CalOptima Health Community Network Initial Onboarding

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Presentation Overview

- CalOptima Health's Delivery Model
- CalOptima Health Direct and CalOptima Health Community Network
- Eligibility
- Customer Service
- Medical Management and Authorization Requirements
- Claims Administration
- Blood Lead Screening of Young Children

Presentation Overview (cont.)

- Initial Health Appointment
- Electronic Visit Verification
- CalOptima Health Provider Portal
- CalAIM
- Fraud, Waste and Abuse and Compliance
- Resource and Website Training

CalOptima Health Delivery Model

Medi-Cal
CalOptima Health

CalOptima Health Direct (Fee-for-Service)	Health Networks (Shared Risk)	Health Networks (Full Risk)
• CalOptima Health Direct (COD) • CalOptima Health Community Network (CCN) • Behavioral Health • Vision Service Plan (VSP)	• AltaMed Health Services (PMG) • Noble Mid-Orange County (PMG) • United Care Medical Group (PMG)	• AMVI Care Health Network (PHC) • CHOC Health Alliance (PHC) • Family Choice Health Services (HMO) • HPN-Regal (HMO) • Optum (HMO) • Prospect Medical Group (HMO)

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CalOptima Health

PACE
CalOptima Health

On-Site All-Inclusive Interdisciplinary Team

- Primary care
- Specialist care
- Prescription drugs/lab tests
- Dental, vision, podiatry and hearing services
- Physical, occupational and speech therapies
- Registered dietitian
- Social work
- Recreation
- Home care
- Pharmacy
- Hospital care and emergency services

CalOptima Health Direct (COD) and CalOptima Health Community Network (CCN)

COD/CCN Network Structure

- COD/CCN
- COD is a program CalOptima Health administers for CalOptima Health beneficiaries

CalOptima Health Direct Administrative

Members do not have an assigned primary care provider (PCP)

Members have 45 days to choose a health network and PCP

CalOptima Health Community Network

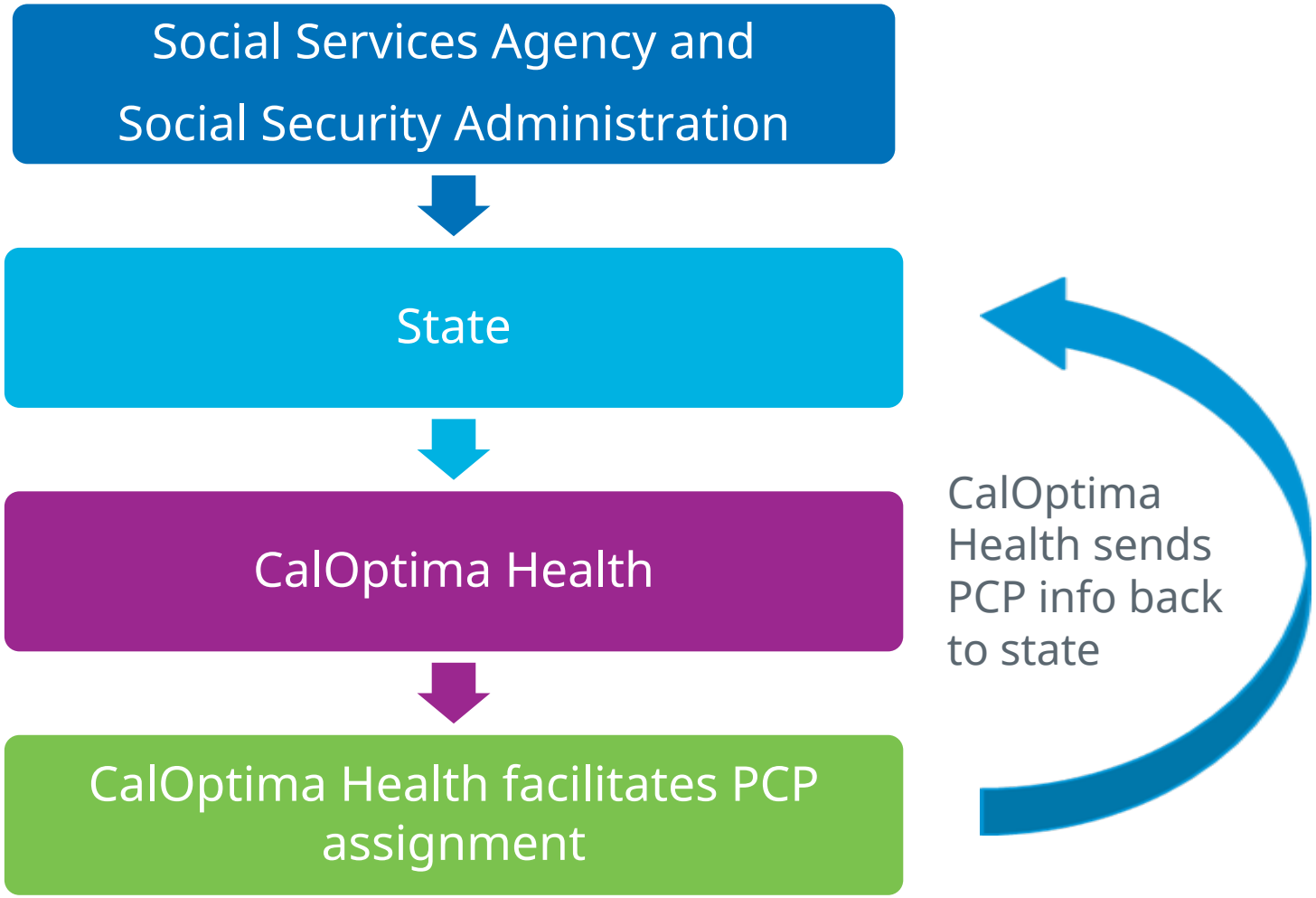
Members have an assigned PCP

Medi-Cal CCN

CalOptima Health

Eligibility

Member Eligibility

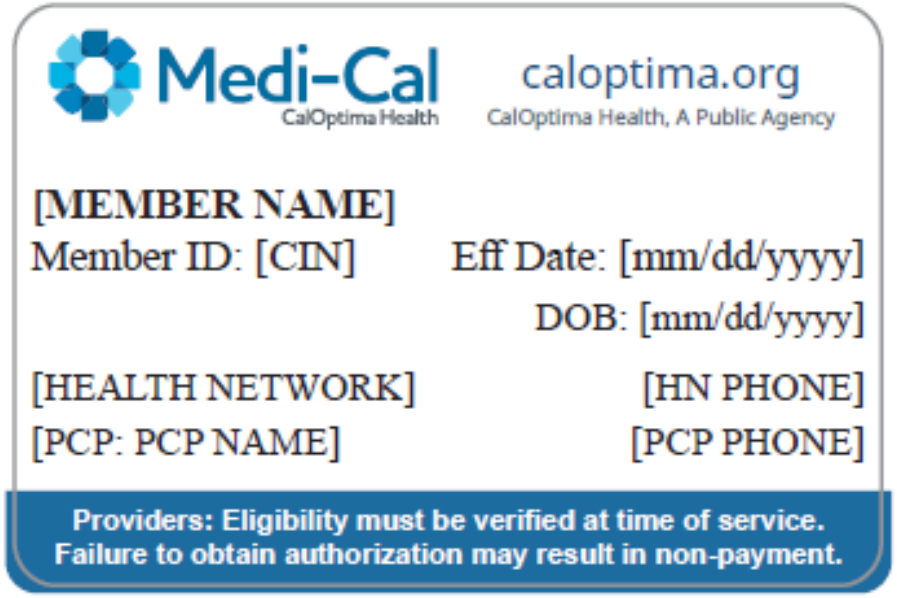


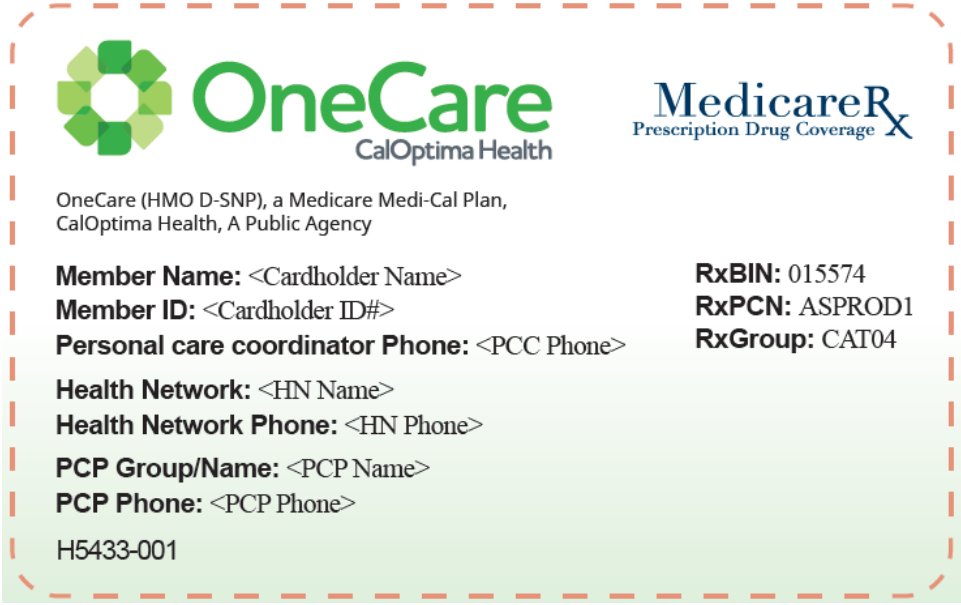
Member Eligibility Verification System

- Providers should always verify eligibility prior to rendering service
- State Eligibility Verification System
  - Medi-Cal website: Providers can verify Medi-Cal eligibility on the Medi-Cal portal at www.medi-cal.ca.gov
  - Automated Eligibility Verification System (AEVS): Call Department of Health Care Services (DHCS) at 800-456-2387
- CalOptima Health's Eligibility Verification Systems
  - Provider Portal (Providers must register to utilize this service)

Identification Card

- CalOptima Health member ID cards are used to help identify members and are **NOT proof of member eligibility**





CalOptima Health

CCN Member PCP Change Requests

- A member may request to change their PCP on a monthly basis by contacting CalOptima Health's Customer Service
  - If the member requests a PCP change prior to the 16th of the month **before** seeing their assigned PCP, CalOptima Health shall make the change effective the first calendar day of the current month
  - If the member requests a PCP change **after** the 16th of the month or after seeing their assigned PCP, CalOptima Health shall make the change effective the first calendar day of the following month
- Please contact the CalOptima Health Customer Service Line at **888-587-8088** or **TTY 800-735-2929**

CalOptima Health

Member Rights and Responsibilities

- CalOptima Health is required to inform its members of their rights and responsibilities and ensure that members rights are respected and observed. CalOptima Health provides this information to members in the Member Handbook upon enrollment, annually in the member newsletters, on CalOptima Health's website and upon request
- Providers are required to post the members' right and responsibilities in the waiting room of the facility where services are rendered

Member Rights and Responsibilities (cont.)

- CalOptima Health members have the right to:
  - Be treated with respect and dignity by all CalOptima Health and provider staff
  - Privacy and to have medical information kept confidential
  - Get information about CalOptima Health, our providers, provider services and their member rights and responsibilities
  - Choose a doctor within CalOptima Health's network
  - Talk openly with health care providers about medically necessary treatment options, regardless of cost benefits
  - Help make decisions about their health care, including the right to say "no" to medical treatment
  - Voice complaints or appeals, either verbally or in writing, about CalOptima Health or the care we provide

Member Rights and Responsibilities (cont.)

- CalOptima Health members have the right to:
  - Get oral interpretation services in a language that they understand
  - Make an advance directive
  - Access family planning services, Federally Qualified Health Centers, Indian Health Services facilities, sexually transmitted disease services and emergency services outside of CalOptima Health's network
  - Ask for a state hearing, including information on the conditions under which a state hearing can be expedited
  - Have access to their medical record and, where legally appropriate, get copies of, update or correct their medical record
  - Access minor consent services

Member Rights and Responsibilities (cont.)

- CalOptima Health members have the right to:
  - Get written member information in large-size print and other formats upon request and in a timely manner for the format being requested
  - Be free from any form of control or limitation used as a means of pressure, punishment, convenience or revenge
  - Get information about their medical condition and treatment plan options in a way that is easy to understand
  - Make suggestions to CalOptima Health about their member rights and responsibilities
  - Freely use these rights without negatively affecting how they are treated by CalOptima Health, providers or the state

Customer Service

Customer Service Department

- **Members** can reach Customer Service by calling the Member Line at **888-587-8088** for Medi-Cal and **877-412-2734** for OneCare

- **Providers** can reach the CalOptima Health Provider Relations department by calling **714-246-8600** Monday–Friday, 8 a.m.–5 p.m., or by emailing providerservicesinbox@caloptima.org

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Support Services

- CalOptima Health's Member Liaison Program
  - Dedicated to helping seniors, members with disabilities or chronic conditions, and members without housing get needed health care services

- A member liaison can help with:
  - Scheduling visits with a doctor
  - Obtaining non-emergency medical transportation
  - Resolving medication access issues
  - Obtaining Durable Medical Equipment, including wheelchairs, crutches and other disposable supplies

Providers can call CalOptima Health Customer Service at **714-246-8500**, toll-free **888-587-8088** (TTY **711**), and ask for the Member Liaison Program

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Support Services (cont.)

- Cultural and Linguistics (C&L)
  - CalOptima Health offers free interpreter services to all limited English proficient members
  - Using a family member or friend to interpret should be discouraged
  - Documenting refusal of interpreter services in the member record not only protects the provider, but it also ensures consistency when medical records are monitored through site reviews or audits

Support Services (cont.)

- CalOptima Health's C&L services cover two areas:
  - Interpreter services (telephonic and face-to-face interpretation)
  - Translation services (materials available in threshold languages)

- CalOptima Health providers can call CalOptima Health Customer Service at **888-587-8088** and ask for the Interpreter Service Program, or email any questions directly to culturallinguistic@caloptima.org

Medical Management and Authorization Requirements

Case Management

- Case management is the coordination of care and services for members who have experienced a critical event or diagnosis, or are high-risk members
- Who qualifies for case management?
  - Complex/catastrophic diagnoses
  - Frequent acute hospitalizations
  - Members typically requiring extensive use of resources and need assistance in navigating the health care delivery system
- How to refer?
  - Call the triage nurse at **714-347-3226** or email cmtriage@caloptima.org

CalOptima Health

CCN/COD Member Authorization Requirements

Physician Type	Regular Visits	Urgent Referrals
PCP	No prior authorization is required for: • Assigned PCP • Affiliated group physician	Urgent referrals are only to be submitted if the normal time frame for authorization will: • Be detrimental to the patient's life or health • Jeopardize patients' ability to regain maximum function • Result in loss of life, limb or other major bodily function All referrals not meeting urgent criteria will be downgraded to a routine referral request and follow routine turnaround times
Specialty Care (SCP)	All initial requests for specialty consults require a prior authorization from: • Assigned PCP • Contracted SCP The initial prior authorization will include: • One specialty consult • As many routine follow-ups as necessary (excluding office code 99215, which requires a new prior authorization)	

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Steps to Obtain Prior Authorization

- Online authorization submissions via Provider Portal
  - Outpatient services
  - Routine services
- Hard copy submission via Authorization Request Form (ARF)
  - Urgent authorization requests (see urgent definitions on ARF)
  - Inpatient authorizations
  - A copy of the ARF is available on CalOptima Health's website, www.caloptima.org, under the Common Forms sections

Prior Authorization Tips

- Check eligibility prior to providing services using one of the eligibility verification systems
- Check Prior Authorization Required Code List
  - If the code is not on the list, do **NOT** submit an authorization request
- Verify Current Procedural Terminology (CPT) code on the Medi-Cal fee schedule before rendering services
- Attach supporting notes
- Authorization status can be viewed in Provider Portal
- For questions or status, call CalOptima Health Utilization Management at **714-246-8686**

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Services That Do Not Require Authorization

- Emergency services
- Family planning services for network or out-of-plan providers
- Sensitive services (which include family planning)
- Sexually transmitted disease services
- Human immunodeficiency virus (HIV) testing
- Basic prenatal care services

Services That Do Not Require Authorization (cont.)

- Routine obstetric services
- Pediatric preventive services
- Minor consent services
- Primary and preventive care services
- For questions or status, call CalOptima Health Utilization Management at **714-246-8686**

Claims Administration

Claims Submission Methods

- Electronic claims submission
  - CalOptima Health is contracted with two data clearinghouses that receive and transmit Electronic Data Interchange (EDI) claims to CalOptima Health. To register and submit claims electronically, contact one of the vendors below:
    - **Office Ally** for electronic submission of Professional CMS1500 claims: 360-975-7000 or www.officeally.com. Payor ID: CALOP
    - **Emdeon** for electronic submission of facility and long-term care claims: 877-271-0054 or www.emdeon.com. Emdeon Office Product User Payor ID: CALOP, Emdeon Claim Master Product User: 99250
- CalOptima Health has timely filing guidelines that allow providers one year from the date of service to submit a claim

Hard Copy Claims Submission

COD and CCN	
Medi-Cal: PO Box 11037 Orange, CA 92856	OneCare: PO Box 11070 Orange, CA 92856

- For claim status, contact Claims Customer Service at **714-246-8600** Monday – Friday, from 8 a.m. to 5 p.m.

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Claims Denials/Complaint Process

- A Provider Dispute Resolution (PDR) is a request to review a contested claim
  - Visit CalOptima Health website to access information on:
    - Provider Complaint Process
    - Provider Dispute Resolution (PDR) form
  - Refer to Provider Manual, section H10, for common claims denial reasons

Claims Denials/Complaint Process (cont.)

- Key points:
  - Provider disputes should be sent within one year (365 calendar days) from the last determination for timely filing consideration
  - CalOptima Health requires providers to submit a dispute regardless of the party at fault
  - Follow the PDR submission instructions on the PDR form
    - Ensure all necessary supporting documents are attached, such as high-cost invoices, authorizations, medical records, etc.
  - Note: CalOptima Health has 45 working days to render a decision
    - To avoid delays in processing your PDR, please complete the form with all required fields marked with an asterisk (*)

Claims Denials/Complaint Process (cont.)

- PDR Contact information
  - Mail completed form to:

Medi-Cal	OneCare
CalOptima Health Attention: Grievances and Appeals Resolution Services 505 City Parkway West Orange, CA 92868	CalOptima Health Attention: Grievances and Appeals Resolution Services 505 City Parkway West Orange, CA 92868

  - Call CalOptima Health Claims Provider Line at **714-246-8600** for PDR status update

InstaMed: Electronic Fund Transfer

- Register for your InstaMed Healthcare Payments Account and get paid! InstaMed for payer payments are directly deposited into your existing bank account at no cost to you
  - Refer to the following link for information and registration: https://register.instamed.com/eraeft
  - For provider questions about enrollment, contact the InstaMed enrollment team by calling 877-855-7160 or email connect@instamed.com
  - For provider questions about an existing account, contact the InstaMed support team by calling 877-833-6821 or email support@instamed.com

Blood Lead Screening of Young Children

APL 20-016: Blood Lead Screening of Young Children

- On September 29, 2020, DHCS issued APL 20-016: Blood Lead Screening of Young Children. The purpose of this APL was to provide requirements for blood lead screening tests and associated monitoring and reporting for Medi-Cal managed care health plans (MCPs) like CalOptima Health
  - You may view APL 20-016 in its entirely by visiting: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf
  - This APL superseded APL 18-017, located at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-017.pdf

APL 20-016 (cont.)

- CalOptima Health Policy GG.1717: Blood Lead Screening of Young Children
  - This policy outlines the process by which CalOptima Health or a health network ensures the provision of blood lead screening to members 6 months of age and continuing until 72 months of age
  - CalOptima Health developed this policy to ensure compliance with DHCS APL 20-016 (Revised): Blood Lead Screening of Young Children
- CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
  - This policy defines the PCP role and responsibilities in providing covered services and case management to members
  - CalOptima Health revised this policy to ensure compliance with DHCS APL 20-016 (Revised): Blood Lead Screening of Young Children

Initial Health Appointment (IHA)

IHA Overview

- Comprehensive assessment for **newly enrolled Medi-Cal members**
  - Provided in a way that is culturally and linguistically appropriate for the member
- Completed by a **PCP** within **120 days** of member enrollment into CalOptima Health
  - May not be completed by specialists

IHA Overview

- IHA documentation includes, but is not limited to:
  - A physical exam
  - Member’s office visit date, physical and mental health history
  - Identification of health risks
  - Preventive screenings or services
  - Diagnosis and a plan for treatment for any diseases
  - Health education
  - All efforts to complete IHA, including a minimum of three attempts to contact member, member refusal and missed appointments

DHCS All Plan Letter (APL) 22-030: Initial Health Appointment

- **Effective January 1, 2023**:
  - Staying Healthy Assessment (SHA) tools are no longer required
  - The standard screening requirements for each age group are still in effect
    - **All ages**: Assessment of need for preventive screenings or services as recommended by the United States Preventive Services Task Force (USPSTF)*
    - **Age 21 and under**: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings per American Academy of Pediatrics/Bright Futures periodicity schedule.** When requested, an appointment must be made for members under age 21 within 10 working days of the request***
- Department of Health Care Services (DHCS) will:
  - Measure primary care visits as a proxy for IHA completion
  - Leverage Healthcare Effectiveness Data and Information Set (HEDIS) measures specific to infant and child/adolescent well-being visits, as well as adult preventive visits

* USPSTF Guidelines **As referenced in APL 19-010 *** CalOptima Health DHCS 2024 Contract, Exhibit A: Page 367, bullet 2

CalOptima Health

Resources

Direct link	Access Path from www.caloptima.org
IHA Reference Guide for PCPs	Providers → Resources → Health Education → View IHA Reference Guide
Health and Wellness page	Members → Health and Wellness → Self-Care Guides
Health and Wellness Referral Form	Providers → Resources → Common Forms → Find under “H”
Wellness Programs and Services page	Members → Wellness Programs
Member Health Rewards Program	Members → Wellness Programs → Member Health Rewards
Blood Lead Refusal Form (English)	Providers → Resources → Common Forms → Anticipatory Guidance (multiple languages available)
Initial Health Appointment CME/CE — Recording	N/A

Electronic Visit Verification

Electronic Visit Verification

- Providers offering in-home services need to register with California's Electronic Visit Verification (CalEVV) system to be compliant with DHCS regulations
- Federal laws mandate that California use an EVV for Medi-Cal-funded personal care services (PCS) and home health care services (HHCS) provided in the home. DHCS implemented CalEVV for PCS on January 1, 2022, and for HHCS on January 1, 2023
  - Emergency remote services (ERS) for personal and home health care are also subject to EVV requirements
- CalEVV is a telephone- and computer-based application that electronically verifies when in-home PCS or HHCS occur

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Electronic Visit Verification (cont.)

- CalEVV verifies:
  1. Type of service performed
  2. Date of service
  3. Individual providing the services
  4. Individual receiving the service
  5. Location of service delivery
  6. Time the service begins and ends
- To register, please use the California Provider Self-Registration Portal
- DHCS CalEVV resources:
  - APL 22-014: Electronic Visit Verification Implementation Requirements
  - DHCS-approved procedure codes, service description and place of service
  - Quick reference guide to register for CalEVV Provider Portal
  - Training videos
  - DHCS EVV Email: evv@dhcs.ca.gov

CalOptima Health Provider Portal

CalOptima Health Provider Portal Registration

- CalOptima Health's Provider Portal has resources and tools to help you:
  - Obtain member eligibility information
  - Submit referrals online
  - View authorization status
  - View claims status
  - Remittance advice
  - And more
- Register at https://providers.caloptima.org/#/login

CalOptima Health Provider Portal Registration (cont.)

- To ensure Health Insurance Portability and Accountability Act (HIPAA) compliance and allow providers the ability to manage their users, CalOptima Health's Provider Portal requires provider offices and groups to designate a site administrator
- The site administrator has the ability to:
  - View list of users with access
  - Edit user access roles
  - Deactivate users

CalOptima Health Provider Portal Registration (cont.)

- Change in site administrator
  - Notify Provider Relations when a site administrator is no longer employed by the current provider office or group
  - The provider or authorized representative must designate a new site administrator as soon as possible

NO SHARING PASSWORDS

Transforming Medi-Cal through California Advancing and Innovating Medi-Cal (CalAIM)

Overview

- What are the goals of the Department of Health Care Services (DHCS) for CalAIM?
  - New and improved services
  - Going beyond the doctor's office or hospital
  - A more coordinated, person-centered and equitable health system
  - Addressing all physical and mental health needs

- DHCS is introducing many initiatives to achieve these goals, including Enhanced Care Management (ECM) and Community Supports

Enhanced Care Management

- A whole-person approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs
- Members will have a single lead care manager who will coordinate care and services among the physical, behavioral, dental, developmental and social services delivery systems
- Eligibility is based off Populations of Focus

Community Supports

- Community Supports are services that help address members' health-related social needs, help members live healthier lives, and help members avoid higher, costlier levels of care
- CalOptima Health offers all 14 Community Supports
  - Each Community Support has individualized eligibility criteria
  - All 14 Community Supports are on CalOptima Health's website:
    - https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/CommunitySupports
- Services include housing navigation, medically tailored meals, asthma remediation, etc.

How to Refer Members for ECM and Community Supports

- Referral forms can be found on CalOptima Health's website
- Referral forms can be filled out by:
  - Member/member representative
  - Hospital
  - Community-Based Organizations (CBOs)
  - Community Supports vendors
  - Case managers

Fraud, Waste and Abuse and Compliance Training

Fraud, Waste and Abuse (FWA)

- What is Fraud, Waste and Abuse?
  - Fraud is an intentional or deliberate act to deprive another of property or money by deception or other unfair means. The ways in which fraud occurs are as unique as the individual perpetrators, their motives and the situations they exploit. For the purposes of this training, fraud is intentionally submitting false information to the government (including situations in which you should have known the information was false) to get money or a benefit
  - Waste includes practices that, directly or indirectly, result in unnecessary costs to federally funded programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources
  - Abuse includes actions that may, directly or indirectly, result in unnecessary costs to federally funded programs. Abuse involves paying for items or services when there is no legal entitlement to that payment

Fraud, Waste and Abuse (FWA) (cont.)

- Potential FWA cases can be referred to CalOptima Health's Special Investigations Unit (SIU) by:
  - Emailing the Suspected Fraud or Abuse Referral form to fraud@caloptima.org
  - Calling the anonymous Compliance and Ethics Hotline at **855-507-1805**
  - Anonymously mailing:

    CalOptima Health SIU

    505 City Parkway West

    Orange, CA 92868
- CalOptima Health will report, as appropriate, to all local, state and federal entities

Provider Overpayment Investigation and Determination

- CalOptima Health may receive complaints of suspected FWA from any of the following sources, including but not limited to:
  - Compliance and Ethics Hotline
  - FWA detection software runs
  - Internal audits
  - Internal operational reviews, such as claims auditing
  - External agencies, including audits conducted by consultants and regulatory agencies (U.S. Department of Justice, Centers for Medicare & Medicaid Services [CMS], Department of Health Care Services [DHCS])

Provider Overpayment Investigation and Determination (cont.)

- CalOptima Health may receive complaints of suspected FWA from any of the following sources, including but not limited to:
  - Pharmacy Benefits Manager (PBM)
  - Compliance Committee
  - Delegation Oversight Committee (DOC)
  - Internal department referrals
  - Any other source that identifies potential FWA

Provider Overpayment Investigation and Determination (cont.)

- All referrals of potential FWA is assessed or investigated
- CalOptima Health reports all suspected FWA to the regulatory authorities within the required regulatory timeframes
- For additional information regarding provider overpayment investigation and determination, please review **CalOptima Health Policy HH. 5000: Provider Overpayment Investigation and Determination**

False Claims Act

- CalOptima Health is responsible for establishing policies and communicating information regarding federal and California False Claims acts and related whistleblower protection laws to all CalOptima Health employees, members of the governing body, and First Tier, Downstream and Related Entities (FDRs)
- The Federal False Claims Act, 31 U.S.C. Sections 3729 through 3731, and the California False Claims Act, California Government Code, Section 12650 et seq, addresses penalties for the submission of false claims to the federal government and relator whistleblower protections as discussed in **CalOptima Health Policy HH.5004: False Claims Act Education Addendum A**

False Claims Act (cont.)

- False claims for health care providers can include, but are not limited to:
  - Billing for services that are not medically necessary
  - Billing for a higher level of service and reimbursement than supported by the medical records
  - Double billing
  - Billing for medical items and/or services not provided and/or drugs not administered
  - Billing for brand name drugs when generic drugs are provided
  - The offer, payment, solicitation or receipt of monetary or non-monetary remuneration in exchange for the referral of patients, items or services paid for by federal and state health care programs that violates the Anti-Kickback Statute

False Claims Act (cont.)

- False claims for health care providers include, but are not limited to:
  - The submission of false certifications related to risk adjustment data
  - The submission of false certifications of data and document submissions required by Medicaid managed care regulations
  - The failure to refund known Medicare and/or Medi-Cal overpayments
  - Submitting multiple billing codes instead of one billing code to increase reimbursement (i.e., unbundling)

Compliance Training

- CalOptima Health requires Board members, employees and FDRs, regardless of role or position with CalOptima Health, to complete mandatory compliance training courses
- Mandatory compliance trainings include:
  - The fundamentals of the compliance program
  - FWA training
  - Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements
  - Ethics
  - High-level overview of the Medicare and Medi-Cal programs

Resources and Website Tools

Website Tools

- CalOptima Health website: www.caloptima.org
  - Provider search tool and directories
  - Authorization Required Code List
  - Important forms
  - Provider communications
  - Provider Manual
  - Pediatric Preventive Services (PPS) Resource Guide
  - IHA
  - Provider Portal
  - Training links
  - Provider training topics
  - Personal Care Coordinator trainings

CalOptima Health

Stay Connected With Us

www.caloptima.org

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