Methodology section above, CCA Health uses the Part D Medication Management and Reporting data to identify and prioritize opportunities for improvement and take action.

Accessibility of Services

CCA Health ensures that for each provider the quality improvement mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, an d appropriate preventive health services based on reasonable standards established by regulatory agencies.

CCA Health has established standards to assure access to primary care, specialty care, and behavioral health and member services. Standards include, but are not limited to:

- Preventive care appointments

- Regular and routine care appointments
- Urgent care appointments
- After-hours care
- Wait times
- Telephone service

CCA Health conducts annual access to care internal audits to implement measure improvement.

Annual QI Work Plan

The CCA Health's annual QI Work Plan provides a schedule of QI objectives, scope, and planned projects or activities for the year. The QI Work Plan includes scheduled monitoring of previously identified issues and tracking of issues over time. The QI Work Plan also contains schedules for reporting QI activities to the board, annual Evaluation of the QI program, updating of the QI Program Description, and establishment of a new QI work plan for the coming year. If any QI activities have been delegated to other entities, the QI Work Plan contains a schedule for the evaluation of those activities. Components of the QI work plan includes written measurable objectives that identify the action items, timeframes, and responsible parties.

The annual QI Work Plan is presented to the QI subcommittee for review and approval.

Annual QI Program Evaluation

The QI Program Description and QI Work Plan govern the QI Program structure and activities for a period of one (1) calendar year. Annually the QI Department facilitates a formal evaluation of the QI program, which is an assessment of the effectiveness of the QI Program in improving the quality of care and service provided. The plan uses the annual QI Program Evaluation as an opportunity to make QI Program revisions and identify QI Work Plan objectives and activities for the coming year. When the QI Program has not met its goals, barriers to improvement are identified and appropriate changes are integrated into the subsequent annual QI Work Plan.

The annual QI Program Evaluation includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- An evaluation of the results of QI activities, including trending of measures to show performance over time compared with established performance thresholds.
- An analysis of the results of QI initiatives, including barrier analysis to identify reason when goals are not met.
- Recommendations for the upcoming year, including identification of activities that should carry over to the next year.
- An evaluation of the overall effectiveness of the QI Program, including adequacy of resources, committee structure, practitioner participation, and leadership involvement in the QI Program.

The written annual QI Program Evaluation is presented to the QI subcommittee for review and approval.

- Delegation of responsibilities

Network Access and Accessibility Standards

See the Network section above for information regarding CCA Health's network access and adequacy standards.

CMS Star Ratings

Several industry quality programs, including the programs for CMS star ratings, provide external validation of our MA and Part D benefit plan performance and quality progress. Quality scores are provided on a one- to five-star scale, with one star representing the lowest quality and five stars representing the highest quality. Star ratings scores are derived from several sources:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Healthcare Effectiveness Data and Information Set Health Outcomes Survey Part D Pharmacy performance
- CMS administrative data

To learn more about star ratings and view current star ratings for MA and Part D benefit plans, go to the CMS consumer website at: www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data

Serious Reportable Events/Adverse Events/Sentinel Events:

As an MA provider, you must comply with all CMS guidance regarding billing, coding, claims submission, and reimbursement rules including reporting serious adverse events (defined as an unintended harm, injury, or loss that is more likely associated with a patient's interaction with the healthcare system than from an attendant disease process) by populating the present-on-admission indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. If the never event has not been reported, we will attempt to determine if any charges filed with us meet the criteria, as outlined by the National Quality Forum and adopted by CMS, as a serious reportable adverse event. If you fail to comply with these requirements, your claim will be denied and will be your liability; you may not bill the member for these charges.

SECTION 15: Sales and Marketing

Gifts and Business Courtesies

Even if certain types of remuneration are permitted by law, the plan discourages providers from giving gifts, meals, entertainment, or other business courtesies to prevent the appearance of or an actual conflict of interest.

Marketing and Beneficiary Inducements

CCA Health is responsible for any comparative/descriptive marketing materials developed and distributed on our behalf by providers. As such, we must ensure that any providers and their subcontractors comply with the CMS marketing rules.

Providers and their subcontractors may not:

- Offer sales/appointment forms or accept enrollment applications
- Direct, urge, or attempt to persuade members to enroll in a specific plan based on financial or other interests
- Mail marketing materials on behalf of plan sponsors
- Offer anything of value to induce plan members to select them as their provider
- Offer inducements to persuade members to enroll in a particular plan
- Screen for health when distributing information to patients
- Accept compensation directly or indirectly from the plan for enrollment activities
- Use the CCA Health logo, or engage in co-branding, without CCA Health's prior written consent

Under no circumstances may a provider steer, or attempt to steer, an undecided potential member toward a particular plan, or limited number of plans, offered either by the plan or another plan sponsor, based on the financial interest of the provider or its subcontractors. Providers should remain neutral parties in assisting plan sponsors with marketing to members or assisting with enrollment decisions.

Providers may, however, provide the names of plans with which they contract and objective information on all benefits based on a particular patient's medications and healthcare needs. Providers may also make available or distribute plan marketing materials, display posters for all plan sponsors being offered, and refer their patients to other sources of information, such as the CMS website or phone number at www.medicare.gov and 1-800-MEDICARE (800-434-0222).

SECTION 16: Compliance and Fraud, Waste and Abuse (FWA)

Preventing Health Care Fraud, Waste and Abuse

CMS Regulations

CCA Health is a Medicare Advantage plan (HMO) and has established this section to address compliance with the laws and regulations governing the delivery of healthcare services as a Medicare Advantage Organization as set forth by the Centers of Medicare & Medicaid Services (CMS).

All regulations are required to be communicated to all providers through policies, standards, and manuals. Providers are responsible for implementing and adhering to all CMS regulations outlined in the manual and contract.

Fraud, Waste and Abuse

Health care fraud is a significant concern for CCA Health and the entire health insurance industry. According to National Health Care Anti-Fraud Association estimates, 3 to 10 percent of what Americans spend annually on health care is lost to fraud — that's between $84 billion and $280 billion a year. Health care fraud can also put members' safety at risk.

We take a proactive approach to detecting and investigating potential healthcare fraud, waste and abuse. CCA Health has a Fraud, Waste and Abuse Program to detect and investigate allegations of fraud, waste and abuse. The FWA Program detects potential fraud, waste and abuse through ongoing audits and analysis of billing patterns. The FWA Program also receives reports or complaints of suspected fraud, waste and abuse. Regardless of how the issue is detected, the FWA Program investigates each instance of potential fraud, waste or abuse, including collection of necessary documents, data and information.

The mission of the CCA Health FWA Program is to prevent, detect, investigate, report and, when appropriate, recover money lost to healthcare fraud and abuse.

CCA Health strives to protect all healthcare dollars that otherwise might be lost or wasted. Our FWA Program works with members; providers; state, federal and other law enforcement agencies; and other healthcare providers to address fraud and abuse. The FWA Program is authorized to conduct pre-payment and post-payment reviews to ensure compliance with regulations and contract provisions.

Regulations

In accordance with 42 C.F.R. §§ 422.504(i)(4)(v), all business conducted by CCA, and its contracted entities must be in compliance with applicable federal and state requirements, laws, and regulations; applicable local laws and ordinances; and the ethical standards/practices of the industry.

General Compliance and Fraud, Waste and & Abuse Training

All providers contracted with CCA are required to complete general compliance and FWA training on an annual basis. If a provider is enrolled in the Medicare Part A or B program, these training and education requirements are determined to have been satisfied. The Centers for Medicare and & Medicaid Services (CMS) has developed a "Medicare Parts C and D General Compliance Training" program and a "Medicare Parts C and D Fraud Waste and Abuse Training." There is a "certificate of completion" at the end of the training, and we encourage all providers and their employees to retain a copy of the certificate in their records. CCA reserves the right to request verification and/or conduct audits of our providers to verify adherence to this training requirement.

What are Fraud, Waste, and Abuse?

Federal and state laws have specific provisions describing fraud, waste and abuse, which providers must follow, and CCA Health helps enforce. In addition, CCA Health provider contracts have important terms addressing fraud, waste and abuse.

One example of a federal anti-fraud law is the Anti-Kickback Statute (42 U.S.C. § 1320a- 7b), which imposes criminal sanctions for the exchange (or offer to exchange) of anything of value to induce (or reward) the referral of business paid by

Medicare funds. Another example is the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), which imposes substantial financial penalties against a provider for certain activities including knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way or offering or giving something of value to any beneficiary of a federal healthcare program likely to influence the receipt of reimbursable items or services. The following are more examples of fraud, waste, and abuse.

Fraud: This occurs when someone makes a false statement, false claim or false representation to CCA Health where the person knows or should reasonably know the statement, claim or representation is false; and where the false statement, claim or representation could result in an unauthorized benefit to the person or some other person. Fraud includes, but is not limited to, intentionally committing the following acts:

- Billing for services or supplies that were not provided.
- Altering claims to receive a higher payment.
- Offering bribes or kickbacks in exchange for referrals.
- Allowing someone who is not eligible for CCA Health coverage to use a member's ID card.
- Altering or creating documents to show delivery of items not received or services not rendered.

Waste: This is any over-utilization of services and misuse of resources that is not caused by fraud or abuse. Examples of waste include:

- Ordering excessive laboratory tests.
- Submitting excessive duplicate claims.

Abuse: Abusive practices are not one-time errors. They include misusing codes on a claim, such as upcoding or unbundling codes, as well as balance billing or imposing unauthorized charges on a members. They may include any of the following:

- A pattern of practice that is inconsistent with sound fiscal, business or medical practices and either directly or indirectly result in unnecessary costs to CCA Health, or that fail to meet professionally recognized standards for healthcare, including:
  - Practices that result in unnecessary costs to the federal and state program funds that CCA Health administers
  - Practices that result in reimbursement for services that are not medically necessary
  - Practices that fail to meet professionally recognized standards for health service
- Member practices that result in unnecessary cost to CCA Health
- Substantial failure to provide medically necessary items and services that are required to be provided to a member if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the member

Documentation

Providers must develop and maintain health service records to seek a claim for payment from CCA Health. Each occurrence of a health service must be documented and retained in the member's health record in accordance with CCA Health, state and federal requirements. Claims paid for health care, services, supplies or equipment not documented in the health service record are subject to recovery by CCA Health, and may be considered fraud, waste or abuse.

The record must be legible at a minimum to the individual providing the care or service and contain the following elements, when applicable:

- The date on which the entry is made.
- The date or dates on which the health service is provided.
- The length of time spent with the member, if the amount paid for the service depends on time spent.

- The signature and title of the person from whom the member received the service.
- Report of the member's progress or response to treatment, and changes in the treatment or diagnosis.
- The countersignature of the supervisor and documentation of supervision (if applicable).
- A copy of authorization for the service or item (if applicable).
- All other state and/or federal requirements.

In addition, the record must state, as applicable:

- The member's case history and health condition as determined by the provider's examination or assessment
- The results of all diagnostic tests and examinations
- The diagnosis resulting from the examination
- Reports of consultations that are ordered for the member
- The member's plan of care, individual treatment plan or individual program plan
- The record of a laboratory or radiology service must document the provider's order for service
- For other service-specific record requirements, refer to the appropriate chapter in this manual

Investigative Process

The CCA Health FWA Program, in conducting fraud, waste and abuse investigations, may:

- Interview providers, members, or other witnesses
- Visit a provider's facility to collect records or inspect the equipment and premises
- Request records via mail, fax, or verbal request
- Inspect business records, payroll, inventory, or other items

Providers are required to cooperate with CCA Health audits or investigations, consistent with your CCA Health contract provisions, CCA Health policy and applicable laws. The lookback period related to FWA recoveries shall supersede any audit period or lookback period stipulated in any CCA Health contract provisions. Failure to cooperate may result in claim payments being denied or recovered by CCA Health.

If an investigation finds there is evidence of fraud, waste, or abuse, CCA Health may recover identified overpayments, place the provider on a corrective action plan, bar the provider from billing certain codes, require submission of records, and if necessary, suspend or terminate the provider's participation. If a credible allegation of fraud is uncovered, CCA Health may suspend payment to the provider in accordance with state and federal requirements and applicable law. In the event that overpayments are identified by or reported to the FWA Program, they will be recovered in a manner that complies with CCA's Encounter reporting and will be reported to state and federal agencies accordingly. As required by law, CCA Health makes referrals as appropriate to the National Benefit Integrity (NBI) MEDIC or law enforcement agencies.

Avoiding and Preventing Healthcare Fraud

Avoid and prevent fraud by following applicable laws and regulations along with CCA Health contract requirements for claims submission and payment. Here are some other tips:

- Always remain current with billing and coding requirements for your area of service.
- Monitor your patient base for potential card sharing and other acts of misrepresentation.
- Only bill for service or equipment that was rendered, and only that which has been properly documented.

- Implement internal audit or self-audit protocol to identify mistakes and errors in billing.
- Proactively void, replace or request adjustment to any claims you identify as erroneous (see Section 10, Claims).
- Most importantly, report any suspected fraud, waste or abuse to CCA Health. If you suspect any compliance concern, including suspected incidents of FWA related to CCA member or program, please report it via in one of the following methods:
  - Call the CCA Interim Chief Compliance Officer at 617-426--0600 (ext. 52376)
  - Call the CCA Compliance Hotline at 866-457-4953. The Compliance Hotline is a confidential and anonymous avenue for reporting a compliance concern such as a suspected fraud, waste, or abuse case
  - Submit a Compliance Incident Report
  - Email cca_compliance@commonwealthcare.org. Please note that this is not an anonymous method.

Policies and Procedures

CCA maintains Compliance and FWA policies, including the following relevant topics:

Compliance Training and Education

Fraud, Waste, and Abuse

Reporting, Investigating, and Externally Reporting a Compliance Concern

Compliance Monitoring

Compliance Auditing

Whistleblower Protections, False Claims Act, and Deficit Reduction Act

Anti-Kickback Statute and Stark Law

Obligations for Providers of Services to Medicare Advantage Enrollees

Providers of administrative or healthcare services to Medicare eligible individuals, including the CCA Health Medicare Advantage plan, are considered first-tier entities as defined by the Centers for Medicare & Medicaid Services (CMS). (See the CMS Medicare Managed Care Manuals Chapters 9 and 21). To meet the CMS requirements related to CCA Health oversight of first-tier entities, we require providers to attest to the following:

- Provider or delegate confirms that its owners, controlling interest parties, managing employees, employees and applicable downstream entities are not excluded from participation in state or federal healthcare programs prior to hire or contract, and annually thereafter.
- Provider or delegate Code of Conduct is comparable to the CCA Health Code of Conduct in that it meets the requirements of the Medicare Managed Care Manuals, Chapters 9 and 21.
- Employees and applicable downstream entities have completed compliance and fraud, waste and abuse training that meets required standards. CMS requires completion of compliance and fraud, waste and abuse training by employees of organizations that provide healthcare or administrative services for Medicare eligible individuals under the Medicare Advantage and Medicare Part D programs. This training must be completed within 90 days of hire and annually thereafter. The annual training must be completed no later than December 31 each year.
  - One way to satisfy this requirement is by completing CMS' web-based training through the CMS Medicare Learning Network for providers at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.
  - Select the publications title Combatting Medicare Parts C and D Fraud, Waste and Abuse and Medicare Parts C and D General Compliance . Note: you will need to register with the MLN prior to taking these trainings: How to Access and Use the Medicare Learning Network (MLN) Learning.

    - CCA Health along with other Medicare Advantage organizations (sponsors) participating in the industry collaborative effort (ICE), agreed to collaborate and use the same attestation form with other sponsors to facilitate the oversight and monitoring for first-tier entities compliance with the CMS, and other federal and state requirements, laws, rules, and regulations. We are asking our first-tier entities to complete and an Attestation form that will be shared with other sponsors that participate in ICE for shared compliance. To participate, an Attestation form must be signed by an individual with the authority to attest to the accuracy and completeness of the information provided. First-tier entities that want to participate must submit the completed Attestation form within 15 days of contracting with the plan. Timely submission is a condition of continued first-tier entities and sponsor contracting.

- Provider will report suspected Medicare or Medicaid program violations and fraud, waste, and abuse concerns to CCA Health and provider's employees are trained on reporting processes including to the appropriate health plan. CCA Health has a strict no-retaliation policy for good-faith reporting.
    - Failure to report suspected Medicare or Medicaid program violations or fraud, waste and abuse concerns may result in disciplinary action up to and including termination of provider's contract with CCA Health.
- Monitoring your downstream entities. Providers who are first-tier entities, as defined in the Medicare Managed Care Manuals Chapters 9 and 21, must ensure they have a system in place to monitor any of their downstream entities' compliance with Medicare or Medicaid program requirements. Prohibited affiliations per 42 CFR 438.610 must be reported immediately in writing to CCA Health upon discovery.
- To accomplish oversight of these Medicare requirements, CCA Health may:
    - Audit the provider
    - Require self-monitoring reporting, such as training completion evidence, of the provider;
    - Require the provider complete a survey or submit an attestation

Offshore Subcontracting

First-tier, downstream, and related entities (FDRs) must have policies that:

- Ensure that personal health information and other personal information remain secure
- Appropriately limit subcontractors' access to Medicare data
- Allow for immediate termination of the subcontractor upon discovery of a significant security breach
- Include language that requires compliance with applicable laws and CMS regulatory guidance

The CCA Health Code of Conduct

As a provider serving CCA Health members, you are a critical component of CCA Health corporate culture of integrity and openness. The CCA Health Code of Conduct reflects the ethical and legal expectations for our employees, volunteers, Board of Directors and business partners—such as you. CCA Health mission and values, and this Code of Conduct, express a consistent message of doing the right thing for CCA Health members, CCA Health employees and company, our business partners and government agencies.

Written Standards

First-tier, downstream, and related entities (FDRs) must have written standards, either stated in a separate Medicare-specific stand-alone document or within a corporate Code of Conduct, which describe at a minimum the FDRs:

- Mission and commitment to compliance with law and to the highest ethical standards
- Procedures to avoid conflict of interest
- Procedures for fraud, waste, and abuse prevention, detection, and correction
- Policy of non-intimidation and non-retaliation
- Method of frequency by which provider distributes standards of conduct to employees and downstream entities (required within 90 days of hire, upon update and annually thereafter)
- System for routine monitoring and identification of compliance risks
- Compliance Officer and high-level oversight

Exclusions Screening, Oversight, and Records

- Ensure that no persons or entities are excluded or become excluded from participation in federal programs. See Social Security Act 1862 (e)(1)(B), 42 CFR 422.752 (a)(6), 1001.1901
- Describe oversight of FDRs and process to monitor and audit FDRs
- Specify retention of compliance related records for 10 years, or longer, if required by applicable law

No Incentives for Providers to Deny or Restrict Care

Our policy is to comply with federal and state requirements concerning physician incentives. CCA Health and our delegates will never offer or give providers anything of value in exchange for denying or restricting medically necessary care for a member.

Payment arrangements that place physicians at financial risk for referral services are appropriate, but they must be reviewed closely by appropriate staff to ensure compliance.

Clear, Accurate, and Appropriate Marketing Information

We provide members and potential members clear, accurate, and appropriate information about our services and members' rights. Our policy is to comply with all federal and state requirements for government agency review of marketing materials and other materials distributed to members. Employees and our delegates with direct contact with members and potential members are trained to provide accurate information. If an inaccuracy is discovered–particularly in materials describing benefits and plan rules–members will be informed as soon as possible. CCA Health sales agents are prohibited from conducting door-to-door marketing, and all sales and marketing activities must comply with applicable Medicare guidelines.

No Illegal Gifts

CCA Health and our delegates do not offer cash or monetary rebates to individuals to induce their enrollment and follows applicable federal anti-kickback laws and laws prohibiting inducement. However, we may offer promotional gifts of nominal

value in compliance with regulatory agency marketing requirements. In addition, health promotion programs may provide members gifts in exchange for using preventive health-related services.

Employees and delegates involved in marketing and health promotion programs must consult their supervisors, or the Chief Compliance Officer, if they have any questions about providing members and potential members with gifts or incentives.

Required Benefits

CCA Health complies with all benefit requirements imposed by law and defined by government agencies such as the Center for Medicare & Medicaid Services (CMS). For example, we do not require providers or members to seek CCA Health prior approval before providing or receiving urgent care and emergency medical services. In addition, we do not deny claims for payment where the service provided meets the criteria of a medical emergency, according to a prudent layperson standard.

Open Communication

CCA Health never imposes incentives or requirements on physicians to discourage free and open communication about healthcare treatment options with members. We proactively respond to member concerns and questions. At members request and as required by law, we provide information or access to information. For example, we must respond to a member's question about how we pay providers.

No Discrimination

CCA Health does not discriminate against beneficiaries, applicants, enrollees, or the public at-large based on race, color, national origin, sex, age, or disability in any of our products. Additionally, CCA Health accepts all eligible beneficiaries who select or are assigned to CCA Health without regard to medical condition, health status, receipt of healthcare services, claims experience, medical history, genetic information, disability (including mental or physical impairment), marital status , age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance status, or political beliefs. This means that CCA Health does not do the following based on the classifications noted above:

- Deny, cancel, limit, or refuse to issue or renew health insurance
- Deny or limit coverage of a claim
- Impose additional cost sharing or other limitations or restrictions on coverage
- Use discriminatory marketing practices or benefit designs
- Have categorical exclusions or limitations in coverage for all healthcare services related to gender transition, as permitted under other legal, regulatory, or contractual obligations

CCA Health members must receive services free of any illegal discrimination, including violation of federal and state civil rights laws. Any person who believes someone has been subjected to discrimination by CCA Health employees, contractors, subcontractors, or delegates based on race, color, national origin, sex, age or disability may file a grievance. It is against the law for CCA Health to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Non-English-Speaking Population

CCA Health members with Limited English Proficiency (LEP) are entitled to Free and Timely language assistance services.

CCA Health and our delegates must know how to assist members with LEP. CCA Health LEP language assistance services include, among other things, information to guide employees and our delegates, such as: how to access interpreters, how CCA Health ensures the competence of interpreters, contact information for CCA Health Member Services for accessing LEP services and the complaint process for members.

We also make meaningful efforts in marketing, member communication, and healthcare delivery to recognize cultural differences among members and potential members. For example, we provide member materials in alternative formats or

in non-English languages in a timely manner and free to members. We cover language and sign interpreter services when members are eligible for such services.

In carrying out the activities outlined in CCA Health LEP services, we ensure members with LEP have access to information that will help them understand and receive the services and benefits available to them.

Maintaining Member Confidentiality

CCA Health and our delegates will follow CCA Health policies and procedures to ensure that confidential information about members is protected. Violation of confidentiality requirements results in disciplinary action, up to and including termination of employment. Any unauthorized release of or access to protected health information must be reported to a supervisor, the Privacy and Security Officer, or the Chief Compliance Officer.

Anti-Kickback Laws

Federal and state anti-kickback laws prohibit CCA Health and our delegates and providers from knowingly and willfully offering, paying, asking, or receiving any cash or other payment (such as a discount or an item of value), directly or indirectly, in return for referrals, arrangements, or orders for any good or service that could be reimbursed by public healthcare programs.

CCA Health Code of Conduct: Contacting CCA Health

Anyone conducting business with CCA is expected to report Compliance concerns or any suspected cases of fraud, waste, or abuse to CCA through one of the following reporting mechanisms, without fear of retaliation or retribution for reports made in good faith:

- Fill out a Compliance Incident Report
- Report to the CCA Compliance Hotline at 866-457-4953 (may be reported anonymously)
- Email cca_compliance@commonwealthcare.org
- Mail directly to:

  Commonwealth Care Alliance
  Attn: Fraud, Waste, and Abuse Program
  30 Winter Street, 11th Floor
  Boston, MA 02108

SECTION 18: Appendix B – Member Grievance and Appeal Form (Sample)

MEMBER GRIEVANCE AND APPEAL FORM

STEP 1:
Please call a Member Services Representative to discuss your compliant. He or she may be able to save you time and resolve your issue. A CCA Health Member Services Representative is available to helpyou at 1-866-333-3530 for additional information. (TTY users should call 711). Hours are 8 a.m. to 8p.m., seven days a week from October 1 through March 31, except holidays, and 8 a.m. to 8 p.m., Monday through Friday, from April 1 through September 30, except holidays. Messages received on holidays and outside of our business hours will be returned within one business day.

STEP 2:
Please complete the Member Grievance and Appeal Request form below with as much information as possible. You may also choose to send your own letter describing your concerns.

STEP 3:
If you appoint someone to act as your representative with your grievance or appeal, you and your Appointment of Representative (AOR) must send a completed the Appointment of Representative form. Please contact a CCA Health Member Services Representative to have the AOR form mailed to you. Also, the AOR form is available via our website: www.ccahealthca.org.

Sending in all the necessary forms together as described above will support a timely review.

STEP 4:
Once this form is completed please return this form and/or appointment of representative documentation via facsimile at 1-866-207-6539 or mail to:

CCA Health California
Attention: Grievances and Appeals Department
18000 Studebaker Road, Suite 150
Cerritos, CA 90703

MEMBER NAME:	DAYTIME PHONE:
ADDRESS:	
MEMBER ID #:	DATE OF EVENT:
DATE OF SERVICE OF GRIEVANCE OR APPEAL:	
NAME OF FACILITY OR PROVIDER INVOLVED (if applicable):	
FACILITY OR PROVIDER PHONE #:	FACILITY OR PROVIDER ADDRESS:

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For more information and the fully approved copy of the Member Grievance and Appeal form please visit our website at: https://www.commonwealthcarealliance.org/ca/members/member-rights-and-responsibilities/complaints-and-grievances

Please provide information about your complaint. Please feel free to attach extra pages if you need more space.

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MEMBER'S SIGNATURE: ________________________________ **DATE:** __________

(We must have your signature and date in order to process your appeal)

CCA Health California is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-333-3530 (TTY: 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-333-3530 (TTY:711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-333-3530（TTY：711）。

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