
# Central Valley Health Plan Provider Manual – 2025

For:

Physicians

Other Health Care Professionals

Ancillary Providers

Facilities

Central Valley Health Plan

## Contents

## Using this Guide

The Central Valley Health Plan ("CVHP") Provider Manual contains essential information on the administrative components of Central Valley Health Plan's operations including:

- Claims billing and submission, provider disputes, coordination of benefits
- Prior authorization and referral information
- Health care access and coordination

**Disclaimer**

The contents of this guide are supplemental to the *Provider Participation Agreement (PPA) and/or Ancillary Services Agreement (ASA)**. When the contents of this guide conflict with the *PPA or ASA*, the *PPA or ASA* takes precedence. Updates to the information in this guide are made through provider updates or signed letters distributed by fax, the United States Postal Service or other carrier. Provider updates and signed letters are to be considered amendments to this guide.

This guide is not intended to provide legal advice on any matter and may not be relied on as a substitute for obtaining advice from a legal professional.

**Definitions**

"**Emergency medical condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(4) "Active labor" means a labor at a time at which either of the following would occur: There is inadequate time to effect safe transfer to another hospital prior to delivery.

"**Emergency services and care**" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. It

also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts.

**"Health Plan"** means any health plan in which CVHP has a plan-to-plan agreement to enroll members.

**"In Network"** refers to providers that are considered in-network with Central Valley Health Plan's upstream health plans and is comprised of contracted Medical Groups/IPAs, hospitals, and ancillary facilities. A list of In-Network providers is available via links at www.centralvalleyhealthplan.com or by contacting the upstream health plan.

**"Out of Area"** refers to facilities that are outside of the geography established by the upstream health plan in its benefit plan. Out of Network refers to providers that are not considered in-network with Central Valley Health Plan's upstream health plans or Central Valley Health Plan within Fresno and Madera counties. Out-of-Area or Out-of-Network services are reimbursable for emergency services or scheduled, authorized services which are not available "In-Network.

**"State"** refers to the state of California.

## About Central Valley Health Plan

Central Valley Health Plan ("CVHP") is licensed by the Department of Managed Health Care ("DMHC") as a restricted Knox-Keene entity allowing Central Valley Health Plan to accept responsibility for medical costs and management of health plan enrollees. Central Valley Health Plan contracts with Unrestricted Knox-Keene health plans to create unique insurance products that are high-quality, consumer focused and price competitive.

### Central Valley Health Plan Mission

Central Valley Health Plan is committed to providing high value care to the diverse population in the Service Area. In support of this commitment, CVHP's mission is:

*"Central Valley Health Plan is a locally owned, integrated partnership of industry leading healthcare organizations delivering high value health services to the California Central Valley focusing on accessible, compassionate care through clinical collaboration with measurable results."*

### Central Valley Health Plan Online

Central Valley Health Plan, on its website **www.centralvalleyhealthplan.com**, provides a directory of its provider network through links to its contracted upstream health plan and IPAs/Medical Groups. Users can search for physicians, hospitals, and ancillary providers by specialty name, language(s) spoken, zip code, city and distance. For a printed copy of our provider directory please call 833-882-2847. Central Valley Health Plan complies with the requirements of California Health and Safety Code Section 1367.27(c)(2).

## Claims Submission - Quick Reference Guide

This section of the Provider Manual provides a quick reference guide for providers to use when submitting claims to Central Valley Health Plan. This material is also referenced later in the manual in the Claims Submission Information section.

**Checking Member Eligibility**

Providers are responsible for verifying a member's eligibility for all medical services rendered. Providers may verify member eligibility in the following ways:

- Access the member's health plan website or call the health plan contact center. See the member's health plan ID card for this information.
- Provider Portal - https://www.capcms.com/CapConnect/loginv2.aspx
- Contact Central Valley Health Plan Provider Services between 8:30-5:00pm (Pacific time) Monday through Friday at 818-461-5000. (Administered by Conifer Value-Based Care)

**Filing a Claim**

Providers are encouraged to file claims electronically whenever possible. Submitted claims should provide all required information; those claims submitted with missing data may result in a delay in processing or denial.

All Central Valley Health Plan institutional and facility claims are processed by Conifer Value-Based Care. Electronic submission is the preferred method via Change Health. Professional claims are processed by the participating Medical Groups and/or their respective vendors.

**Where to Submit a Claim?**

| | |
|---|---|
| Paper claims can be mailed to: | Central Valley Health Plan, P.O. Box 261040, Encino, CA 91426 |
| Provider Disputes/Appeals: | Central Valley Health Plan, P.O. Box 261760, Encino, CA 91426 |
| Claims Department phone number: | 818-461-5000, IVR available 24/7 |
| All other Provider inquiries: | 818-461-5000 |

## Electronic Claims Submission

| Clearinghouse Name | Phone Number | Payer ID |
|---|---|---|
| **Change Health Optum** | **866-371-9066** | **95399** |
| **Office Ally** | **866-575-4120** | **CAPMN** |

## Website Information

- Conifer Value-Based Care website - www.Coniferhealth.com
    - This portal provides access to query and view status on facility claims, eligibility status, contracted providers, and other important information. Call Provider Services at 818-461-5000 and they can assist you with access.
- Provider Portal **-** https://www.capcms.com/CapConnect/loginv2.aspx
- Portal support: Reach out to product management via email: vbc-productmanagement@coniferhealth.com

- Central Valley Health Plan website – **www.centralvalleyhealthplan.com**
    - The CVHP website provides general information about Central Valley Health Plan as well as a searchable Physician and Hospital directory. There is a "Provider" section of the website that provides additional information for Providers about Central Valley Health Plan.

## General Questions - Central Valley Health Plan Providers

- Central Valley Health Plan Provider Services: 818-461-5000

Central Valley Health Plan

# Participating Health Plans

## Role of the Health Plan with a Knox-Keene License

Under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), the California Department of Managed Health Care ("DMHC") requires licensure for any entity that assumes global financial risk for professional health services and/or hospital and other institutional health care services. Central Valley Health Plan operates under a Restricted Knox-Keene license. This type of license allows Central Valley Health Plan to assume global risk by accepting both institutional and professional risk-based capitation payments as subcontractors to unrestricted, full-service plans.

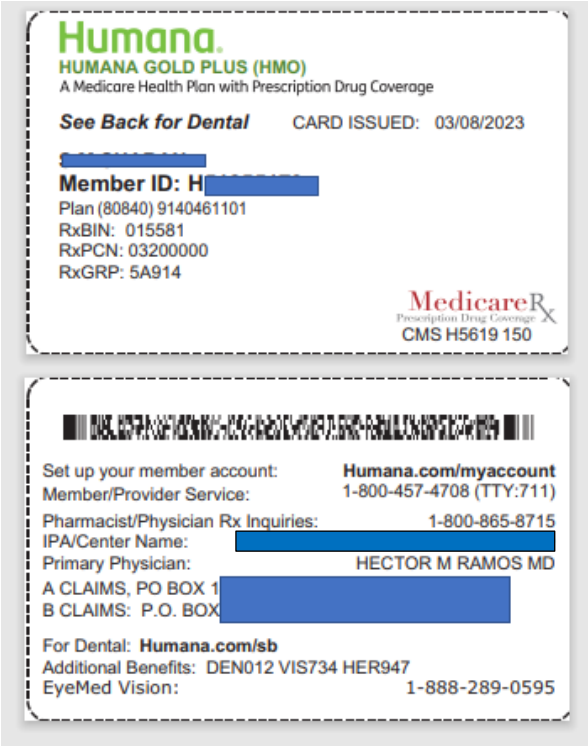
## Health Plan Identification (ID) Cards

Central Valley Health Plan members receive health plan ID cards containing information needed for providers to submit claims. Information may vary in appearance or location on the card for different payers or other unique requirements. However, all cards display the following information:

- Identification of Member's Primary Care Provider and Specialty Network (IPA)
- Member name and ID number; group number
- Health plan
- Copayment information
- Eligibility information

Instructions for health care providers: Please check the Member's health care ID card at each visit and keep a copy of both sides of the health care ID card for your records. Additionally, it is important that you verify eligibility and benefits before or at the point of service for each office visit by calling the customer service number on the member's ID card or the numbers noted above.

Below is a sample of Humana Medicare Advantage Gold Plus Healthcare Identification (ID) Card (HOLD)



## Health Plan Partners

### Humana

For calendar year 2024, CVHP is contracted with Humana for its Medicare Advantage Gold Plus members in Fresno and Madera counties.

The Plan identification numbers are:

Fresno County

- Humana Gold Plus H5619-012 (HMO)
- Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP)
- Humana Gold Plus H5619-150
- Humana Honor H5619-121
- Humana Gold Plus H5619-148

Madera County

- Humana Gold Plus H5619-012 (HMO)
- Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP)
- Humana Gold Plus H5619-150
- Humana Honor H5619-121
- Humana Gold Plus H5619-148

Contact information for Humana Member Services

- 1-800-457-4708, TTY users 711
- Humana.com

## Humana SNP/Complex Case Management and Disease Management Programs

Humana Care Management supports members in Medicare and Dual Eligible Plans via their Complex Case Management, Disease Management and Special Needs Care Management programs. CVHP and its contracted physicians refer members to these programs when a need is identified. A description of these programs and eligibility criteria are provided in the following table. To refer a member for one of these programs, contact CVHP at 833-882-2847.

Central Valley Health Plan

# Humana Care Management supports members in Medicare and Dual Eligible plans

## Humana Care Management Programs and Services

**OUR PROGRAMS**

**Humana Care Support**

*Telephonic Care Mgmt for high risk members*

*Supports NCQA accreditation*

*Transitions*
*CCM*
*HCCP*
*Gaps in care*
*SCM*

***Complex Care Mgmt Triage & Support***

**SNP**

*Telephonic Care Mgmt for members in C-SNP and D-SNP plans*

*Ensures Compliance with CMS requirements for D-SNP and C-SNP plans*

**IL MMP**

*Telephonic Care Mgmt for Medicare / Medicaid mbrs in Illinois*

*Ensures Compliance with CMS and state requirements*

**OTHER SERVICES**

- BH Consult
- Life Assistance Line
- Findhelp

# Multiple Program Components of Humana Care Support for MA & Group Members

**HUMANA CARE SUPPORT**

| | Complex Care | Triage & Support | Other Services |
|---|---|---|---|
| **DESCRIPTION** | Proactive Care Mgmt. for **highest risk members** (3-5 mos.)<br><br>Includes work required for **NCQA** accreditation<br><br>Multi-disciplinary care team approach | Serves members needing episodic support (<1 mo.)<br><br>Primarily **post-discharge** and **inbound referrals**<br><br>Multi-disciplinary care team approach | Work required for **other run-the-business** activity (e.g., inbound behavioral health support, inbound provider Care Concierge line) |
| **ELIGIBILITY** | High risk predictive model score<br><br>Chronic Care Management (CCM) **(NCQA)** qualified | Readmission predictive model score<br><br>Referrals from providers | Inbound lines and other CM support functions |

*Teams include nurses, behavioral health clinicians, social workers, pharmacists, pharmacy technicians, and care management support specialists.*

*What makes*
**HUMANA CARE SUPPORT**
*different?*

**IMPROVED INTEGRATION**
*Improved member data integration and tech-enabled collaboration among care team members & pharmacy*

**ENHANCED ANALYTICS**
*Eligibility based on machine learning and advanced analytics predictive models*

**NEW TECHNOLOGY PLATFORM**
*More agile, providing singular, comprehensive view of the member*

## Participating Physicians

Central Valley Health Plan contracts with the following IPAs:

- Central Valley Medical Providers
- Santé Physicians IPA Medical Corp

Each of the above IPAs are professional provider networks contracted with Central Valley Health Plan. Members have access to the entire cadre of physicians in the IPA network they have selected as their specialty network upon enrollment. Members may see specialists outside of their IPA if the specialty service is not available within the network and the service is preauthorized.

An IPA is an Independent Physicians Association with a dedicated team of primary care physicians and specialists focused on quality healthcare from Allergy to Urology and Pediatrics to Geriatrics. Each IPA brings the benefits of coordinated healthcare to thousands of patients throughout Fresno and Madera Counties serving a diversity of cultures, socioeconomic groups, and ages.

Policies and procedures related to quality and utilization management, professional billing and claims, and clinical health services are available at Central Valley Health Plan's participating Medical Groups' and IPAs' websites and directly through customer service at the respective provider groups.

IPA Contact information:

| IPA | Customer Service Telephone | Website |
|---|---|---|
| Central Valley Medical Providers | MedPOINT Management (866)423-0060 | https://cvmedpro.com |
| Santé Physicians IPA Medical Corp | (559) 228-5400 (800) 652-2900 | https://www.santehealth.net |

Central Valley Health Plan Provider Relations Contact:

Janine Stephenson-Barnes

Phone number: 559-450-5278

Email address: janine.stephenson-barnes@samc.com

## Selection and Role of the Primary Care Physician

All Central Valley Health Plan members are required to select a primary care physician (PCP) and a participating Medical Group/IPA at the time of enrollment. For children, a pediatrician or family medicine physician may be designated as the primary care physician. For women, an obstetrician/gynecologist ("OB/GYN") may serve as the designated primary care physician if the OB/GYN agrees to serve in that capacity. Additionally, seniors may designate a gerontologist and those with an AIDS/HIV diagnosis may designate an AIDS/HIV specialist as their primary care physician, if that physician agrees to serve in that capacity. If a member does not choose a PCP, the Central Valley Health Plan participating health plan will assign a PCP for the member and their dependents. To change the designated primary care physician, members are required to contact their health plan.

Members are required to visit their primary care physician for non-urgent or non-emergency care. Primary care physicians may request that a member be reassigned to a different primary care physician if there is concern that the member's home or work address is not close enough to the PCP's location to allow reasonable access to care. The State of California mandates that a member's PCP be within 10-15 miles or 30-minutes' drive time of a member's home.

The PCP is responsible for providing and coordinating medical care for their patients, including referrals to specialists, hospitals and other healthcare providers anywhere in the Central Valley Health Plan Network.

## Specialty Care

Central Valley Health Plan provides access to the following physician specialists:

Allergy and Immunology
Anesthesiology
Bariatric surgery
Breast Center
Cardiology
Cardiothoracic Surgery
Chiropractic Colorectal Surgery
Critical Care Medicine
Dermatology
Ear, Nose and Throat
Endocrinology
Gastroenterology
General Surgery
Genetics
Gynecologic Oncology
Hand Surgery
Hematology/Oncology
HIV/AIDS Specialist
Hyperbaric oxygen
Infectious Disease
Nephrology
Neurology
Neurosurgery
Nuclear Medicine
Obstetrics/Gynecology
Occupational Therapy
Ophthalmology
Optometry
Oral & Maxillofacial Surgery
Orthopedic Surgery
Orthotics/Prosthetics
Otolaryngology
Pain Management
Palliative Care
Perinatology
Physical Medicine (PMR)
Physical Therapy
Plastic surgery
Podiatry
Psychiatry
Psychology
Pulmonary Disease
Radiation Oncology
Radiology
Reproductive Endocrinology and Fertility
Rheumatology
Thoracic Surgery
Urology
Vascular Surgery
Wound Care

Central Valley Health Plan PCPs refer members for specialty services when clinically appropriate, choosing any participating Central Valley Health Plan specialist within the members' selected IPA. Such referrals are entered in each Medical Group/IPA's authorization system via their provider portal:

| IPA | Provider Portal |
|---|---|
| Central Valley Medical Providers | https://portal.medpointmanagement.com/sign-in |
| Santé Physicians | https://Quickcap.santehealth.net<br>www.santephysicians.com |

Referrals for some specialty care require prior authorization. Additional details regarding the Central Valley Health Plan Referral Policy are covered in the next section.

## Central Valley Health Plan Referral Policy

Referral to a specialist is coordinated by the member's primary care physician. When clinically appropriate, the requesting physician initiates a written or electronic referral that is entered in the member's Medical Group/IPA authorization system. Approved authorizations prompt standard notification to both the member and the "referred to" specialist and include details of the referral such as the number of visits, services approved and the time referral expires, typically 60-days.

## Behavioral Health Access, Triage and Referral

Access to behavioral health services is coordinated through the member's primary care physician. Authorization for behavioral services is dependent on a member's health plan benefits, however, Central Valley Health Plan does not require prior authorization for the provision of emergency services and care to a patient with a psychiatric emergency.

### Central Valley Health Plan Hospitals and Contact Information

**St. Agnes Medical Center**
1303 E Herndon Ave, Fresno, CA 93720
(559) 450-3000

Appointments: www.samc.com

Online care: www.saintagnescare.com

## Inpatient Services

Central Valley Health Plan members requiring non-emergent/non-urgent inpatient services may obtain these services at any In-Network Central Valley Health Plan hospital where their Central Valley Health Plan attending physician is credentialed and has hospital privileges. St. Agnes Medical Center is the preferred provider for Central Valley Health Plan, although Medicare Advantage members may choose a hospital that is In-Network and contracted with their upstream health plan.

Prior authorization is required for non-emergent/non-urgent admissions to acute or post-acute health care facilities. This process is discussed in more detail in the Utilization Management section of this manual. Care management and discharge planning is a collaborative process between the inpatient facility and the member's Medical Group/IPA.

If a Central Valley Health Plan member is being considered for admission to an Out-of-Network facility, that member may be considered for repatriation to a Central Valley Health Plan facility. Such a transfer may take place only when these circumstances apply:

- The member has been medically stabilized;
- The transferring and receiving health care providers determine that no material clinical deterioration of the member is likely to occur during or upon transfer;
- The transferring and receiving health care providers believe that further inpatient health care treatment is medically necessary; and
- The member cannot safely be discharged home.

If a Central Valley Health Plan member cannot obtain non-emergent/non-urgent medically necessary inpatient services at an In-Network facility, the member's physician may refer the member to an Out-of-Network facility. Prior authorization and medical review are required for non-emergent/non-urgent inpatient services at Out-of-Network facilities.

## Emergency Services

"Emergency Services" means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize emergency medical conditions.

All Emergency Services are covered without prior authorization and do not require medical record review. These requests cannot be denied for failure to obtain a prior approval when approval would be impossible, e.g., the member is unconscious and in need of immediate care, or where a prior approval process could reasonably be expected to result in any of the following: 1) placing the member's health in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part at the time medical treatment is required.

Per California 28 CCR 1300.71.4 (b) and (d):

The following rules set forth emergency medical condition and post stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until a member can be discharged or transferred. These rules do not apply to a specialized health care service plan contract that does not provide for medically necessary health care services following stabilization of an emergency condition.

In the case when a member is stabilized but the health care provider believes that the member requires additional medically necessary health care services and may not be discharged safely, the following applies:

(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one hour of the request.

(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one hour of the request, the necessary post stabilization medical care shall be deemed authorized. Central Valley Health Plan shall have the authority to deny payment for delivering new or continued medically necessary care after the patient has been stabilized only if the health care service plan notifies the treating provider before delivering new or continued care. In that case, the Plan is not obligated to pay for the continued care starting from the time it notified the treating provider about denial of authorization but allowing for time needed to discharge or transfer the member to an authorized facility for ongoing care. The denial of authorization may not have an adverse impact on the efficacy of care or on the member's medical condition.

Central Valley Health Plan shall pay for all medically necessary health care services provided to a member that are necessary to maintain the member's stabilized condition until the member is discharged or transferred to another facility for care. All requests for authorizations of medically necessary health care services after stabilization and all responses to such authorization requests will be fully documented in the Utilization Management tracking system of the member's Health Plan. Treating physicians will document provision of all medically necessary health care services in their usual medical record.

When Central Valley Health Plan's IPA Utilization Management departments denies requests for authorization of post stabilization medical care at outside facilities and they elect to transfer a member to another health care provider, the following applies:

- When a health care service plan informs the treating provider of the plan's decision to transfer the member to another health care provider;
- The plan shall effectuate the transfer of the member as soon as possible;
- Central Valley Health Plan pays for all medically necessary health care services provided to a member to maintain the member's stabilized condition up to the time that CVHP effectuates the member's transfer.

A physician or other appropriate practitioner reviews presenting symptoms and discharge diagnoses for emergency services. The Medical Group/IPAs may not restrict emergency medical conditions based on lists of diagnoses or symptoms. Behavioral health care practitioners are available to review psychiatric emergency conditions.

Out-of-Network providers are paid for the treatment of the emergency medical condition, including medical necessary services rendered to a member, until the member's condition has stabilized sufficiently to permit discharge or referral and transfer to a contracted facility.

Ambulance services are covered when the member reasonably believed the condition was an emergency.

## Ancillary Providers and Services

Central Valley Health Plan has listed below preferred providers for ancillary services. These providers are recommended by CVHP to its members for their quality of care, customer service and accessibility. Medicare Advantage members may choose any ancillary facility that is In-Network and contracted with their upstream health plan. These facilities are available on the member's upstream contracted health plan's website and are inclusive of CVHP preferred providers.

A physician referral is required for ancillary services, however, depending on the service it may not require prior authorization. Members should refer to their benefit plan descriptions, their upstream health plan's website or by calling their health plan benefit provider. In general, the following services typically do not require prior authorization.

- Urgent care centers
- Routine laboratory tests
- Diagnostic imaging: plain x-rays and non-contrast ultrasound
- Preventive services

**Central Valley Health Plan Preferred Ancillary Providers**

**Durable Medical Equipment**

180 Medical, Inc.
1283 Linda Vista
San Marcos, CA 92078
888-718-0633

California Home Medical
7946 N. Maple, Suite 111
Fresno, CA 93720
559-298-2022

Gordian Medical, Inc. dba AMT (DME and wound care)
17595 Cartwright Road
Irvine, CA 92614
800-232-9266

Goodnight Medical/Respicare (Home O2, CPAP, Nebulizers, DME)
5470 W. Spruce Avenue, Suite 104

Fresno, CA 93722
559-432-4455

Rest Easy Medical (HomeO2 and CPAP BiPAP Respiratory Services)
7065 N. Chestnut Avenue, #106
Fresno, CA 93720
559-325-7500

SuperCare Health (DME Respiratory, enterals, high flow oxygen)
8345 Firestone Blvd., Suite 210
Downey, CA 90241
888-260-2550 X5791

**Skilled Nursing Facilities**

Fresno Valley SNF LLC (Orchard Post-Acute)
4840 E Tulare Ave
Fresno, CA 93727
559-251-7161

Horizon Health and Subacute, LLC
3034 E. Herndon Avenue
Fresno, CA 93720
559-321-0883

Majestic Mountain Care Center/Oakhurst Skilled Care LLC
40131 Highway 49
Oakhurst, CA 93644
559-683-2244

Sunbridge Care Enterprises West LLC - Kingsburg Center
1101 Stroud Avenue
Kingsburg, CA 93631
559-897-5841

Willow Creek
650 W. Alluvial
Clovis, CA 93611
559-323-6200

**Orthotics and Prosthetics**

Hanger Prosthetics & Orthotics
1247 E. Alluvial Ave, Suite 103
Fresno, CA 93720
559-431-7045

Hanger Prosthetics & Orthotics
3520 E. Shields Ave., Suite 102
Fresno, CA 93726
559-221-1933

**Facility and Home Infusion**

Integrated Care Systems (HOME)
7140 W. Pershing Court
Visalia, CA 93291
559-734-2896

**Sleep Studies (Diagnostic)**

Renaissance Sleep Center
7065 N. Chestnut Avenue, #105
Fresno, CA 93720
559-322-6900

**Home Health and Hospice**

Saint Agnes Home Health and Hospice
6729 N Willow Ave # 103
Fresno, CA 93710
559-450-5112

**Diagnostic Radiology**

Saint Agnes Imaging and Breast Center (X-ray, Ultrasound, CT/MRI, Mammography)
1510 E Herndon Avenue
Fresno, CA 93720
559-450-6742

**Outpatient Infusion**

Saint Agnes Medical Center
1303 E. Herndon Ave.
Fresno, CA 93720
559-450-3000

**Ambulatory Surgery Center**

Saint Agnes Medical Center
1303 E. Herndon Ave.
Fresno, CA 93720
559-450-3000

**Clinical Laboratory**

Saint Agnes Medical Center Laboratory
1303 E. Herndon Avenue
Fresno, CA 93720
559-450-3000

**Urgent Care**

Saint Agnes Medical Foundation
4770 W. Herndon Avenue Suite 111
Fresno, CA 93722
559--450-2273

Saint Agnes Medical Foundation
1245 E. Herndon Avenue
Fresno, CA 93720
559-450-2273

Saint Agnes Medical Foundation
2497 Herndon Avenue
Fresno, CA 93720
559-450-8886

## Provider Directory and Online Access

The Central Valley Health Plan Provider Directory ("Directory") includes providers currently contracted with Central Valley Health Plan. This Directory is available to Central Valley Health Plan members, health care providers and the public without any restrictions or limitations through the member services department of CVHP's contracted upstream health plans. All Central Valley Health Plan enrollees receive full and equal access to covered services, regardless of disability, as required by the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973. Member questions and concerns should be directed to the member's primary care physician or by calling Humana, CVHP's upstream health plan, at 1-800-457-4708 TTY users 711.

### Online Provider Directory

The Directory is available online at centralvalleyhealthplan.com, with links to member upstream contracted health plans and to Central Valley Health Plan contracted physicians. Medicare Advantage members should check their contracted health plan website for a comprehensive directory of In-Network facilities. Members can search the Directory by provider name, specialty, service type or zip code.

### Printed Provider Directory

The printed version of the Central Valley Health Plan Provider Directory contains the same information available through the online Directory. To request a printed copy of this directory, members and providers may call Humana at 1-800-457-4708 TTY users 711 or by sending a written request to: Central Valley Health Plan, 1111 E Spruce Ave, Fresno, CA 93720.

### Provider Directory Updating

Central Valley Health Plan, through its upstream contracted health plan meets or exceeds DMHC requirements for updating, maintaining, and ensuring accuracy of the provider profiles in its Directory. Updates to the Directory occur weekly in the online version of the Directory and quarterly in the printed version.

Central Valley Health Plan's contracted Medical Group/IPAs are required to provide weekly Directory updates. Contracted providers must notify Central Valley Health Plan and its contracted upstream health

plan within five (5) business days of status change, such as if they start or stop accepting new patients. The weekly update of the Directory includes notification if there is a change in any of the following:

- Demographic information including name, address, phone number, email address
- If the provider is accepting new patients
- Any change of participation in a health plan or product
- Hospital affiliation
- Group practice membership
- Specialty certification or license status
- If the provider becomes inactive or retires
- Any other information with a material effect on the content or accuracy of the Directory

The weekly update also includes information received during investigations prompted by a member's or provider's report of an inaccuracy in the Directory. Weekly updates also delete providers from the Directory if they are no longer contracted with the plan, no longer seeing patients, have retired from clinical practice, or experienced other changes impacting their ability to serve as a contracted provider.

**Reports of Inaccuracy and Plan Investigation**

Central Valley Health Plan, through its contracted upstream health plans, provides a clearly identifiable and user-friendly means for providers and members to report inaccuracies in the Directory. In addition to an annual review process, each of CVHP's contracted upstream health plans has a process to allow both members and healthcare providers to notify the health plan about potential inaccuracies in the Directory. All reported inaccuracies are investigated promptly, and changes or corrections are updated weekly online and quarterly in the printed directory. Providers are contacted within five (5) days of a reported inaccuracy. Corrections required will be completed within thirty (30) days of being reported. Required changes to the Directory are entered during the next weekly update. CVHP's contracted upstream health plan documents receipt of the reported inaccuracy, investigative process and outcome of all investigations. Members who find an inaccuracy in the Directory have three options to report the potential error to Central Valley Health Plan:

1. By completing an online form at Humana.com
2. By calling Humana at 1-800-457-4708 TTY users 711.
3. By sending a written request to: Central Valley Health Plan, 1111 E Spruce Ave, Fresno, CA 93720.

Members who complete the online form receive an immediate acknowledgement that their report has been received. If the member reports that a physician is no longer accepting new patients, the Humana Member Services Representative and Central Valley Health Plan staff help the member to find a new physician. All reports are tracked, monitored and reported monthly to the Quality Management Committee

Providers who wish to report an inaccuracy or to make a change to their existing profile in the Directory may do so by:

1. By completing an online form at Humana.com
2. Calling the Central Valley Health Plan Provider Service Center at 818-461-5000.
3. Mailing a report to the Central Valley Health Plan at 1111 E Spruce Ave, Fresno, CA 93720.

Providers who complete the online form receive an immediate acknowledgement that their report has been received. Provider submitted updates will be made during the next regular weekly update of the Directory.

**Provider Verification**

An annual audit will be conducted of all contracted providers, requesting them to review their current profile in the Central Valley Health Plan Provider Directory and submit any corrections or changes. All Central Valley Health Plan providers are notified in advance of the audit. Providers are given their current Directory profile, including the networks and plan products they participate in, whether they are accepting new patients or not, their hospital and group affiliations, specialty and board certification, and demographic information. Providers are asked to confirm their posted information's accuracy and submit any corrections or changes to their Directory listing. Providers must submit a completed response to CVHP's contracted upstream health plan within 30 business days of receiving their Directory information. The upstream plan may then take an additional 15 business days to verify the provider's information. The process and outcomes of attempts to verify providers' Directory entries is documented. If the upstream

plan is unable to verify the provider's information, the provider is notified that she or he will be removed from the Directory unless response is received within 10 days of the request.

Semi-annual audits are conducted of ancillary providers contracted directly with Central Valley Health Plan.

**Provider Obligations and Plan Oversight**

If a Central Valley Health Plan member contacts a provider seeking to become a new patient and that provider is not accepting new patients, the provider will direct the member to their upstream contracted health plan. Any provider not accepting new patients will contact their IPA/Medical Group, which then notifies the upstream plan and CVHP. Central Valley Health Plan, through its contracted upstream health plan, ensures Directory errors are investigated and corrected as required. This investigation is tracked from receipt of the information regarding the inaccuracy to the final outcomes.

In all provider agreements, Central Valley Health Plan includes a stipulation that if a contracted provider is no longer accepting new patients, or if the provider was previously not accepting new patients, but is currently accepting new patients, the provider is mandated contractually to notify Central Valley Health Plan within five (5) business days and its contracted upstream health plan.

# Claims Submission Information

## Filing a Claim

Providers are encouraged to file claims electronically whenever possible. Submitted claims should provide all required information; those submitted with missing data may result in a delay in processing or denial.

All Central Valley Health Plan institutional, facility and ancillary claims are processed by Conifer Value Based Care. Professional claims are processed by the participating Medical Groups and/or their respective vendors.

For institutional providers, Conifer provides a portal for providers to query and view status on facility claims, eligibility status, contracted providers, and other important information. To access the portal, go online to https://www.capcms.com/CapConnect/login.aspx, scroll to the bottom and on the right-hand side select Cap Connect.

## Electronic Claims Submission

Central Valley Health Plan, through Conifer Value Based Care, its Managed Service Organization ("MSO"), contracts with Change Healthcare for submission of electronic claims. The benefits of electronic claim submission include:

- reduction or elimination of costs associated with printing and mailing paper claims
- improvement of data integrity using clearinghouse edits
- faster receipt of claims by Central Valley Health Plan, resulting in reduced processing time and quicker payment
- confirmation of receipt of claims by the clearinghouse
- availability of reports when electronic claims are rejected
- the ability to track electronic claims, resulting in greater accountability

| Clearinghouse Name | Phone Number | Payer ID |
|---|---|---|
| Change Health Optum | 866-371-9066 | 95399 |
| Office Ally | 866-575-4120 | CAPMN |

## Electronic Data Interchange (EDI) questions

For questions regarding electronic claim submission, please call Conifer Provider Services at 818-461-5000 or Change Healthcare at the number listed above. Conifer Customer Service Department is open Monday – Friday 8:30-5:00 pm PST.

## Paper Claims Submission and Conifer Contact Information

| | |
|---|---|
| Paper claims can be mailed to: | Central Valley Health Plan, C/O Conifer Value Based Care P.O. Box 261040, Encino, CA 91426 |
| Provider Disputes/Appeals: | Central Valley Health Plan, C/O Conifer Value Based Care P.O. Box 261760, Encino, CA 91426 |
| Claims Department phone number: | 818-461-5000, IVR available 24/7 |
| All other Provider inquiries: | 818-461-5000 |

## Website Information

- Conifer Value-Based Care website - www.Coniferhealth.com
- Provider Portal - https://www.capcms.com/CapConnect/loginv2.aspx
- Portal support: Reach out to product management via email: vbc-productmanagement@coniferhealth.com.

## Electronic Funds Transfer (EFT)

Central Valley Health Plan provides EFT for its providers for facility claims. Providers may contact Conifer Customer Service Department at 818-461-5000 for more information.

## Clean Claim Guidelines

A “clean claim” is a claim that can be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

A claim is considered “clean” when the following conditions are met:

- all required information has been received by Central Valley Health Plan
- the claim meets all DMHC submission requirements
- the claim is legible enough to permit electronic image scanning
- any errors in the data provided have been corrected
- all medical documentation required for medical review has been provided

Reasons for claim denial include, but are not limited to, the following:

- duplicate submission
- member is not eligible for date(s) of service(s) (“DOS”)
- incomplete data
- non-covered services

## Timely Filing Guidelines

California Code of Regulations Title 28 Rule 1300.71 provides claims submission timelines for Commercial claims as follows:

- **Contracted Providers**: Billing Limitation – within 90 calendar days (3 months) from the Date of Service (DOS). Refer to each provider’s contract for variations in the claims filing limit.
- **Non-Contracted Providers**: Billing Limitation – within 180 calendar days (6 months) from the Date of Service (DOS).

## Corrected Claims

Providers must correct and resubmit claims to Central Valley Health Plan within the 12-month clean claim time frame. When resubmitting a denied claim, the provider must submit a new claim containing all previously submitted lines. The original claim reference number from the remittance advice (“RA”) must be included on the claim so that Central Valley Health Plan can identify the resubmitted claim. If the claim reference number is missing, the claim may be entered as a new claim and denied for being submitted

beyond the initial submission time frame. Corrected claims must be appropriately marked as such and submitted to the appropriate claims electronic processor or mailing address.

## Balance Billing

Balance billing is the practice of a participating provider billing a member for the difference between the contracted amount and billed charges for covered services. When participating providers contract with Central Valley Health Plan or its upstream health plan partners, they agree to accept Central Valley Health Plan's contracted rate as payment in full. Billing members for any covered services above and beyond the contracted rate is a breach of contract. Participating providers may only seek reimbursement from Central Valley Health Plan members for appropriate cost-share amounts, including copayments, coinsurance, and/or deductibles.

AB72 is the "surprise billing" legislation that establishes a payment rate, which is the greater of the average of a Health Plan's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services; and an independent dispute resolution process (IDRP) for claims and claim disputes related to covered services provided at a contracted health facility by a non-contracting individual health care professional for health plan contracts and health policies issued, amended, or renewed on or after July 1, 2017. This legislation limits member and insured cost sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional.

Guidelines for billing Central Valley Health Plan members are listed as follows:

- Providers may bill a Central Valley Health Plan member when the member knowingly receives non-covered services. The provider must notify the member in advance of the charges and have the member sign a statement agreeing to pay for the services. This signed document should be entered into the member's medical record.
- Central Valley Health Plan members must not be balance billed or reported to a collection agency for any covered service that has been provided.
- Providers may not charge members for services that are denied or reduced due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization or lack of clean claim status.

- Providers must not collect copayments, coinsurance or deductibles from members with other insurance such as Medicare or another commercial carrier.

## Coordination of Benefits

Coordination of benefits ("COB") is required before submitting claims for members who are covered by one or more health insurers other than their primary health plan. Central Valley Health Plan follows the applicable regulations regarding coordination of benefits between both commercial and government insurance products.

Participating providers are required to administer COB according to the applicable regulations. The participating provider should ask the member about coverage through another health plan and enter that other health insurance information on the claim.

## Providing COB information

For Central Valley Health Plan to document member records and process claims appropriately, include the following information on all COB claims:

- name of the other carrier
- subscriber ID number with the other carrier including contact information, primary subscriber, or preferable a COB form from the provider.

If a Central Valley Health Plan member has other group health insurance coverage, follow these steps:

- File the claim with the primary carrier, as determined by the applicable regulations.
- After the primary carrier has paid, attach a copy of the *Explanation of Payment (EOP)* or Explanation of Benefits (*EOB)* to a copy of the claim and submit both to Central Valley Health Plan within six months from the date of service. COB claims can also be submitted electronically with the details from the other payer ERA appropriately submitted in the 837 transaction COB loops.
- If the primary carrier has not made payment or issued a denial, submit the claim to Central Valley Health Plan prior to the timely filing limit of six months from the date of service. If denied based on timeliness, the claims are treated as non-reimbursable, and the member cannot be billed.

## COB payment calculations

Central Valley Health Plan coordinates benefits and pays balances, up to the member's liability, for covered services. However, in cases where Central Valley Health Plan is not the primary payer, the dollar value of the balance payment cannot exceed the dollar value of the amount that would have been paid had Central Valley Health Plan been the primary payer.

In some cases, members who have coverage through two carriers are not responsible for cost-shares or copayments. Therefore, it is advisable to wait until payment is received from both carriers before collecting from the member.

## Overpayments

Central Valley Health Plan makes every attempt to identify a claim overpayment and indicate the correct processing of the claim on the provider's Remittance Advice (RA). An automatic system offset, where applicable, might occur in accordance with the reprocessing of the claim for the overpayment, or on immediate subsequent check runs.

- If a provider independently identifies an overpayment from Central Valley Health Plan (such as a credit balance), the following steps are required to be taken by the provider:
- Send the overpayment refund and applicable details to:
    - Central Valley Health Plan c/o Conifer Value Based Care, P.O. Box 261060, Encino, CA 91426
- Include a copy of the RA that accompanied the overpayment to expedite Central Valley Health Plan's adjustment of the provider's account. It takes longer for Central Valley Health Plan to process the overpayment refund without the RA. If the RA is not available, the following information must be provided:
    - member name and Central Valley Health Plan member ID number
    - date of service
    - payment amount
    - vendor name and number
    - provider tax ID number
    - reason for the overpayment refund

If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Central Valley Health Plan, the provider should follow the overpayment refund instructions provided by the vendor.

If a provider believes he or she has received a Central Valley Health Plan check in error and has not cashed the check, he or she should return the check to the address above with the applicable RA and a cover letter indicating why the check is being returned.

**Additional information**

Contact the Conifer Customer Service Department at 818-461-5000, Monday – Friday 8:30 a.m. – 5:00 p.m. Pacific Time with questions regarding third-party recovery, coordination of benefits or overpayments.

## Provider Disputes

A provider dispute is a written notice from the provider to Central Valley Health Plan that:

- challenges, appeals or requests reconsideration of a claim (including a bundled group of similar claims) that has been denied, adjusted or contested;
- challenges a request for reimbursement for an overpayment of a claim; and/or seeks resolution of billing or other contractual disputes;
- Providers should exhaust all authorized processing procedures and follow the guidelines below before filing a claim dispute with Central Valley Health Plan:
    - If the provider has not received a RA identifying the status of the claim, he or she should call the CVHP Provider Services Center to inquire whether the claim has been received, processed and is the status.
    - Providers should allow ample time following claim submission before inquiring about a claim. However, providers should inquire well before six months from the date of service because of the time frame for initial claim submission and for filing a claim dispute.
    - If a claim is pending in the Central Valley Health Plan claim system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim may be cause for a claim dispute on a pended claim provided all claim dispute deadlines are met.

If the provider has exhausted all authorized processing procedures, the provider has a right to request a provider fair hearing through the DMHC.

- Providers who are contracted with Central Valley Health Plan should submit their disputes to DMHC via their process detailed here: http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx
- Providers not contracted with Central Valley Health Plan should use the "Non-Emergency Services Independent Dispute Resolution Process (AB 72 IDRP) through DMHC, detailed here: http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/NonEmergencyServicesIndependentDisputeResolutionProcess.aspx

Providers can send provider disputes to: Central Valley Health Plan c/o Conifer Value Based Care, P.O. Box 261760, Encino, CA 91426

**Provider Dispute Time Frame**

Disputes are accepted if they are submitted no later than 12 months from the date of payment. If the provider's contractual agreement provides for a dispute-filing deadline that is greater or less than 365 calendar days, the contract timing applies unless, and until, the contract is amended.

**Submitting Provider Disputes**

Providers should submit provider disputes on a Provider Dispute Resolution Request form. If the dispute is for multiple and substantially similar claims, a Provider Dispute Resolution Request spreadsheet should be submitted along with the form. Providers may download an electronic copy of the Provider Dispute Resolution Request form through the Cap Connect portal at www.coniferhealth.com. The provider dispute form must include the provider's name, NPI ID number, contact information including telephone number, and the number assigned to the original claim. Additional information required includes:

- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include a clear identification of the disputed item, the date of service, and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.

- If the dispute is not about a claim, a clear explanation of the issue and the basis of the provider's position.

If the provider dispute does not include the required submission elements as outlined above, the dispute is returned to the provider along with a written statement requesting the missing information necessary to resolve the dispute. The provider must resubmit an amended dispute along with the required missing information.

Central Valley Health Plan does not discriminate or retaliate against a provider due to a provider's use of the provider dispute process.

**Past Due Payments**

If the provider dispute involves a claim and it is determined to be in favor of the provider, Central Valley Health Plan pays any outstanding money due, including any required interest or penalties, within 15 business days of the date of the decision. When applicable, accrual of the interest commences on the day following the date by which the claim should have been processed.

**Provider Disputes for Authorization Denials (Health Plan Appeals Process)**

A provider dispute that is submitted on behalf of a member for denial of authorization for services that have not yet been rendered or billed should be submitted via the member appeals process through the member's upstream contracted benefit plan.

**Resolution Time Frame**

Provider Disputes (Member Appeals) for authorization denials are handled by each upstream contracted benefit plan's grievance and appeals department within DMHC regulated timeframes following receipt of the dispute (grievance/appeal) and a written determination will be provided.

**Dispute Resolution Costs**

A provider dispute is processed without charge to the provider; however, Central Valley Health Plan has no obligation to reimburse any costs that the provider has incurred during the dispute process.

## Utilization Management

### Prior Authorization

Where utilization management is delegated to Central Valley Health Plan, this function is conducted by the Utilization Management department of each of Central Valley Health Plan's contracted Medical Group/IPA or by a Central Valley Health Plan's delegated vendor, depending on the requested service. Where authorization decisions are not delegated to Central Valley Health Plan, the upstream contracted health plan receives and processes these requests and communicates its authorization decisions.

Participating Central Valley Health Plan Medical Groups/IPAs process requests for services requiring authorization for members submitted by their primary care and specialty physicians in accordance with NCQA standards. Central Valley Health Plan's participating Medical Groups/IPAs enact prior authorization policy and procedures as required by the member's upstream contracted health benefit plan, and/or federal and state regulations.

Certain benefited services may be provided by a participating Central Valley Health Plan Medical Groups/IPAs to a member without requiring prior authorization. These are specified and uniform across Central Valley Health Plan's delegated Medical Group's and IPAs. The list of such services that should be auto adjudicated include the following, per DMHC and other regulations:

- Emergency services
- Basic prenatal care
- Family planning services
- Sexually transmitted disease services
- Preventive services
- HIV testing
- Involuntary psychiatric inpatient admission
- Self-referral for behavioral health
- Services provided by the PCP (except procedures requiring prior authorization as listed below).

Referrals for the following services require prior authorization by a participating Central Valley Health Plan physician through its Medical Groups/IPAs Utilization Management Departments or its participating health plans. The list below is not all inclusive and may vary depending on individual member's benefit plans.

- Out of network referrals
- Bariatric-related services
- Durable medical equipment, including prosthetics
- Home health and infusion services
- Elective interventional cardiology procedures, including cardiac catheterization and procedures requiring contrast
- Non-emergent inpatient medical admissions
- Rehabilitation therapies such as physical, occupational, and speech therapy
- Pain management procedures
- Elective interventional radiology procedures requiring contrast administration
- Transplant-related services
- Clinical trials
- Experimental/investigational services and new technologies
- Gender reassignment surgery
- Some level III prescription drugs

**Denial Notification**

Participating Central Valley Health Plan Medical Groups/IPAs shall notify the "referred to" and referring providers and members about authorized services. Providers receive electronic notification through auto fax and through the Conifer Value Based Care Cap Connect portal. Members receive letters through U.S. mail.

If additional data is required prior to authorization of a request for service, the Medical Group/IPA shall send notice to the requesting provider describing specific information required for approval.

Participating Medical Groups/IPAs shall send a notice of denial and notify providers and members about denied authorization requests per the applicable State law. Verbal and written notice of denials and communications must meet upstream contracted health plan requirements.

## Emergencies

Central Valley Health Plan provides coverage for emergency services to all members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity, such that the member could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services to stabilize an emergency medical condition in inpatient and outpatient settings are covered when furnished by a qualified provider.

Emergency services are covered both In-Network and Out-of-Network and do not require prior authorization. Emergency room screening and stabilization services do not require prior approval to be covered by Central Valley Health Plan and its upstream contracted health plans.

## Notification of Admission

All elective acute care hospital and skilled nursing facility ("SNF") admissions require authorization. Timeframes for notification are determined by the policies and procedures of each participating Medical Group/IPA. Emergency admissions do not require prior authorization; however, notification should be made to the patient's Medical Groups/IPAs within 24 hours or the next business day of presentation.

## Utilization Review

Central Valley Health Plan Medical Groups/IPAs conduct the following types of review per their respective policies and procedures, and in coordination with the member's health benefit plan, including but not limited to:

- Prospective Hospital Review
- Concurrent Review of patients admitted to acute care hospitals, rehab facilities and skilled nursing facilities
- Discharge Planning
- Ancillary Services Management
- Medication Reconciliation

Additionally, inpatient admissions may be subject to a pre-payment review.

## Quality and Case Management

Central Valley Health Plan collaborates with its contracted physicians, facilities and health plans to ensure adherence to quality standards established by federal, state and local agencies and accreditation entities. Central Valley Health Plan establishes annual goals to optimize patient care and appropriateness of care for its members. Quality management and case management are discussed in the following sections.

### Quality Management Program

The Quality Management ("QM") Program for Central Valley Health Plan is designed to review and improve the quality of health care provided to Central Valley Health Plan assigned Health Plan members. All contracted entities, including Medical Group/IPAs, hospitals and other health care facilities, are contractually obligated to comply with Central Valley Health Plan's quality management policies and procedures. To the extent applicable, the QM Program also monitors and ensures that members receive behavioral health services from their contracted health plan, based on established behavioral health parity regulations and clinical practice guidelines.

The QM Program monitors quality of care, access, continuity and, through its oversight of the Central Valley Health Plan Utilization Management Committee, utilization of services offered to Central Valley Health Plan members through its network of providers. The QM program conducts structured, comprehensive review of the quality, safety and appropriateness of care delivered by the entire network of clinical services. When necessary, corrective action plans are developed and tracked.

Central Valley Health Plan assures that no economic pressure is exerted to cause institutions to grant privileges to health care providers that would not otherwise be granted or to pressure health care providers or institutions to render care beyond the scope of their training or experience.
The QM Program ensures that all treatment decisions rendered by appropriate clinical staff are void of any influence or oversight by the finance departments of Central Valley Health Plan providers or by the Central Valley Health Plan finance department.

This QM Program document contains the QM standards, policies and procedures, and monitoring activities, and is available to all health care practitioners and alliance participants upon request. Any changes are communicated to providers in writing in a timely manner as required by law or accreditation standard.

The goals of the Central Valley Health Plan's QM Program are to:

- Improve the safety and quality of care and service to all members by:
    - ensuring that the quality and continuity of care meet professionally recognized standards of practice and are delivered to all members, and
    - identifying, evaluating and working with Central Valley Health Plan providers to correct quality of care problems within all partner organizations;
- Optimize satisfaction of members and practitioners/providers by assessing, pursuing and monitoring opportunities for improvement;
- Ensure optimized service delivery, including care accessibility, availability, and utilization of services, to meet professionally recognized standards of practice;
- Foster a multi-disciplinary and collaborative approach to quality improvement involving all Central Valley Health Plan partnering medical groups, IPAs, hospitals, other providers, and health plans whose services directly affect members' health care quality, service, access, and safety;
- Review and update existing quality related policies and procedures, ensure compliance with all external requirements and standards and create new policies and procedures as needed;
- Maintain systems to collect, synthesize, and report data about quality and service reliably and in a timely fashion from various sources. Sound study designs and statistical techniques are applied when monitoring and developing reports to ensure that appropriate follow-up actions may be taken;

- Monitor procedures ensuring that members do not experience discrimination based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation or source of payment in the delivery of health care services; and

- Ensure the identification, evaluation and planning for individual members is done consistently across all Medical Groups/IPAs wherever this function is delegated to Central Valley Health Plan by the Health Plan.

**Care Management Program**

Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes (NCQA), MCG Guidelines®, AHRQ and NCQA standards are utilized to identify case types, establish clinical assessment criteria and supportive services for care planning.

Central Valley Health Plan's care management program include case management for members with complex care needs, whether for acute or chronic conditions as well as care coordination services to include consideration of the member's health plan benefits, diagnoses, co-morbidities, psychosocial needs and community program access. CVHP Medical Group/IPAs notify and collaborate with PCPs, treating specialists and health plans to coordinate care for members. The goals of Central Valley Health Plan's care management programs are to help patients and their families and others in their support network to manage medical conditions and related psychosocial problems more effectively, optimize the member's functional health status, coordinate care across various providers and care settings and eliminate duplication of services.

Central Valley Health Plan may delegate care management services to its Medical Groups/IPAs or accredited third party vendors. Delegates must pass health plan audits before they are contracted to offer specific types of care management services. Whether offered through the vendor or directly by the member's Medical Group/IPA, care management services follow the following requirements:

- Care Managers can be accessed during normal business hours.

- The Medical Groups/IPAs must maintain and coordinate care records among providers to assure access and in accordance with HIPAA and professional standards.
- PCPs are notified in writing about a member who meets criteria for and enrollment in care management. All patients are informed of their right to refuse case management services.
- Services offered as part of the program include but are not limited to:
    - Emergency Room Follow-up
    - Education about the condition
    - Medication reconciliation and self-care-training
    - Assistance with arranging doctor visits/appointments
    - Help with referrals to different care providers or services
    - Assistance with identifying different community support or services available to meet individual needs (In Home Support Service, Community Based Adult Services, Medicare Shared Savings Program, Nutrition Services, assistance with utilities, other community support programs)
    - Help with physician access and involvement in developing a treatment plan
    - Assist members in communicating with their health care providers
    - Advanced illness management and life planning discussion when needed

## Complex Case Management

Complex case managers facilitate medical care and offer support for Central Valley Health Plan members experiencing critical events or with a diagnosis requiring extensive use of resources, to help members and their caregivers navigate the systems of care and minimize morbidity.

Case managers will coordinate services to ease transitions of care for members before and after hospitalization for those who at risk for re-hospitalization and/or would benefit from help with follow up appointments.

More information on Central Valley Health Plan and its quality management programs is available by calling Central Valley Health Plan at 833-882-2847 .

Disease management programs for specific conditions are typically not delegated to Central Valley Health Plan and are offered directly through the member's upstream health benefit plan.

## Access to Care

The California Department of Managed Health Care requires Knox-Keene licensed entities to adhere to the following standards for timely access to care. All Central Valley Health Plan participating providers must meet these standards for appointment and telephone wait times.

**Appointment Wait Times**

Central Valley Health Plan members have the right to appointments within the following time frames:

- Non-urgent appointments with Primary Care Physicians within 10 business days of request
- Non-urgent appointments with Specialist Physicians within 15 business days of request
- Urgent care appointments that do not require prior authorization within 48 hours of request
- Urgent care appointments that require prior authorization within 96 hours of request
- Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness or other health condition) within 15 business days of request
- Non-urgent appointments with a non-physician mental health care provider within 10 business days of request.

Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment.

Appointment wait times are surveyed and reviewed by CVHP/Upstream health plan annually to ensure adequate member experience as required of Access Care Standards

**Telephone Wait Times**

- Central Valley Health Plan members may call 24 hours a day, 7 days a week, to talk with a qualified health professional in their Medical group/IPA to determine urgency of a health care condition. If the member must wait for a professional to call back, that call must occur within 30 minutes. Phone numbers are printed on the member's ID card.
- During normal business hours, the phone must be answered within ten minutes.

## Exceptions to Timely Access Requirements

- The purpose of the timely access law is to make sure members receive the care they need. Sometimes members need appointments even sooner than the law requires. In this case, members and PCPs can request that the appointment be sooner.
- Providers may give members a longer wait time if it would not be harmful to their health. It must be noted in the medical record why a longer wait time is necessary and that it will not be harmful to the member's health.
- If a member cannot get a timely appointment in the service area because there are not enough Alliance providers, Central Valley Health Plan and the member's medical group will assist the member to get an appointment with an appropriate provider out of network.
    - Need to add how a contracting provider or member can contact the health care service plan to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

## After-Hours Access

Central Valley Health Plan, through its participating providers, upstream contracted health plans and internal processes provides 24 hours a day, 7 days per week telephone triage for immediate clinical support of everyday health issues and questions. The triage or screening waiting time does not exceed 30 minutes. Registered nurses may respond to calls and may: provide protocol-based advice for minor injuries and illnesses, identify emergency health situations, explain medications, and preparing patients for doctor visits.

Central Valley Health Plan ensures the immediate availability of and accessibility to emergency health care, including behavioral care within the service area, 24 hours a day, 7 days a week. These services include crisis intervention and stabilization as well as psychiatric inpatient hospital services within the service area, 24 hours a day, 7 days a week.

## General Administrative Requirements

**Provider Responsibilities**

Participating providers are responsible for:

- Providing health care services within the scope of the provider's practice and qualifications, that are consistent with generally accepted standards of practice;
- Accepting Central Valley Health Plan members as patients on the same basis that the provider accepts other patients (nondiscrimination);
- Following the Central Valley Health Plan Referral Policy and providing timely communication and feedback regarding member healthcare needs to affiliated physicians;
- Obtaining current insurance information from the member;
- Adhering to standards of care and Central Valley Health Plan policies to perform utilization management and quality improvement activities, including prior authorization of necessary services and referrals;
- Informing the member that services may not be covered when referring to physicians outside the network unless prior authorization has been issued;
- Cooperating with Central Valley Health Plan and its participating providers to provide or arrange for continuity of care to members undergoing an active course of treatment in the event of provider termination;
- Operating and providing contracting services in compliance with all applicable local, state and federal laws, rules, regulations, and institutional and professional standards of care, including federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), the anti-kickback statute (section 1128B(b)) of the Social Security Act), and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164.

## Provider rights to advocate on behalf of the member

Central Valley Health Plan ensures that its providers, acting within the lawful scope of their practices, are not prohibited or otherwise restricted from advising or advocating, on behalf of members who are the providers' patients, for the following:

- the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- any information the member needs to decide among all relevant treatment options
- the risks, benefits and consequences of treatment or non-treatment
- the member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions

## Nondiscrimination

Central Valley Health Plan and its participating providers must not discriminate against any provider that serves high-risk populations or specializes in conditions that require costly treatment.

## Encounter Data Submission

All Central Valley Health Plan contracted Medical Groups/IPAs are contractually obligated to provide encounter data in a data file format determined by Central Valley Health Plan. Encounter data is to be submitted monthly to the member's upstream health plan, as well as to Conifer VBC. Encounter data is used for regulatory compliance reporting and performance evaluation of the Central Valley Health Plan alliance.

## Member Financial Responsibility

Central Valley Health Plan members are responsible for co-pays or coinsurance as determined by their individual employee benefit plan.

Central Valley Health Plan providers agree to accept payment per their contract as payment in full. Balance billing for the difference between the contracting amount and billed charges for covered services is prohibited and is considered a breach of contract, as well as a violation of the PPA and state and federal (ARS 20-1072) statutes. In some instances, balance billing of members can result in civil penalties as stated in ARS 36-2903.01(L).

- Providers may bill a Central Valley Health Plan member when the member knowingly receives non-covered services. The provider must notify the member in advance of the charges and have the member sign a statement agreeing to pay for the services and must file the signed statement in the member's medical record.
- Central Valley Health Plan members may not be reported to a collection agency for any covered services rendered by a Central Valley Health Plan provider
- Central Valley Health Plan members may not be charged for services that are denied or limited due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization, or lack of clean claim status.

## Credentialing and Re-credentialing

Credentialing and re-credentialing of physicians and licensed individual practitioners is delegated to Central Valley Health Plan's partner medical groups/IPAs and/or an accredited third-party vendor. Central Valley Health Plan's Chief Medical Officer chairs the Central Valley Health Plan Credentialing Committee which oversees these activities conducted by each IPA's credentialing committee.

Central Valley Health Plan credentials participating ancillary facilities through Conifer Value Based Care. CVHP members may also access ancillary facilities which have been credentialed by CVHP's upstream health plans as part of their Medicare Advantage plan's network. CVHP's upstream health plan (s) provide a directory of contracted and credentialed providers to the CVHP Credentialing Committee. The directory of upstream contracted and credentialed ancillary facilities is accessible to members on CVHP's website

and on the upstream health plan's website as well as by contacting the upstream health plan's member services department. Ancillary facilities are credentialed per state and federal regulations; such documentation and verification are provided to the Central Valley Health Plan Credentialing Committee.

**Customer Appeals, Grievances and Complaints**

Medical appeal or grievance: Central Valley Health Plan members who wish to initiate an appeal or grievance about medical services received or requested should contact their upstream health plan. Contact information is available under the Member section of the Central Valley Health Plan website or under the section in this Manual "Participating Health Plans". CVHP's contracted upstream health plan is Humana, which can be contacted by calling 1-800-457-4708 TTY users 711.

Other appeals or grievances: Central Valley Health Plan members with an appeal or grievance about mental health and substance abuse, chiropractic, or acupuncture services received or requested should review their upstream contracted Health Plan's EOC documents for contact information.