Contra Costa Health Plan
2024 Q2 Provider Network Training
Tuesday, April 30, 2024
Virtual Venue: Zoom

CHAIR

Irene J. Lo, M.D. – Chief Medical Officer

CO-CHAIR

Nicolas E. Barcelo, M.D. – Director of Quality

ATTENDANCE

Asher Balagot, Brandon Needens, Brenda Cordova, Christina Gallo, Crystal L., Erin Mellas, Gretchen Graves, Gurbir Kaur, Irene Lo, M.D., Ivana Woolfson, Jay Myers, Jenese Culp, Jill Perez, Juliana Mondragon, Kelly Liao, Malu Trehan, Maria Aisa Laico, Mary Whitlock, Mia Janay Henderson-Bonilla, Michael Lange, Michele Arnone, Michele Zorovic, Nicolas E. Barcelo, MD, Phyllis Carol, Sara Levin, MD, Sharon Jones, MD, Suresh Sachdeva, Suzanne Tsang, Vicky Tejada

GUEST: K. Wortman, PhD, Clinical Neuropsychologist

Topic	Discussion/ Decision Action	Person Assigned and Follow-Up Date
Call to Order	Meeting started at 12:03 p.m. and ended at 1:24 p.m.	*Irene Lo, M.D., Chief Medical Officer, CCHP*
	Regular Reports	
Agenda Overview	Navigating ADHD: Integrating Neuropsychological Assessments into PCP, Behavioral Health Updates, Quality Updates, Transitional Care Services, Non-Emergency Medical Transportation, Community Health Workers, Provider Disputes, Claims and Chief Medical Officer Updates	*Irene J. Lo, M.D., Chief Medical Officer, CCHP*

Navigating ADHD: Integrating Neuropsychological Assessment into Primary Care Provider (PCP)	ADHD Diagnosis, Subtypes, and Co-Occurring Conditions
	• *Diagnosis and Symptoms of ADHD.*
	  ○ Neurodevelopmental symptoms should have started before age 12.
	  ○ Symptoms present in 2 settings (home, school or work; with friends or relatives; in other activities)
	  ○ Functional impairment – interferes with or reduce the quality of social, school or work functioning.
	  ○ Symptoms are not better explained by another mental disorder; i.e. PTSD or other medical diagnosis, a TBI, a sleep disorder, etc.
	• *Diagnostic and Statistical Manual of Mental Disorders (DSM) – 5 TR ADHD Symptoms.*
	  ○ Inattention (should meet 5+ symptoms for adults)
		K. Wortman, PhD, Clinical Neuropsychologist

	○ Hyperactivity and Impulsivity (should meet 5+ symptoms for adults) ○ There is a lot of sensory processing difficulties and communication difficulties. A lot of these people use stimming to help with attention. • *Three Subtypes of ADHD*. Three subtypes of ADHD: inattentive, hyperactive, and combined, and noted that ADHD is highly heritable. • *ADHD is Highly Heritable*. Research shows thirty percent (30%) of those with ADHD have a first-degree relative who also have the diagnosis or another divergent diagnosis. • *Co-occurring Conditions*. Common co-occurring conditions: such as anxiety, sleep disorders, and thyroid dysfunction. • *ADHD and Autism*. ADHD and autism are highly comorbid, When looking at ADHD, also considering autism as another neurodevelopmental disorder and that ADHD and PTSD can be difficult to distinguish. The increase in ADHD referrals was attributed to a greater awareness of the condition, as well as changes in work environments due to Covid. • *Body-doubling*. Dr. Nicolas B. and Dr. K discussed the concept of "body doubling" in the context of ADHD and its potential benefits. Body doubling could be a helpful way for individuals with ADHD to be more accountable and perform better by introducing the idea of checking in with a per about the deficits and needs. • *Therapy.* Also emphasized is the importance of therapy as a key component for emotion regulation and undoing years of being told one is not good enough. Suggested writing things out having patients anticipate how they will complete tasks. Having a visual and verbal is nice as you are encoding in 2 ways. Find a therapist who works with ADHD. • *Co-morbidities*. Management of primary care conditions with a focus on co-morbidities and the referral process for complex cases. Dr. Wortman recommended a stepped approach to managing conditions such as ADHD, diabetes, and PTSD, emphasizing the importance of treating medical needs first before considering referral to mental health. Make sure that medical needs are being met. • *Referring providers* need to make sure that the medical needs are being met. The referral needs to show how you are having an issue with the patient so Dr. K. can help with next steps. Need to clarify why Dr. Wortman should evaluate with a full neuropsychological battery prior to getting this patient on, i.e. CPAP. Ask 2 extra questions about the cognitive issues before sending/referring out. • *Cognitive Profile*. Commonly see deficits in executive functioning, large contrast between obtained scores and daily functioning, and non-timed tasks. Need support in their daily lives.	

	• *ADHS Tips in a Primary Care Setting*. Having a visual and verbal encodes it 2 ways and putting it on the patient. Having an extra question about planning is useful for these patients.	

	• *Neuropsychological Testing.* Multiple indications for which Neuropsychological testing should be considered. Chose to discuss ADHD because it is a challenging diagnosis and we have seen an uptick in the referrals received.
	• *Medi-Cal Non-Specialty Mental Health Provider Manual*. Medical necessity determinations are guided by Medi-Cal Non-Specialty Mental Health Provider Manual and very high-level questions that contributes to determining medical necessity, especially in adults. Email Dr. Barcelo directly to get a copy.
	• *Evidence-based Referrals.* Dr. Barcelo presented the use of neuropsychological testing, highlighting that it should be considered as a diagnostic tool only after medical interventions for physical conditions have been tried and found ineffective. Why would one need neuro psychological testing in the presence of a known diagnosis. Evidence-based (medical necessity) decision-making in the referral process for ADHD and other conditions is very important.
	• *Mild/Moderate Mental Health*. Dr. Barcelo reminded the providers about the changes in accessing mental health services, emphasizing that authorization for outpatient psychotherapy and psychiatry is no longer required for mild and moderate outpatient services. Providers need to identify themselves when making referrals to avoid delays, emphasizing the importance of completing initial health appointments within 120 days of plan enrollment for Medi-Cal members. Resources on shared decision-making tools were shared. Dr. Levin outlined the responsibilities of the plan and case management team in providing transitional care services for high-risk members.
	  ○ To Initiate Referrals or Access Services. There are multiple options to send referrals: Internal, ccLink portal, Access Line (member-facing call center that connects members with providers), or members can call Access directly at their own time at which time they will go through a screening to determine the appropriate level of support needed.
	  ○ Transitions of Care Tool will be requested from the referring provider for movement from one mental health system to another; i.e. specialty mental health to non-specialty mental health or vice-versa, or add services in the mental health system. You can also request for the transition of care tool. This tool and training are available via the ccLink Provider Portal.
	• *Behavioral Health Treatment.* Authorization is required for services relating to autism, including Comprehensive Diagnostic Evaluation (CDE), Functional Behavioral Assessment (FBA) and Ongoing Applied Behavioral Analysis (ABA). Reviewing authorizations within 5-14
		Nicolas E. Barcelo, M.D.
		Medical Director, CCHP
		Behavioral Health

	days. Reach out to connect with an ABA provider. We conduct an internal audit for CDEs submitted to ensure you receive a result back to get member the needed services. • *Notification Regarding Expectations and Requirements.* All services requiring authorizations need referring providers to identify referral destination (for all types of referrals). If referral is missing this information, referral will be sent back to referring provider. • *Go-Live* for Neuro Psych and CDE is anticipated by end of Q2 or start of Q3.	
Quality Updates	• *Timely Access to Care.* All California Residents have a right to timely access to appointments based on established timelines: o Urgent Care ▪ Prior authorization is not required: 48 hours ▪ Prior authorization is required: 96 hours o Non-urgent Care ▪ Primary Care (non-physician) = 10 business days ▪ Specialty Care (Physician) = 15 business days ▪ Mental Health (non-physician) = 10 business days ▪ Appointment (ancillary provider) = 15 business days o Follow-up Care ▪ Mental health/Substance Use Disorder Follow-up Appointment (non-physician) = 10 business days from prior appointment o Appointment timeframes can be shortened/extended as clinically appropriate. o If extended, it must be documented within the member medical record that it is not detrimental to the member's health and provider must notify member of their right to file a grievance. • *Initial Health Appointment (IHA)* In order to establish care for patients newly enrolled in Medi-Cal: o New Medicaid members should have an Initial Health Appointment (IHA) completed within 120 days from plan enrollment to establish care. The IHA must include: ▪ Physical and mental health history ▪ Identification of risks ▪ Assessment of need for preventive screening or services (including immunizations, USPSTF screenings, alcohol/drug screening) ▪ Individual health education ▪ Diagnosis and plan for treatment of any diseases. o All USPSTF screenings are still required but do not all need to be completed in the initial appointment. o Staying Health Assessment is no longer a	*Irene J. Lo, M.D., Chief Medical Officer, CCHP* *for Elizabeth Hernandez, Director of Quality, CCHP*

	requirement. • *Shared Decision-Making Tools* (a collaborative process between patients and providers about tests, treatments, and care plans) o Shared resources as well as additional information on shared decision making. ▪ Mayo Clinic – Diabetes Medical Choice in deciding on antihyperglycemic agents ▪ University of Pittsburgh Medical Center - Optimal medication or lifestyle change. ▪ Cancer Center Ontario – Treatment for Kidney Failure ▪ American Medical Association – Heart Disease interactive video for aortic stenosis ▪ America College of Cardiology – Atrial Fibrillation, aortic stenosis ▪ SAMSHA – Decisions in Recovery – Treatment for Opioid use Disorder Handbook.	
Transitional Care Services (TCS)	• *Transitional Care Services.* Requirement is to provider a 30-day episode of transitional care from any time a member transfers from one level of care setting to another, i.e. hospital discharges, psychiatric inpatient discharges, residential treatment discharges and discharges from skilled nursing facilities. o Support Members with the Transition to the least restrictive level of care that meets their needs and is aligned with their preferences. o Provide support and coordination needed for a safe and secure transition by connecting them to support and services, causing the least burden on the member. o TCS is available to all members. A single point-of-contact/case manager is assigned/provided to the highest risk members. They need to be made aware of access to case management services. • *Goals:* o Prevention of Readmission, institutionalization, re-institutionalization, or relapse. o Identify appropriate institutionalized members for transition to the community for those in custodial care trying to get back to the community. o Ensure timely, high-quality, relevant care and services in the vulnerable period after a transition. • *Services and How TCS Works.* CCHP need to be notified of all admissions, discharges, and transfers so services can be activated for our members and be assigned a single point-of-contact/care manager. o For High-risk members: A single point-of-contact will be assigned to coordinate discharge with the facility. o Ensure discharge planning documents are shared with the member/patient, primary care provider, and other providers. o Ensure follow-up with doctor appointments,	*Sara Levin, MD, Medical Director – Cal AIM, CCHP*

	medication reconciliation and that referrals are completed within the 30-day period. Medication reconciliation should happen within a week. ○ Within a 30-day Period post discharge: need to arrange for long term care management, as needed, an any community supports the member may be eligible for. Case management assignment as needed based on assessment. • *Referral Portal screenshot* was shared with the following information: ○ By Portal – REF162 ○ By Phone 925-313-6887 ○ By Fax 925-252-2609	
Medi-Cal Transportation Benefit	• This benefit is only available to members who have no means of getting to their medical appointments on their own or through the assistance of a family member. • *Types of Transportation* ○ Non-Medical Transportation (NMT) – for those member who can get in/out of a vehicle on their own or those who use a paratransit, bus, Lyft/Uber and a taxicab. ○ Non-Emergency Medical Transportation (NEMT) for non-ambulatory members unable to safely take because they may have altered mental status, shortness of breath, use crutches, etc.. , i.e. wheelchair van, gurney/litter van, non-emergency BLS and ambulance. For dialysis, make a notation about the rationale or the need of a wheelchair van. ○ Modes of Transportation: ▪ Wheelchair van - incapable of sitting of sitting in a car or van for long periods of time for their transport or they require a wheelchair and assistance to and from place of residence/treatment due to disabling physical or mental limitation. Example: For those with altered mental status or need oxygen without monitoring. ▪ Gurney/Litter van – for members who require transport in a prone or suping position…unable to sit and are usually bedbound. They are non-ambulatory and unable to use a wheelchair. ▪ Basic Life Support (BLS) Ambulance for members who are on oxygen with oxygen monitoring or on IV medication(s) or medical monitoring device. This also applies to transfers between facilities requiring observation. • *Non-Emergency Medical Transportation (NEMT)* requires a prior authorization before booking a ride which can be submitted through ccLink (provider portal). Physician Certification Form needs to be submitted through ccLink	*Suzanne Tsang, MPH* *Director of Marketing and Member Services and Public Relations, CCHP*

	for up to a period for one (1) year. You need to calculate the number of rides that will be needed for the year. Indicate the mode of transportation the member needs and the justification for the NEMT need.
	• The *Certification Statement* has to be signed by a prescriber (MD, DO, NP, PA, dentists, podiatrist, mental health professional, SUD treatment professional, etc…).
	• *Prior Authorization Process*:
	  ○ Turnaround Time
	  ▪ Urgent: Seventy-two (72) hours
	  ▪ Routine: Five (5) business days
	  ○ CCHP Provider Line for assistance 877-800-74123, Option 3
	  ○ Upon meeting clinical criteria, authorization for the lowest cost type of NEMT services adequate for the member's medical needs (per medical professional) will be approved.
	  ○ Member and Provider will be notified of the preauthorization decision. (CCHP is currently in the process of having all prior authorizations appear in the member's MyChart.)
	  ○ Upon approval, ride arrangement can be scheduled via CHCP Transportation Line.
	• *Booking NEMT Rides* through CCHP Transportation Line
	  ○ 24/7 Hotline is available
	  ○ Advance notice: Book rides 7-10 business days in advance.
	  ○ Urgent rides: Book as soon as possible
	  ○ Provide the following information:
	  ▪ Date and time of appointment
	  ▪ Pick-up and Drop-off address
	  ▪ Appointment length time
	  ▪ Mode of Transportation needed
	  ○ NEMT Prior Authorization and Physician Certification Statement (PCS) forms must be on file
	  ○ If CCHP is unable to confirm appointment with the member then NEMT might not be arranged. Always call CCHP to cancel rides and to reschedule rides.
	• *Questions?* Call up the Transportation Line at 877-800-74123, Option 3
	• *How To Submit Ride Request(s)*
	  ○ Submit via ccLink Provider Portal. Dr. Lo went through the step-by-step process of submitting a ride request as screenshots were presen.
	  ▪ Always indicate reason and date range, mode and reason.
	  ▪ According to Medi-Cal guidelines, we have to review each request.
	  ▪ We will review, provide authorization or request for additional information.
	  ▪ PCS form is very important. We cannot	

	process a request an NEMT without that form. A signature is required to be considered complete for review and prior authorization.	
Community Health Workers (CHW)	• *New Benefit to Medi-Cal* Members knows as the Community Health Worker (CHW). They help people negotiate barriers and has lived experience providing them a level of understanding aiding them to provide guidance and support that sometimes people who do not have that shared life experience can do. o *Health Education* ▪ CHWs are trained as health educators. They provide information, education, and referrals to community supports/community resources. Establish and maintain enrollment in social assistance programs, i.e. Medi-Cal. o *Health Care Navigation* ▪ CHWs work directly with the clients o *Screening and Assessments* ▪ CHWs encourage members to get medical screenings done and go to some appointments as a second set of ears. They collaborate with members to determine social, and healthcare needs to connect to available services that aligns with identified needs and priorities. o Individual Support and/or Advocacy ▪ CHWs work through cultural and language barriers, navigate the relationship with their healthcare providers and access services a member needs to best care for themselves. They act as the link for members to health care services to decrease exacerbation, injury prevention, and violence prevention. o Lived Experience ▪ CHWs serve as cultural liaisons between the member and available services. They have a level of understanding of the challenges faces in communication when accessing health care. Understanding barriers help establish effective relationships. They offer individual support and advocacy. • *CHW Criteria:* o Must have lived experience such as: ▪ Incarceration, disability, mental health conditions, homelessness, cultural background, pregnancy birth, military service, foster care placement, shared race, substance abuse, survivor of violence/abuse, exploitation, shared gender identity or shared language. ▪ Lived experience helps with community health work assess individual needs and	*Stephanie Schram, PHN, BSN, MSHCA Director – Case Management, Long-Term Care Liaison, CCHP*

	work with the member to establish the needed help to access. Understanding the path the member is on to get them where they need to go is invaluable. ○ Required Qualifications (can be one of the following): ▪ Community Health Worker (CHW) Certificate • www.dvc.edu/academics/allied-health/index.html ▪ Violence Prevention Certificate ▪ Work Experience Pathway (Employer can show documentation of 2,000 hours of CHW services worked in the last three (3) years). ▪ Must complete a minimum of six (6) hours of additional training annually. ▪ CHWs are not required to enroll as Medi-Cal Providers. • CHW Referral Process through ccLink Portal ○ It is under Case Management and complete form then submit. • CHW - What is Covered? ○ Four 6-hour blocks per member for the initial referral ▪ Additional hours are available but requires an approved prior authorization and a referral from a medical provider establishing medical necessity for the service. ○ Claims must be submitted by a Medi-Cal enrolled provider. Employers of the CHWs will file the claims on their behalf.	
Provider Disputes and Claims	•*Provider Disputes and Claims* ○ Disputes can be submitted on claim denials, underpayments, overpayments, authorizations, or other billing and/or reimbursement issues. ○ Claims must be disputed within 365 days from the last determination date. ○ Requests for consideration/disputes must be submitted with **supporting documents**. ○ Upload and submit provider disputes via: • *ccLink Provider Portal* – quickest way to get a determination: •https://www.cchealth.org/home/showpublisheddocument/7795/638262423385870000 •*Certified Mail* at: •Contra Costa Health Plan *Attn: Claims Dept., Provider Disputes* 595 Center Avenue, Martinez, CA 94553 • *On Member Assignment Issues*. Member Assignment Issues go through our Member Services Dept. and not through Provider Disputes.	*Erin Mellas, Director of Operations, CCHP*

	• *On Claims Submissions*. CCHP Claims Unit ensures timely payment of clean claims: responding, processing and returning claims to provider if missing information.
	• *On Availity.* Availity is CCHP'S EDI Clearinghouse.
	  ○ To submit EDI claims, you need to:
	  ▪ Register with Availity at https://www.availity.com/provider-portal-registration
	  ▪ **CCHP Payer ID: CCHS**
	  ○ To review payment status:
	  ▪ Check in the provider portal (ccLink Provider Portal).
	  ○ Sign-up for ccLink to access claims being reviewed. Check for status through ccLink. To enroll follow these steps:
	  ▪ Visit https://www.cchealth.org/showpublisheddocuments/909/638240903887870000
	  ▪ Complete the Provider Portal Access Agreement Form and email to: CCHPPortalsupport@cchealth.org
	  ○ For Paper Claims:
	  ▪ Submit claims to P.O. Box 5122, Lake Forest, CA 92609
	• *Reminders:*
	  ○ If payment has not been received for45 business days, you can call up CCHP to check on claim status for fastest responses.
	  ○ Check on your original claim status before calling CCHP.
	  ○ Duplicate Claims creates significant backlog and payment delay.	

Chief Medical Officer (CMO) Update	***CMO Updates Outline*** • 2024 Transitions •Authorization/Utilization Updates •Member Appeals, Member Grievances *On 2024 Transition Populations.* As of January 01, 2024, a multitude of populations have transitioned to CCHP as we became the Single-Plan Model (SPM) in Contra Costa County, namely Anthem Blue Cross and Medi-Cal. We also carved in Long-Term Care (LTC) facilities such as Intermediate Care Facility for the Developmentally Disabled (ICF/DD), adult and pediatric sub-acute care facilities. *Adult Expansion* now covers undocumented individuals ages 26 years old through 49 years old and the monthly transitioning of members from fee-for-service (FFS) to managed care with Contra Costa Health. Our *network expansion* requires a lot of communicating, collaborating and maintaining continuity of care (CoC) through different modes of communication with our providers to keep	*Irene J. Lo, M.D., Chief Medical Officer, CCHP*

everyone current and informed.

Continuity of Care (CoC) is a huge component of the transitions. Policies and procedures and workflows have been created to help with management of CoC, and CCHP staff on all levels have been provided and have received appropriate training.

POLICIES UPDATES/REFRESHERS:

Utilization Management (UM)

- Effective November 01, 2024:
  - No authorization required for services completed within the patient's service network and must be completed with a CCHP Provider.
  - Prior Authorization is required for services performed outside of the patient's network or with a non-contracted provider, or a tertiary provider.
- Enhancements for Prior Authorization Requests for Certain Visits to improve workflow and processes within CCHP Providers:
  - Specialty Office Visits.
    - Consults and follow-ups for all specialties will no longer require prior authorization except for neurosurgery and transgender services.
    - Any specialty procedures will continue to require authorization.
  - Bariatric Surgery Guidelines
    - Consults and follow-up will no longer require authorization.
    - Procedures/surgeries will require authorization.
      - One (1) dietician consultation will be required prior to surgery for approval.
      - Mental health evaluation will no longer be required.
  - Pain Management
    - Consultations and follow-ups will no longer require authorization.
    - Procedures for pain management will require authorization.
- ***NOTE**: All the above-indicated services must be provided with a contracted in-network provider in order for no prior-authorization to no longer be needed/required.*
- UM Contact Information
  - Questions:
    - Call 877-800-7423
    - Email: CCHPAuthorizations@cchealth.org
  - Urgent Issues or Escalations:
    - Auth-UMSupport@cchealth.org

- We will triage issues/escalations accordingly

Member Appeals and Member Grievances

- Member Appeals and Member Grievances
  - If members are dissatisfied with the service delivered by a provider, member can file a complaint or grievance
  - If a member believes that a service or payment for a service has been denied, deferred, or modified inappropriately, the member may submit an appeal.
- Ways to File a Grievance or Appeal:
  - *Call Member Services* at 877-661-6230 (Opt#2) (TTY711)
  - Available Mon. – Fri. from 8:00 a.m. – 5:00 p.m.
  - Urgent: Call 24-hourse Advice Nurse: 877-661-6230 (Option 1) (TTY) 711)
  - *Write a letter or download and print out a form:* Grievance/Appeals Form: https://www.cchealth.org/home/showpublisheddocument/6625/638258414383817000
  - *Mail or Fax to:*
    - Contra Costa Health Plan (CCHP)
      Attention: Grievance/Appeals
      595 Center Avenue, Suite 100, Martinez, CA 94553
      Fax: 925-313-6047
  - *Online Submission* https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/file-a-complaint

- If a member wants someone else to help them file a grievance or appeal on their behalf, CCHP will contact the member for verbal permission to process the grievance or appeal.
- Providers can file a member appeal on behalf of their patients, however, the provide will need to submit a signed member consent form to file the appeal.

  https://www.cchealth.org/home/showpublisheddocument/6623/638258414381070000
- *Process*
  - Members will receive a letter informing them of receipt of grievance or appeal.
  - Review and case resolution within thirty (30) calendar days.
- *Expedited Grievances and Appeals*
  - A member can request for an expedited review within seventy-two (72) hours upon filing a grievance.
  - CCHP will provide an expedited review if waiting

	for thirty (30) for a resolution would seriously harm the health of the member. ○ Cases requiring expedited review: CCHP will make a decision no later than seventy-two (72) hours after the request is received. ○ If CCHP denies the request for an expedited review, CCHP will downgrade the grievance or appeal from expedited to routine. The member will be notified in writing and CHCP will then follow the usual thirty (30) day process.	
Questions?	No questions were posed by any of the attendees.	
In Closing	We will send links and slides of today's presentations. We welcome feedback and ideas about any topics or concept or programs that you would like more information on. Thank you!	*Irene J. Lo, M.D., Chief Medical Officer, CCHP*

Additional Follow-up:
Here is some additional follow-up from Dr. Lo regarding Initial Health Appointments (IHA).
There were questions regarding this topic and here is some helpful information.

- Per the DHCS Policy Guide: "The Initial Health Appointment(s) is not required if the member's PCP determines that the member's medical record contains complete information that was updated within the previous 12 months. This information must be assessed by the PCP during the first 120 days of member enrollment. The conclusion of the PCP's assessment must be documented in the member's medical record."
- CCHP sends out a welcome letter when someone enrolls that welcomes them to health plan, gives them their PCP assignment info and encourages them to establish care with PCP.