THE RAINBOW GUIDE PROVIDER RESOURCES

3rd Edition

CalViva Health has an Administrative Services Agreement with Health Net Community Solutions ("Health Net") to provide certain administrative services on CalViva's behalf. CalViva Health also has a Capitated Provider Services Agreement with Health Net for the provision of health care services to CalViva Health members through Health Net's network of contracted providers. This Rainbow Guide serves as a resource of information, benefits, and services for CalViva Health Providers.

Requesting an Interpreter

Interpreter Services: 1-888-893-1569
TTY/TDD Users: 711
Request Interpreter Service Materials: 1-800-977-6750

The Health Care Language Assistance Regulations require CalViva Health to provide language assistance and culturally responsive services to patients with Limited-English Proficiency (LEP), limited reading skills, are deaf or have hearing impairment, or have diverse cultural and ethnic backgrounds. Cultural & Linguistics Services/ Health Equity Department provides the Language Assistance Program (LAP) to participating physician groups (PPGs), physicians and ancillary providers, including nurses and physician assistants, to support CalViva Health members' linguistic and cultural needs. Participating providers are required to support CalViva Health's LAP. It is very easy to use the language services provided by CalViva Health.

- There is NO COST to use an Interpreter for CalViva Health patients, when coordinated through CalViva Health's LAP.
- Call 1-888-893-1569 for an Interpreter for CalViva Health patients.
- Telephone interpreters are available 24 hours a day, and 7 days a week. Advance notice is not required.
- Interpreter services are available in more than 150 non-English languages.
- In person interpreters, including sign language, are available when requested a minimum of five business days in advance of the appointment.
- CalViva Health patients should be discouraged from using family members or friends as interpreters. A CalViva Health patient's medical record should include any request for, or refusal of interpreter services. The use of minors as interpreters is prohibited unless in an emergency involving an imminent threat.
- Providers are required to use qualified bilingual/multilingual staff to communicate with CalViva Health LEP members to ensure compliance with new state and federal laws.

Requesting an Interpreter

Requesting an Interpreter

Questions

Requesting an Interpreter

1. What types of Interpreter Services are available for CalViva Health patients?
2. How do you handle a request for a patient to use family, friends or minors as interpreters?
3. Is there a charge to use the Interpreter Services available to the patient?
4. When are interpreter services available?
5. Do I need to document the use of an interpreter in the patients' medical record?

Maintaining Privacy and Confidentiality

Provider Services: 1-888-893-1569
Health Net Privacy Department: privacy@healthnet.com
CalViva Health Privacy Department: privacy@calvivahealth.org
Provider Website: Provider.healthnet.com
CalViva Health Website: Calvivahealth.org

Participating providers and staff must maintain the confidentiality of patient information. An office procedure should be in place which guards against unauthorized disclosure of confidential patient information.

- The office should ensure the privacy and confidentiality of CalViva Health patients' information.
- A separate medical record should be available for each CalViva Health patient and be accessible within the facility, or an approved health record storage facility.
- Medical records SHOULD NOT be released without written, signed consent from the patient or patient's representative.
- The office should be trained with respect to the Health Insurance Portability and Accountability Act (HIPAA) and pertinent privacy and security requirements.
- Staff should practice the "minimum necessary" principle when appropriate.
- Providers should ensure the appropriate parties are notified when a breach in patient information occurs.
- Medical records should be maintained for a minimum of 10 years.

Maintaining Privacy and Confidentiality

Maintaining Privacy and Confidentiality

Questions

Maintaining Privacy and Confidentiality

1. How do you keep your patient's information private?
2. Where are your medical records stored?
3. How long should you keep medical records?
4. What training do you provide to your staff about privacy, security, and confidentiality of patient information?
5. What information do you require to release a patients' medical record?

Reporting Fraud and Abuse

Health Net Fraud Hot Line: 1-800-977-3565
CalViva Health Fraud Hot Line: 1-866-863-2465
Provider Services: 1-888-893-1569
Provider Website: Provider.healthnet.com
CalViva Health Website: Calvivahealth.org

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. Waste means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in the Centers of Medicare and Medicaid Services ("CMS") Fraud, Waste, and Abuse Toolkit (42 CFR 455.2). Abuse means practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medi-Cal program.

- Everyone should report suspected cases of health care fraud, waste, and abuse to CalViva Health or Health Net.
- Examples of health care fraud include but are not limited to billing for services or supplies not provided, altering or falsifying claims, deliberately misrepresenting services, resulting in unnecessary costs, improper payments, or overpayment.
- Examples of health care waste include but are not limited to inefficiencies in the provision of health care goods and services (i.e. peak staffing during non-peak hours, treatment by a higher-level provider) and overproduction (i.e. unused meals, materials, etc.).
- Examples of health care abuse include but are not limited to providing medically unnecessary services, charging in excess for services or supplies, providing services that do not meet professionally recognized standards.
- Call 1-800-977-3565 or 1-866-863-2465 to report suspected health care fraud, waste & abuse cases. You can also email suspected fraud, waste, or abuse cases to FraudTips@calvivahealth.org.
- CalViva will not retaliate against any individual if they inform CalViva, DHCS, or the Federal government of suspected Fraud, Waste and /or Abuse.

Reporting Fraud and Abuse

Reporting Fraud, Waste and Abuse

Questions

Reporting Fraud and Abuse

1. How do I report suspected fraud & abuse cases to CalViva Health?

2. Who is required to report fraud?

Patient Rights

Member Services: 1-888-893-1569
Provider Services: 1-888-893-1569
Report a Grievance or Complaint: 1-888-893-1569
Provider Website: Provider.healthnet.com
CalViva Health Website: Calvivahealth.org

CalViva Health patients have the right to expect a certain level of service from their health care providers. CalViva Health patients are responsible for cooperating with providers in obtaining health care services. These patient rights and responsibilities apply to the patient's relationship with CalViva Health, and all participating providers responsible for patient care.

In addition to patient rights and responsibilities, medical services must be provided in a culturally competent manner without regard to race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, physical or mental handicap, or disability.

Patient Rights include but are not limited to the following:

- To submit a grievance or a complaint if they are dissatisfied for any reason.
- Your patient has a right to be treated with dignity and respect.
- Your patient has a right to request a second opinion.
- Your patient has a right to access you and other health care services within a reasonable period.
- Your patients 18 years of age or older have the right to create an advance directive if they choose so others can speak for them when they cannot speak for themselves. Your office should have information available about advance directives.
- Your patients have the right to access pregnancy-related services, including family planning.
- Your patients have a right to exercise their rights without adversely affecting how they are treated by you.
- Your patients have a right to change their doctor for any reason.
- Your patients have a right to have access to and receive a copy of their Medical Records.

Patient Rights

Questions

Patient Rights

1. Are your patients allowed to complain about the care or services they receive?

2. Do you treat your CalViva Health patients any differently than your other patients who may have private insurance?

3. If your patient disagrees with your medical recommendation, what do you tell them next?

4. If you receive a complaint about your office, do you treat your patients any differently?

Non-Emergency Medical Transportation and Non-Medical Transportation

Member Services: 888-893-1569
ModivCare Facility Line (for Providers Only): 866-529-2128
ModivCareReservations (for Members): 855-253-6864
Fax ModivCare Form to Utilization Review: 877-457-3352

NEMT:

Non-emergency medical transportation (NEMT) is a covered service when your patient's medical and physical condition is such that transportation by ordinary means of public or private conveyance is medically contraindicated. NEMT modalities are Ambulance, Litter van services, Wheelchair van services, and/or Air. Air requires a health plan authorization and letter of agreement.

- A Physician Certification Statement (PCS) is required.
- Physicians/Providers are required to complete a PCS form and document the patient's limitations and provide specific physical and medical limitations that preclude the patient's ability to reasonably ambulate without assistance or to be transported by public or private vehicles.
- Advanced notice is required when arranging NEMT: 48 hours.

NMT:

Non-medical transportation (NMT) includes round-trip transportation (for medically necessary appointments) by passenger car, taxicab, bus passes, taxi vouchers, train tickets, or other forms of public or private conveyance (private vehicle), as well as mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by the patient and called into the transportation broker for a tracking number to submit for reimbursement.

- A PCS form is not required.
- Available for medically necessary covered services (i.e. patients picking up medication prescriptions that cannot be mailed directly to the patient, patients picking up medical supplies, prosthetics, orthotics, and other equipment.).
- Advanced notice is required when arranging NMT: 24 hours.

Note:

If the PPG is delegated and holds financial risk for NEMT, the provider/requestor will need to contact the PPG for the NEMT arrangement and authorization process. If the PPG is not delegated to arrange transportation, all requests are arranged through our transportation vendor, ModivCare. All NMT transport is arranged through ModivCare.

Who Can Request NEMT & NMT:

- A CalViva Health patient, relative or caregiver can request.
- A CalViva Health minor can request without parental consent in the case of minor consent services (minor consent services are services adolescents, children ages 12 through 17, can obtain without a parental consent – sensitive services) as described below. Patients 12 – 17 years may request transportation:
- For counseling and surgical procedures to end pregnancy from any qualified Medi-Cal provider.
- For behavioral health services, drug and alcohol abuse, outpatient mental health treatments, and counseling.
- For family planning, sexual assault services including rape, and sexually transmitted diseases services from any qualified Medi-Cal provider.
- To pregnancy-related services in their primary care physician's (PCP's) network (medical group)

Non-Emergency Medical Transportation and Non-Medical Transportation

Questions

Non-Emergency Medical Transportation and Non-Medical Transportation

1. Which form of transportation requires documentation of a patient's limitations?

2. Are there any examples of when a patient who is 12-17 can request transportation without parental consent?

3. I have a contract with a PPG, what are the PPG requirements for prior authorizations?

Behavioral Health & More Services For Your Patients

Behavioral Health Services: 1-800-950-4777
Member & Provider Services: 1-888-893-1569
Dental Benefits (Denti-Cal): 1-800-322-6384
California Children and Services: 1-888-893-1569
WIC Program: 1-800-852-5770
Public Programs: 1-800-526-1898

If your mental health screening tools indicate mild to moderate distress for your patient CalViva Health members may obtain the following behavioral health services:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include laboratory work, medications, and supplies
- Outpatient services for the purpose of monitoring medication therapy
- Psychiatric consultation

TYPE OF CARE	STANDARD
Access to mental health care for life-threatening emergency care	Immediately
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization	Within 48 hours of request
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization	Within 96 hours of request
Non-urgent appointment with behavioral health care physician (psychiatrist)	Within 15 business days of request
Non-urgent appointment with non-physician behavioral health care provider	Within 10 business days of request
Non-urgent follow-up appointment with non-physician mental health care provider (NPMH)	Within 10 business days of request

(continued next page)

CalViva Health patients do not need to contact their PCP, PPG, or attending physician to request referrals for behavioral health care office visits. Patients may obtain behavioral health office visits directly through behavioral health network by calling CalViva Health Member Services.

CalViva Health patients may also obtain Behavioral Health Therapy (BHT) services. BHT services may include:

- Psychiatric services, such as ABA, therapy and medication management of specific symptoms related to autism spectrum disorders (ASD), as well as any comorbid psychiatric conditions.
- Family therapy to help parents and siblings cope with the diagnosis and the patient with ASD behaviors; brief psychotherapy to teach behavior modification techniques to parents to assist them in managing their child;
- Individual psychotherapy for adolescents and young adults with ASD.

Primary Care Physicians are responsible for primary care management. This includes coordination of ongoing care for co-existing medical and mental health needs and provision of medically necessary medications, notwithstanding whether the member receives care through CalViva or the County Mental Health Plans (CMHPs). Each county is required by law to provide access to specialty mental health services for Medi-Cal members, which are overseen by the California Department of Mental Health.

SPECIALTY MENTAL HEALTH SERVICES

When screening tools indicate more significant distress (Serious Mental Illness), or impairment of mental, emotional, or behavioral functioning Specialty mental health services are indicated and are covered by the County Mental Health Program and include:

Outpatient services:

- Mental health services, including assessments, plan development, therapy, and rehabilitation.
- Medication support.
- Day treatment services and day rehabilitation
- Crisis intervention and stabilization
- Targeted case management
- Therapeutic behavior services

Residential services:

- Adult residential treatment services
- Crisis residential treatment services

Inpatient services:

- Acute psychiatric inpatient hospital services
- Psychiatric inpatient hospital professional services
- Psychiatric health facility services

ALCOHOL AND DRUG TREATMENT SERVICES

CalViva Health coordinates referrals for members requiring substance use treatment and services. Members receiving services under this program remain enrolled in the plan. Participating PCPs are responsible for maintaining continuity of care for the member.

The alcohol and drug treatment services covered by the Drug Medi-Cal (D/MC) program include:

- Outpatient heroin detoxification services
- Outpatient methadone maintenance services
- Outpatient drug-free treatment services
- Day care habilitative services
- Perinatal residential substance use services

Participating providers are responsible for performing all preliminary testing and procedures necessary to develop a diagnosis. Referrals to D/MC or fee-for-service Medi-Cal (FFS/MC) programs must include the appropriate medical records supporting the diagnosis and additional documentation. The referring provider must obtain a signed release from the member prior to making the referral.

Members may also self-refer to behavioral health services by calling the member services phone number listed on their identification (ID) card.

PUBLIC PROGRAMS

Public health programs provide a wide variety of services to your CalViva Health patients at the county, state, and federal levels. Physicians, public health programs and the health plan coordinate their efforts to assist your CalViva Health patients in receiving the full scope of available benefits and services.

- Your CalViva Health patients may have **Dental Benefits.** Call 1-800-322-6384 for more information.
- Your CalViva Health patients under the age of 21 with a disability or chronic condition may qualify for the **California Children Services (CCS)** program. The CCS program provides specialized medical care, rehabilitation services and case management to children with medical or surgical conditions. Call 559-445-8716 for more information or eligibility. Primary Care Physicians (PCPs) remain responsible for providing primary care services to the member, including coordination with CCS and specialists to ensure continuity of care.
- Your CalViva Health patients may qualify for the **Women, Infant, and Children (WIC)** Program. Call 1-800-852-5770 for more information.
- Your CalViva Health patients' ages 0-3 may qualify for the **Early Start** Program. CalViva Health patients with Developmental Disabilities may qualify for more services. Call 1-800-526-1898 for more information.
- Your CalViva Health patients may also qualify for specialized mental health services, **Community Based Adult Services (formerly Adult Day Health Care)**, and **Regional Center Coordination.** Call 1-800-526-1898 for more information on available public health programs or visit the provider's website at provider.healthnet.com.
- Your CalViva Health patients may qualify for **Major Organ Transplants** (MOTs). All transplant services for Medi-Cal members under age 21 are coordinated through the CCS program. For Members Ages 21 and over, a PCP or specialist who identifies a member as a potential candidate for transplant services must provide applicable medical records to a Medi-Cal approved, the Plan Transplant Performance Center for transplant evaluation. The Center must submit a prior authorization request for the evaluation to the Centene Centralized Transplant Unit (CTU) through the provider portal, or via fax directly to the CTU at 833-769-1141.

Questions

Behavioral Health & More Services For Your Patients

1. How do I refer to Early Start/Early Intervention and/or Developmental Disabilities patients?
2. Whom do I contact when patients may need mild to moderate mental health, or behavioral health care services?
3. Do my CalViva Health patients need a referral or an authorization to access mental health or behavioral health care office visits?
4. Where should I direct my CalViva Health patients who need inpatient or specialty behavioral health care services?
5. If I am treating a patient who is under the age of 21 and has a disability or chronic condition, what other services may be available to the patient?
6. If a CalViva Health patient asks about their Dental benefits, where should I have them call?

Grievance and Appeal Procedures

California Department of Managed Health Care: 1-888-HMO-2219
Hearing/Speech Impaired: 1-877-688-9891
State Hearing: 1-800-952-5253
Ombudsman office 1-888-452-8609
To report a Grievance call Member Services at (888) 893-1569 TTY 711
Provider Website: Provider.healthnet.com
CalViva Health Website: Calvivahealth.org
CalViva Health Grievance Fax: 1-877-831-6019

Patient Grievance Procedure

If a patient wishes to file a complaint or grievance the provider's office is required to:

1. Inform the Member that they may submit grievances electronically, verbally or in writing at any time within 180 days of the date of an occurrence.
2. Have CalViva Health Member Grievance/Complaint forms available for patients upon request. Forms must be available in English, Spanish and Hmong. **Forms are available on the provider website.**
3. Inform the patient that the CalViva Health Member Services Department is available to assist them if they would like to file their grievance over the phone by calling CalViva Health Member Services Department at 888-893-1569.
4. Inform patients that grievances can be completed online via the CalViva Health website "CalVivaHealth.org"
5. Allow patients to file a grievance without fear of discrimination or retaliation.
6. Fax all completed grievance forms to CalViva Health within one business day. Fax completed Grievance Forms to 1-877-831-6019.

Be aware that:

- Grievances and complaints are the same thing.
- CalViva Health provides the patient with a written acknowledgement of receipt of the grievance within five calendar days.
- The patient is informed in writing of the standard grievance resolution within 30 calendar days, if a grievance cannot be resolved within 30 calendar days, a letter of explanation that includes the reason for the delay and an estimated date of resolution are sent to the member. For an expedited grievance within 72 hours.
- Medi-Cal beneficiaries have the right to request a State Hearing from the California Department of

(continued next page)

Grievance and Appeal Procedures

Social Services (DSS) at any time by phone or in writing during the grievance process by contacting the department's Public Inquiry and Response Unit at (800) 952-5253.

Medi-Cal beneficiaries have the right to contact the DMHC for assistance with emergency grievances. They are not required to use CalViva Health's grievance process first. Contact the DMHC directly at (888) 466-2219.

Patient Appeal Procedure

If a patient is dissatisfied with the health plan's denial of a service that required prior authorization, post service claim denial, claim denial, or denial of coverage, the provider should:

1. Inform the patient of their right to appeal (verbally or in writing) the denial within 60 days from the date on the Notice of Action.

2. Instruct the patient to contact the Member Services Representatives at (888) 893-1569 (telephone number is located on the back of the patient's insurance identification card) where a representative can assist them in writing the appeal and initiating the appeal process.

3. Or the provider may submit the appeal directly to CalViva Health on the patient's behalf.

4. Provide the patient or CalViva Health with any additional or supporting documents that the health plan should consider as part of the reevaluation of the denial.

Be aware that:

- Appeals received after the 60-day time- frame will not be considered.
- Appeals submitted by the provider on the patient's behalf are handled in the same manner as those submitted by the patient.
- A written acknowledgment is mailed to the patient within five calendar days of receipt of a standard written appeal.
- A decision is made within 30 days of receipt of a standard appeal or within 72 hours of receipt of an expedited appeal. Patients are notified in writing of the decision made and the rationale for that decision.

If the health plan upholds the initial denial of coverage, the patient receives written notice of the decision and at that point they have the following options:

1. Request a State Hearing from DSS within 120 calendar days from the date on the written response.

2. Request an Independent Medical Review (IMR) within 180 days from the date of the written response or may request an IMR from the DMHC right away if the member's health is in immediate danger.

3. Request a review from the Ombudsman office 1 (888) 452-8609.

Grievance and Appeal Procedures

Questions

Grievance and Appeal Procedures

1. What is your process for handling grievances?
2. Can a provider submit an appeal on a patient's behalf?
3. How can a CalViva Health patient file a grievance?
4. What languages are your grievance forms available in?

Access & Availability

For questions contact Provider Services at (888) 893-1569

CalViva Health patients, including Seniors and Persons with Disabilities (SPDs), will have appropriate access to practitioners, providers, and health care services within a reasonable period of time. PCPs are required to ensure coordinated health care services are available twenty-four hours per day, seven days per week. This includes systems for after-hours urgent care, emergent physician coverage available 24-hours per day and the provision of ongoing follow-up care. State and federal regulations require that services to Medi-Cal patients are provided according to the following timeframes:

Access Standards:

Pregnancy Care	
First prenatal visit	within 10 business days of the request for an appointment
Postpartum visit	within 3-8 weeks after delivery
Well Care	
Regular doctor visit	within 10 business days of the request for an appointment
Well-child visit	within 10 business days of the request for an appointment
Physical exam & wellness check	within 30 calendar days of the request for an appointment
Initial Health Assessment	
CalViva Health Patients	within 120 calendar days of enrollment with CalViva Health
Specialty Care	
Specialist	within 15 business days of the request for an appointment
Urgent Care	
Urgent care with PCP	within 48 hours of request
Urgent care visit requires prior auth	within 96 hours of request
After-Hours Access	
Emergency Care	call 911 or go to emergency room
Urgent Care	call the provider's office 24 hours per day, 7 days per week. Expect a call back from a provider within 30 minutes.

(continued next page)

BEHAVIORAL HEALTH ACCESS STANDARDS:

Non-urgent/Routine care with a mental health physician	within 10 business days of the request for an appointment
Non-urgent care with a mental health provider (non-physician)	within 10 business days of the request for an appointment
Non-urgent follow-up appointment with non-physician mental health care provider	within 10 business days of request
Access to urgent mental health care	within 48 hours of the request for an appointment
Access to non-life threatening emergency mental health care	within 6 hours of request for an appointment
Access to mental health care for life-threatening emergency	call 911 or go to emergency room

AFTER HOURS ACCESS

Medical services must be available and accessible 24 hours a day, seven days a week. Practitioners and providers that do not have services available 24 hours a day may use an answering service or an answering machine to provide patients with clear and simple instructions on after-hours access to medical care. After office hours members can expect a call back from a provider within 30 minutes.

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

Telephone assessment of a patient's health problems or medical condition may only be performed by licensed staff (physicians, registered nurses and nurse practitioners) and only according to established standards of practice.

Note: sample scripts for Answering Service or Answering Machine calls are available online at the Provider Library. These scripts are available in English, Spanish and Hmong.

PROVIDER OFFICE WAIT TIMES

The Department of Health Care Services (DHCS) requires CalViva Health to monitor provider office wait-time. In-office wait times for scheduled appointments must not exceed 30 minutes. To demonstrate compliance with this requirement, CalViva Health requests that providers submit completed in-office wait-time logs every first Tuesday of the month via fax to (559) 446-1998 or email to MMAC@CalVivaHealth.org.

Access & Availability

Questions

Access & Availability

1. How soon can a patient expect a return call from a provider after hours if they indicate they have an urgent medical issue?

2. The Initial Health Appointment for all new patients should be completed within how many days of enrollment?

3. How soon would you schedule a patient that calls with an urgent medical issue?

Informed Consent, Sensitive Services & Permanent Sterilization

For questions contact Provider Services at (888) 893-1569.

INFORMED CONSENT FOR PROCEDURES

Patients shall be informed about any proposed treatment or procedure that includes medically significant risks; this includes any surgical, special diagnostic or therapeutic procedure or when there is a statutory requirement. This process includes a thorough discussion with the patient about the risks, benefits and alternate courses of treatment or non-treatment and the risks involved in each and the name of the person(s) who will carry out the procedure or treatment. Documentation of this discussion and a signed consent form shall be written and included in the patient's medical record.

MINOR CONSENT SERVICES

Medi-Cal patients under age 18 may access minor consent services without parental consent and without prior authorization. Minor Consent Services are services related to:

- Sexual assault, including rape
- Drug or alcohol abuse (age 12 years and older)
- Family planning services
- Pregnancy (including termination)
- HIV counseling and testing
- STI diagnosis and treatment (age 12 years and older)
- Outpatient mental health services

If patient is 12 years old or older may also get these services without your parent or guardian's permission:

- Outpatient mental health care for:
  - Sexual assault
  - Incest
  - Physical assault
  - Child abuse
  - When you have thoughts of hurting yourself or others
- HIV/AIDS prevention, testing, and treatment
- Sexually transmitted infections prevention, testing, and treatment
- Substance use disorder treatment

(continued next page)

Informed Consent, Sensitive Services & Permanent Sterilization

Minors can talk to a representative in private about their health concerns by calling the 24/7 nurse advice line. Call the Member Services phone number at 1-888-893-1569 (TTY 711) and choose the 24-hour nurse advice line option on the menu. CalViva Health will not send information about getting sensitive services to parents or guardians.

CONFIDENTIAL AND SENSITIVE SERVICES

All CalViva Health patients may access sensitive services in a timely manner and without barriers. Patients may access most sensitive services from any qualified provider, in or out-of-network, except obstetrical care for pregnancy and services related to substance abuse and mental health which must be obtained from in-network providers. Sensitive Services include:

- Family planning services
- Abortion
- HIV counseling and testing
- Alcohol and drug treatment services and Mental Health treatment
- Pregnancy testing, including pregnancy termination.
- Diagnosis and treatment for sexually transmitted infections (STI's)

PERMANENT STERILIZATION

Providers must obtain informed consent for all methods of permanent sterilization procedures. Most methods of sterilization (members must be at least age 21 at the time consent is obtained) include: tubal ligation and vasectomy. The Department of Health Care Services (DHCS) Consent Form PM 330 is the only form approved by DHCS for certification of informed consent for sterilization. Before obtaining consent, providers must give Medi-Cal patients to be sterilized the appropriate DHCS-published brochure on sterilization, as listed below:

- Permanent Birth Control for Women
- Método Anticonceptivo Permanente Femenino
- Permanent Birth Control for Men
- Método Anticonceptivo Permanente Masculino

These brochures are the only sterilization informational brochures approved by DHCS. They are available on the DHCS website at **www.dhcs.ca.gov/Pages/PermanentBirthControl.aspx** for providers to download and print.

(continued next page)

Consent Form PM330

Before obtaining consent and completing the PM330 for any sterilization procedure a provider or providers' designee must discuss and furnish the following information to the patient seeking sterilization:

- A full description of available alternative methods of family planning and birth control.
- A description of benefits or advantages that may be expected as a result of sterilization.
- A thorough explanation of the specific sterilization procedure to be performed, including information on whether the procedure is established or new
- The name of the provider performing the procedure. If another provider is substituted, the patient must be notified prior to anesthesia of the new provider's name and the reason for the change
- Advise that the sterilization procedure is considered irreversible
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible side effects of any anesthesia
- Approximate length of hospital stay, recovery time and any cost to the patient
- Advise that the sterilization will not be performed for at least 30 days (except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is fully met)
- Advise that the patient is free to withhold or withdraw consent at any time before the procedure without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the patient might be entitled

The PM 330 must be signed and dated by the member to be sterilized, the interpreter (if one is used in the consent process), the person who secured the consent (for example, physician or intake nurse), and the provider performing the sterilization. The PM 330 must be fully and correctly completed after the above topics have been discussed between the patient and provider. Submit the PM 330 form with the claim form in order for the claim to be paid. The DHCS Consent Form PM 330 is available in English and Spanish on the provider website at provider.healthnet.com in the Provider Library > Forms.

Informed Consent, Sensitive Services & Permanent Sterilization

Questions

Informed Consent, Sensitive Services & Permanent Sterilization

1. What is the process for informed consent?
2. Name two types of Sensitive Services?
3. What consent form must be used to document consent for permanent sterilization?
4. How long is the waiting period before the procedure once the consent for permanent sterilization is signed by the patient (non-emergent situations)?
5. What form must be submitted with the claim form in order for a provider to be paid?

Provider Training

Provider Network Management: HN_Provider_Relations@healthnet.com
CalViva Health Provider Services: (888) 893-1569
Cultural and Linguistic Services/Health Equity Department: (800) 977-6750
Health Education Department: (800) 804-6074

NEW PROVIDER MEDI-CAL TRAINING TRAINING

We are pleased to welcome you as a Medi-Cal participating provider for CalViva Health patients. We are excited to have the opportunity to partner with you to meet the health care needs of Medi-Cal patients. The health plan makes available written provider education materials and online materials to help you and your staff become familiar with CalViva Health's Medi-Cal Managed Care Plan. To request in-person Medi-Cal training contact Provider Engagement or CalViva Health Provider Services.

HEALTH EQUITY TRAINING

CalViva Health providers are required to take Diversity, Equity, and Inclusion (DEI) training.
The Health Equity Department provides training to meet requirements and support the integration of culturally responsive care. The training program includes training content, training presentations and evaluations. The training program also offers consultation and topic specific education as needed by contracted providers. Cultural competency trainings cover non-discrimination based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.

Required DEI training topics for CalViva Health provided by the Health Equity Department include:

- Special Needs and Cultural Competency
- Health Equity and Social Determinants of Health
- Language Assistance Program and Services
- Implicit Bias
- Health Literacy/Plain Language
- Gender Affirming Care
- Community Connect Program - findhelp

Additionally, CalViva providers have access to materials and tipsheets to support culturally competent patient-centered care across our diverse populations. These resources can be accessed in the Provider Portal at https://providerlibrary.healthnetcalifornia.com/medi-cal/health-equity--cultural-and-linguistic-resources-.html or by calling the Health Equity Department toll free number during business hours at (800) 977-6750.

The Health Equity Department also provides the Language Assistance Program (LAP). The LAP offers interpreter services to ensure that Limited-English Proficient (LEP) patients are able to obtain language assistance while accessing health care services. The LAP is available to participating physician groups (PPGs), physicians, and ancillary providers to assist providers in communicating with their CalViva Health patients. This service offers access to qualified interpreters, including sign language interpreters, trained on health care terminology and interpreting protocols and ethics; support to address common communication challenges across cultures, and telephone interpreters in more than 150 languages. Interpreter services for LEP members are available at all medical points of contact, 24 hours a day, seven days a week at no cost. For more information about interpreter services, cultural competency awareness or to schedule training contact the Health Equity Department or CalViva Health Provider Services.

Provider Training

Provider Training

Questions

Provider Training

1. How can providers or their office staff request in-person Medi-Cal training?
2. What new trainings are CalViva providers required to complete at this time?
3. Where can Provider Tip Sheets on providing culturally competent care be located?

Referrals and Prior Authorizations

CalViva Health Provider Services: (888)893-1569
American Specialty Health Plans (ASH): (800)972-4226 option 2
Prior Authorization Request Fax Line: (800)743-1655
Prior Authorization Request Telephone Line: (800)421-8578, (800)628-2705, (800)642-4746

REFERRALS FOR SPECIALTY CARE (SPECIALISTS)

The Primary Care Physician (PCP) is responsible for managing and coordinating the patient's complete medical care, maintaining continuity of care and initiating specialist referrals, if the necessary services fall outside the scope of the PCP's practice. Patients may obtain certain services from qualified in-network or out-of-network providers without a referral.

These Services DO NOT Require Prior Authorization:

- Emergency services
- Family planning services (including visits to an OB/GYN for annual Pap test and pelvic examination), STI diagnosis and treatment, and sexual assault services
- HIV testing and counseling
- Comprehensive Perinatal Services program (CPSP)
- Sensitive Services such as Minor consent services, Therapeutic and Elective Pregnancy Termination, Mental Health Services
- Acupuncture services for certain conditions with a participating provider. (The first two services per month; additional appointments will need a referral)

REFERRALS TO SPECIALIST – FEE-FOR-SERVICE (FFS) PRIMARY CARE PHYSICIAN
A referral is required for cases that are difficult to manage or when care is beyond the PCP's scope of practice. When referring a patient for specialty care, the direct participating FFS PCP must follow the guidelines below.

- The PCP selects the specialist
- Referrals are only valid between participating providers
- When referring a patient to a non-participating provider, prior authorization is required, with the exception of those services for which patients may self-refer without prior authorization
- When scheduling a patient appointment for specialty care, the appointment must not exceed 96 hours from request for urgent care services that need prior authorization, and 15 business days from request for non-urgent care services and must be coordinated with the PCP based on the severity of the patient's condition
- When a specialist determines a patient needs specialty care from a different specialist, the PCP should be notified and initiate the referral process

REFERRALS TO SPECIALIST – CAPITATED PROVIDERS
The health plan delegates the referral process to full and shared risk Participating Provider Group's.

(continued next page)

Referrals and Prior Authorizations

Referrals to participating and non-participating specialists for patients assigned to a delegated PPG are subject to any additional practices or requirements imposed by the PPG. When the PCP is referring a patient for specialty care, the PCP must refer to the PPG's policy and procedures and follow the guidelines below.

- The PCP selects a specialist who is a participating provider of the PPG.
- The PCP must follow the PPG's referral guidelines, procedures, and regulations.
- When scheduling a patient appointment for specialty care, the appointment must not exceed 96 hours from request for urgent care services, and 15 business days from request for non-urgent care services and must be coordinated with the PCP based on the severity of the patient's condition.
- When referring a patient to a non-participating provider, prior authorization is required following the PPG's authorization requirements, with the exception of those services for which patients may self-refer without prior authorization.
- The PCP and capitated PPG's must refer a member to an ASH Plans participating acupuncture provider for covered acupuncture services.

TRACKING REFERRALS

Providers must monitor referrals that have been authorized to ensure that patients access care and follow up with their providers.

PCP RESPONSIBILITIES ARE:

- Maintaining continuity of care for their patients during the referral process.
- Monitoring the referrals to ensure the specialty reports are received for the primary care medical record.
- Confirm the specialist's report is in the patient's medical record within two weeks for any specialty services, including consultation visits, labs, or follow-up visits.

PRIOR AUTHORIZATION REQUESTS

Prior authorization is designed to ensure medical necessity of services, appropriate level of care and use of participating providers, as well as to prevent unanticipated denials of coverage. Providers contracting directly with the health plan (FFS providers) must obtain prior authorization from the Health Services Department. For capitated providers the health plan delegated the prior authorization process to some PPGs. Prior Authorizations for patients assigned to a delegated PPG are subject to any additional rules imposed by the PPG, but PPGs cannot impose prior authorization requirements that conflict with the patient's right to self-refer for specific services.

PRIOR AUTHORIZATION-CAPITATED PROVIDERS

Providers contracted with a PPG must follow the PPG's prior authorization process and procedures. Contact the PPG for information.

PRIOR AUTHORIZATION-FFS PROVIDERS

The prior authorization process for FFS providers provide and coordinate medically necessary care in a timely and efficient manner.

- Prior authorization is required for elective inpatient admissions, elective surgical procedures, and for other services listed on the prior authorization requirements list from the provider website at provider.healthnet.com.
- Specialists are required to send copies of the consultation and treatment plans to the patient's PCP.
- Providers must refer any services related to a California Children's Services (CCS) eligible condition to the local county CCS program for authorization.

Questions

Referrals and Prior Authorizations

1. Who is responsible for referring the patient to the specialist?

2. Are there services that do not require a referral or prior authorization?

3. What are the PPG requirements for prior authorizations if I have a contract with a PPG?

Clinical Services & Case Management

For questions, contact Provider Services at (888) 893-1569.
Locate the RDL at: http://provider.healthnet.com and
http://www.calvivahealth.org/for-providers/

Pharmacy

- Most medications for Medi-Cal patients are covered by MediCalRx not the health plan.
- Medically administered drugs (injectables & physician administered) are still the responsibility of the health plan and may require prior authorization.
- All requests for medication Prior Authorization must be submitted on the state-approved standardized form, also available on the provider website.
- For additional information, please refer to the Medi-Cal Rx Options for PA Submission Guide at **https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf**

Prescription drugs given by a pharmacy are covered by Medi-Cal Rx, a Medi-Cal FFS program. Sometimes, a drug is needed and is not on the Contract Drug List. These drugs will need to be approved before they can be filled at the pharmacy. Medi-Cal Rx will review and decide these requests within 24 hours.

- A pharmacist at your outpatient pharmacy may give you a 72-hour emergency supply if they think you need it. Medi-Cal Rx will pay for the emergency medication supply given by an outpatient pharmacy.
- Medi-Cal Rx may say no to a non-emergency request. If they say no, they will send you a letter to tell you why. They will tell you what your choices are.

To find out if a drug is on the **Contract Drug List:** https://medi-calrx.dhcs.ca.gov/home/cdl/ or to get a copy of the Contract Drug List, call Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711), visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

If a member is filling or refilling a prescription, they must get prescribed drugs from a pharmacy that works with Medi-Cal Rx. You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at https://medi-calrx.dhcs.ca.gov/home/.

You can also find a pharmacy near you or a pharmacy that can mail your prescription to you by calling Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711).

Once the member chooses a pharmacy, they can take it to the selected pharmacy. Providers may also send a prescription electronically to the pharmacy for members. Inform members to give the pharmacy the prescription with their Medi-Cal Benefits Identification Card (BIC). They will want to make sure the pharmacy knows about all medications the patient is taking and any allergies they have. If there are any questions about a prescription, make sure to ask the pharmacist.

Members may also receive transportation services from CalViva Health to get to pharmacies.

(continued next page)

Clinical Services & Case Management

Initial Health Appointment (IHA)

DHCS requires primary care physicians (PCPs) or provider within the primary care setting to conduct an Initial Health Appointment (IHA) for all new CalViva Health patients within 120 calendar days from their date of enrollment. A list of your new CalViva members (New Member List) can be found on the provider portal. The IHA must be conducted in a culturally and linguistically appropriate manner for all patients, including those with disabilities.

New members are sent a welcome packet that includes an IHA notification and information about how to schedule an appointment with their PCPs. The IHA notification instructs new members to schedule an appointment with their PCP. CalViva Health representatives contact new CalViva Health patients by telephone after mailing the new member packet to discuss the importance of scheduling an IHA and to share other relevant information about members using their benefits. If the IHA has not occurred within 45 days of enrollment, the plan conducts a third member contact via phone.

Providers should have an established process for reaching out to new members identified on their New Member List obtained from the provider portal or Cozeva.

If a member, or the parent or guardian of a child member, refuses to have the IHA performed, it must be documented in the member's medical records. within 30 days of enrollment to discuss the importance of scheduling an initial health appointment (IHA).

Chronic Condition / Disease Management Program

CalViva Health provides certain members with the opportunity to participate in a Disease Management Program to support, encourage and inspire people with chronic conditions to take stock of their health, change their lives for the better, and become active self-managers of their health. This program is for patients with conditions including but not limited to:

- **Asthma**
- **Diabetes**
- **Heart failure**

A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the patient's clinical, cultural, and linguistic needs.

The goal of the program is to help improve the care of members with chronic conditions by empowering individuals and working with health care providers to manage their condition and prevent complications. Patients enrolled in the program are mailed educational materials with action plans, information about the program, and contact numbers including the Nurse Advice Line. The Plan conducts outbound telephonic interventions and makes referrals to case management as needed. A Health Plan physician or case manager may also refer members to the program, or members can self-refer.

To refer a member to the program, use the Case Management Referral Form (CalViva Health, Health Net) in the Provider Library. Members may self-refer to the program by calling the customer service number on the back of their ID cards and request a referral to Care Management.

REFERRALS FOR EDUCATION

Providers may call the Health Education Department to order health education materials and refer members into health education programs and services. Patients may self-refer by calling the Health Education department at 1-800-804-6074. Providers may refer patients by calling the Health Education Department at 1-800-804-6074. Other Health Education programs and services include:

- Toll-free Health Education Information Line
- Tobacco Cessation Program
- Weight management programs
- CalViva Pregnancy Program
- Diabetes Prevention Program
- Healthy Hearts, Healthy Lives

(continued next page)

Clinical Services & Case Management

Nurse Advice Line

The Nurse Advice Line is a nurse-driven telephonic support program that empowers patients to better manage their health. The Nurse Advice Line offers assistance to patients coping with chronic and acute illness, episodic or injury-related events. Interpreter services are available at no cost to the patients. The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, provide instructions on home care techniques and offer general health information. Access to evidence based, reliable clinical support after hours increases the likelihood that our patients will seek care at the appropriate level when their physician is not available to support the decision.

Program highlights include:

- Health information managers with experience in health issue discovery and trained in telephone triage
- Improved continuity of care
- Convenient and useful alternatives help to reduce excessive or unnecessary emergency room visits

Symptom Management:
Support for general health information, prevention, and triage services Available: 24 hours a day, 7 days a week, 365 days a year at 1-888-893-1569. Also, if your office or clinic is closed and patients need assistance to determine the need for urgent care or other treatment, patients may use this phone number.

Question

1. What days of the week is the Nurse Advice Line available to CalViva Health patients?

Referrals to Care Management

For questions or to make a referral to Case Management call 888-893-1596 and ask to make a Case Management referral or obtain a Care Management Referral Form available on the physician portal and e-mail it to CASHP.ACM.CMA@healthnet.com. Members can refer themselves to Care Management or they may be referred by a caretaker or their provider.

Your CalViva Health patients may qualify for a program called Case Management. Comprehensive care management is necessary when a member has multiple problems or diagnoses resulting in a high-risk catastrophic or fragile medical condition. The plan's care management program involves identifying medical need and allocating resources.

The program is based upon a model that uses a multi-disciplinary care management team, recognizing that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the primary care physician (PCP) or specialist office with administrative work.

There are two different levels of case management:

- **Basic Care Management.** The PCP is responsible for providing initial primary care management, maintaining continuity of care, and initiating specialist care.
- **Comprehensive Care Management.** A collaborative team manages care for members whose needs are functional and social as well as those with complex physical and or behavioral health conditions such as:
    - Complex chronic conditions, such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), and vascular or active cancers
    - Multiple comorbidities

(continued next page)

- A health event that has the potential for significant consumption of resources (medical or financial)
- Complications relating to frail physical or mental health status
- Pregnancy
- Those experiencing frequent or prolonged hospitalizations or emergency visits
- Multiple psychosocial factors, such as need for support system, transportation, financial resources, decision support, habilitation, or residential needs
- Functional impairment, such as dependency for activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Individuals who are eligible by law, such as those with mental or developmental disabilities

Palliative Care Services

Confirm diagnosis for advanced acute illness to receive palliative care.

Palliative care is patient and family-centered care to provide support and symptom relief to all members, regardless of age and illness. Palliative care includes supporting physical, emotional, social, and spiritual needs to improve our members' quality of life throughout their healthcare continuum. To view the complete list of criteria, please go to Palliative Care in the Provider Library.

A. *Palliative Care eligible members are identified through a variety of mechanisms including Plan Care Management, Transition of Care services, PCPs, specialists.*

B. *Plan staff coordinate Palliative Care referrals with the member's PCP/Specialist.*

C. *The Plan Provider Portal includes Palliative Care information, a list of providers, and the referral process.*

SUBMIT A PRIOR AUTHORIZATION REQUEST WITH MEDICAL RECORDS

The Prior Authorization Request Form can be filled out online and faxed with the medical records. Or print the form, fill it out and fax the information. fax the information to 800-743-1655.

Behavioral Health Care Management

CalViva health strongly supports the integration of both physical and behavioral health services through screening and strengthening prevention and early intervention. Specialty mental health services are not covered under the Plan and are paid under Medi-Cal FFS. The Plan will ensure that Members who need Specialty Mental Health Services are referred to and are provided these services by an appropriate Medi-Cal FFS mental health provider or the local mental health plan in accordance with contract requirements. The Plan will assist members with scheduling referred services with appropriate urgency to the applicable care setting and exchange appropriate information with those providers to ensure coordination and continuity of care.

When staff identifies a member with coexisting medical and behavioral health disorders, the identifying staff will notify the Plan Care Manager of the member. If the member's primary diagnosis is a behavioral health condition; the case is referred to a Behavioral Health Care manager, who serves as the lead Care Manager, working in tandem with the medical care team.

Transition of Care Services

The purpose of the Transition of Care Services Program (TCS) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care.

(continued next page)

Clinical Services & Case Management

Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member. For Transitional Care Services call 866-801-6294.

The program includes:

- Conducting an initial outreach call within 3 to 10 calendar days from discharge to review post hospital instructions and conduct medication reconciliation with the member.
- Outreach to member at hospital to conduct inpatient discharge risk assessment and enroll in program.
- Coordinate care and discharge needs with hospital staff.
- Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.
- Preparation for discussions with other health care professionals and use of a personal health record to support member collaboration with the inter-disciplinary team to enhance post-discharge follow up care.
- Supporting the patient's self-management role
- Educating the member to follow up with the PCP/and or specialist within 7-10 days of discharge if not listed on the post discharge instructions.

During the post discharge period, staff evaluates the member to provide the best support to the member in managing their continued needs.

Perinatal Care Management

CalViva Pregnancy Program (CVPP) Case Management (CM) is for members with medium to high-risk pregnancies. The purpose of this program is to identify pregnant members as early in their pregnancy as possible and assess the health care needs of the member and the unborn child.

Enrollment starts with the completion of:

- The Provider Notice of Pregnancy (NOP)
- Member OB Screen Assessment, or
- OB Case Management Assessment.
- Based upon the assessment responses, a numeric risk score is assigned of high, medium, or low.

Problems identified to be managed during the member's pregnancy include but are not limited to:

- Previous Pre-term Delivery/Potential Current Pre-Term Delivery
- Asthma
- Diabetes/Gestational Diabetes
- Pregnancy Induced Hypertension (HTN)/Chronic HTN
- Urinary Tract Infections (UTIs)/Pyelonephritis
- Current fetal growth restriction
- Shortened cervix this pregnancy
- Current alcohol abuse
- Congenital anomalies
- Mental Health Services

OB cases typically stay open until after the member delivers and the post-partum assessment is completed.

(continued next page)

Enhanced Care Management & Community Supports

CalViva Health covers Enhanced Care Management (ECM) services for members with highly complex needs. ECM is a benefit that provides extra services to help you get the care you need to stay healthy. There is no cost to the member for ECM services. It coordinates the care you get from different doctors. ECM helps coordinate primary care, acute care, behavioral health, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to available community resources.

If a patient qualifies, he/she will be contacted about ECM services. Patients can call CalViva Health to find out if can receive ECM or Provider can find out if patient qualify for ECM and when and how patient can receive it.

If a CalViva patient qualifies for ECM, the patient will have their own care team, including a Lead Care Manager. This person will talk to you and your doctors, specialists, pharmacists, case managers, social services providers, and others to make sure everyone works together to get you the care you need. There is no cost to the member for ECM services.

A Lead Care Manager can also help you find and apply for other services in your community. ECM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social support.

Community Supports may be available under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for Members to receive. If you qualify, these services may help you live more independently. They do not replace benefits that you already get under Medi-Cal. To learn more about CS or to access these services: call CalViva Health at 888-893-1569 (TTY:711) 24 hours a day, 7 days a week.

Population Health Management

CalViva Health provide Members with information about all available PHM programs and services through the following:

- New Member Welcome letter sent via United States (US) Postal Mail
- Unsolicited Phone Call Outreach based on identified health needs post risk stratification
- Solicited Phone Calls for Members who agree to be actively enrolled in programs
- E-mail
- Plan Website
- Annual Plan Newsletter
- Face to face visits

(continued next page)

Clinical Services & Case Management

PHM focus areas

TYPE OF CARE	STANDARD
Improve Preventive Health: Flu Vaccination	All Members 6 months and older, especially high-risk populations.
Tobacco Cessation	Members 13 years and older
Improve Preventive Health: Breast Cancer Screening	Women ages 50-74 years
Diabetes Management Program	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
High-Risk Obstetrics (OB) CM	Pregnant Members at risk for complications of pregnancy as determined by having a notification of pregnancy (NOP) score >34 and/or provider determination
Improve Behavioral Health: Depression and Antidepressant Medication Management	Members ages 18 and older that have been newly prescribed antidepressant medications and are diagnosed with major depression
Cardio-Protective Bundle Project - SHAPE	Members that have diabetes with hypertension and/or cardiovascular disease.

MemberConnections® Program

MemberConnections is a special educational and outreach program designed to help patients navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections Representatives (MCRs) extend the reach of patient engagement and Population Health Team efforts by making home visits and providing personalized service to patients. MCRs are full-time, non-clinical employees who work alongside clinical pharmacy, case management, quality, health education, behavioral health, and member services staff. More specifically, during telephonic outreach and during home visits, MCRs:

- Promote and assist patients on how to use their benefits and health services
- Connect patients to community resources for social service needs
- Facilitate referrals to case management, clinical pharmacy, disease management and health education programs
- Help patients schedule doctor's appointments, arrange transportation and language assistance services

Referrals for Member Connections generally come through the Population Health Team as well as HEDIS Care Gap reports which identify patients who have complex health conditions, low engagement, and multiple psycho-social issues/barriers that require coordinated assistance and would benefit from telephonic outreach and home visits.

Sexually Transmitted Infections (STIs)

Department of Public Health STD Control Branch: (510) 620-3400

Sexually transmitted infections (STI's) are the most common reportable infections. Many are asymptomatic, and if untreated can result in serious long-term health consequences. Diagnosis and treatment of STIs are available to CalViva members without prior authorization. Members may choose any qualified provider, in- or out-of-network, including LHDs and family planning clinics, for care of an STI episode without prior authorization. STI services include education, prevention, screening, counseling, diagnosis, and treatment.

STI screening and treatment guidelines, job aids, clinical quality improvement tools and other related resources are available at www.std.ca.gov, www.cdc.gov/std. For questions and guidance on complicated cases, resistant infections, or treatment failures, contact the CA Department of Public Health STD Control Branch warm line at (510) 620-3400.

(continued next page)

Clinical Services & Case Management

Effective interviewing and counseling skills, characterized by respect, compassion, and a nonjudgmental attitude toward all patients, are essential to obtaining a thorough sexual history and delivering effective prevention messages.

SCREENING
Sexual health screening should be a routine, normalized, and integrated part of general health history procedures for all adolescent and adult patients.

1. Accurate risk assessment and education and counseling of persons at risk regarding ways to avoid STIs through changes in sexual behaviors and use of recommended prevention services.

2. Pre-exposure vaccination for vaccine preventable STIs.

3. Identification of persons with an asymptomatic infection and persons with symptoms associated with an STI.

4. Effective diagnosis, treatment, counseling, and follow up of persons who are infected with an STI.

5. Evaluation, treatment, and counseling of sex partners of persons who are infected with an STI.

Risk Assessment

- Primary prevention of STIs includes assessment of behavioral risk and biologic risk.
- As part of the clinical encounter, health care providers should routinely obtain sexual histories from their patients and address risk reduction.

TREAT INFECTED PATIENTS

- Visit www.cdc.gov/std for the most recent CDC guidelines.

TREAT RECENT SEXUAL PARTNERS

- Reinfection is very common and is associated with a higher risk of adverse health outcomes. The majority of STI reinfections are the result of re-exposure to an untreated sex partner.

(Re)SCREEN

- Reinfection with STIs is very common and is associated with a much higher risk of adverse health outcomes. Therefore, it is essential to retest all patients a few months post-treatment. Counseling messages for patients at their treatment visit should explicitly include education about their high risk for reinfection and the importance of returning for a retest. Retesting is indicated regardless of whether sex partners were known to be treated.

REPORT

- Providers are legally required to report STI cases to the local health department. Reporting provides a comprehensive picture of STI trends and morbidity in California and helps effectively allocate resources to prevent the spread of disease. County-level data are publicly available at www.std.ca.gov.
- What are the legally required reporting timeframes for STI's?

  Syphilis - Within 1 working day of identification

  Gonorrhea, Chlamydia, Pelvic Inflammatory Disease (PID), Chancroid, HIV/AIDS - Within 7 working days of identification

  What report do you use to report STI's to the local health department? STIs (except HIV/AIDS) are reported in one of two ways:

(continued next page)

Paper-Based — Fax a Confidentiality Morbidity Report (CMR) to the local health department.

Web-Based — Report cases via the California Reportable Disease Information Exchange (CalREDIE) provider portal.

Long Term Care & ICF-DD

For more information contact 1-888-893-1569 (TTY 711).

CalViva Health covers these long-term care benefits for members who qualify:

- Long-term care facility services as approved by CalViva Health
- Skilled nursing facility services as approved by CalViva Health

If a patient qualifies for long-term care services, CalViva Health will make sure members are placed in a health care facility that provides the level of care most appropriate to your medical needs.

Members may have to pay a share of the cost each month for your long-term care services. The amount of your share of cost depends on your income and resources. Each month you will pay your own health care bills, including but not limited to Managed Long-Term Support Service (MLTSS) bills, until the amount that you have paid equals your share of the cost. After that, your long-term care will be covered by CalViva Health for that month. You will not be covered by CalViva Health until you have paid your entire long-term care share of cost for the month.

Clinical Services & Case Management

Quality Improvement & HEDIS

Contact Provider Services at (888) 893-1569 for more information

The Quality Improvement Program monitors performance of clinical care and service measures using many internal and external health care data collection systems. It includes the development and implementation of standards for clinical care and service, measurement of compliance to standards, and the implementation of actions to improve performance. The Managed Care Accountability Set (MCAS) reflects the quality measures health plans, and their providers need to meet each year. Using the Healthcare Effectiveness Data and Information Set (HEDIS®), MCAS and the satisfaction survey results will indicate whether clinical care measures improved or declined from Reporting Year to the next Reporting Year. For measurement year 2024 (MY2024) CalViva Health is accountable to meet minimum performance levels at the 50th percentile on the following 18 measures:

1. Asthma Medication Ratio (AMR)
2. Breast Cancer Screening (BCS-E)
3. Cervical Cancer Screening (CCS)
4. Child and Adolescent Well-Care Visits (WCV)
5. Childhood Immunization Status – Combo 10 (CIS-10)
6. Chlamydia Screening in Women (CHL)
7. Glycemic Status Assessment for Patients With Diabetes >9% (GSD)
8. Controlling High Blood Pressure < 140/90 mm Hg (CBP)
9. Developmental Screening in the First Three Years of Life (DEV)
10. Follow-up After ED Visit for Mental Illness – 30 days (FUM)
11. Follow-up After ED Visit for Substance Abuse – 30 days (FUA)
12. Immunizations for Adolescents – Combo 2 (IMA-2)
13. Lead Screening in Children (LSC)
14. Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)
15. Prenatal & Postpartum Care: Postpartum Care – (PPC-Pst)
16. Topical Fluoride for Children (TFL-CH)
17. Well-Child Visits in the First 30 months of Life – Six or more well child visits in the first 15 months (W30-6+)
18. Well-Child Visits in the First 30 Months of Life – Two or more visits during 15–30 months (W30-2+)

QUALITY PERFORMANCE IMPROVEMENT PROJECTS

The Plan conducts performance improvement projects (PIPs) targeting specific health care issues that impact a significant number of members. PIPs may also address use of health services to enhance health outcomes. It includes testing small-scale changes at the provider-, member- and health plan- level to improve the quality of members' health care and outcomes.

The current DHCS PIP cycle is September 2023–September 2026. The projects currently in process are:

- Non-Clinical PIP: Improve the percentage of Provider Notifications for members with a SUD/MH diagnosis following or within seven days of ED visit in Fresno and Madera Counties.
- Clinical PIP: Improving Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) measure rate for their Black/African American populations.

Clinical Services & Case Management

Clinical Services & Case Management

Questions

Clinical Services & Case Management

1. How can you locate a pharmacy that works with Medi-Cal Rx when ordering prescription medication for your patient?

2. Where can you locate your New Member List in order to schedule new patients for Initial Health Appointments (IHA)?

3. How and who can refer a patient to Care Management?

4. What is Enhanced Care Management?