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Provider Training Guide

Welcome to California Health & Wellness!

09/26/2022

Welcome

Welcome to California Health & Wellness:

- We thank you for being part of our network of participating physicians, hospitals, and other healthcare professionals
- We hope this presentation guide is informative and useful
- **For assistance, please call us at 1-877-658-0305**

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About Us

Provider Training Guide

About CA Health & Wellness

Our approach is based on the core belief that **quality healthcare is best delivered locally:**

- Local CEO
- Local Call Center
- Local Integrated Care Teams
- Local Medical Management
- Local Provider Relations & Contracting
- Local Community Involvement & Support
- Local Administrative Offices (Sacramento, Chico, El Centro, Placerville)
- Subsidiary of Centene Corporation

About CA Health & Wellness

California Health & Wellness is a managed care organization

California Department of Health Care Services (DHCS) awarded a contract to CA Health & Wellness to serve Medi-Cal beneficiaries in 19 counties:

Alpine	Glenn	Plumas	Amador	Inyo	Sierra
Butte	Sutter	Mariposa	Calaveras	Mono	Tehama
Colusa	Nevada	Tuolumne	El Dorado	Placer	Yuba

DHCS and the Imperial County Board of Supervisors awarded CA Health & Wellness a contract to serve Medi-Cal beneficiaries in Imperial County

About CA Health & Wellness

- California Health & Wellness provides case management, disease management, care coordination and quality improvement activities.
- California Health & Wellness administers most Medi-Cal benefits, including limited outpatient behavioral health services.
  - Some Medi-Cal benefits are still managed by other state programs (e.g., specialty mental health services, California Children's Services, Home and Community Based Services, etc.).
- Our goal is to ensure members receive the right care, in the right place, at right time.

About Our Members

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Our Members

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Who we cover …

Population	Enrollment
Temporary Assistance for Needy Families (TANF)	Mandatory
Members now eligible through Medi-Cal Expansion	Mandatory
Seniors and Persons with Disabilities (SPD)	Mandatory
Foster Care Children and Youth	Voluntary

Member ID Cards

- In addition to the State of California Benefits Identification Card, members have a California Health & Wellness ID card.

Member Eligibility

To verify member eligibility, use one of the following methods:

- Log on to the secure California Health & Wellness Provider Portal **https://www.cahealthwellness.com/**
- Call California Health & Wellness at 1-877-658-0305 to use our automated Interactive Voice Response System (IVR) or speak to a Provider Services Representative.
- Check online using the CA State Eligibility System-AEVS or CERTS **https://www.medical.ca.gov/mcwebpub/login.aspx**

Transition for New Members

To request consideration for a transition period call California Health & Wellness at 1-877-658-0305.

- California Health & Wellness shall allow any child who has transitioned into Medi-Cal to remain with their Primary Care Provider (PCP) at the time of the transition under certain conditions.

- Some members have other considerations and California Health & Wellness can work on a case specific transition for members with needs.

Continuity of Care

To request consideration for Continuity of Care call California Health & Wellness at 1-877-658-0305.

- Continuity of Care generally applies to new members who have a pre-existing relationship with an out-of-network Physician prior to their effective date with California Health & Wellness or existing members receiving services from a network Physician whose contract with the California Health & Wellness is terminated.

- Continuity of Care, when approved by California Health & Wellness, allows the member to continue to see this Physician under certain circumstances for a limited time frame based on the condition.

California Children's Services (CCS)

For more information on CCS, call California Health & Wellness at 1-877-658-0305.

- California Health & Wellness members will be eligible to enroll in, or continue enrollment in, California Children's Services (CCS).
- This will include children from birth up to 21 years of age with CCS-eligible medical conditions.
  - CCS will pay for services associated with the eligible diagnosis.
  - California Health & Wellness is not responsible for services/conditions that are approved by CCS.
  - CCS will only reimburse services provided by CCS-paneled providers and CCS-approved hospitals
- Providers are expected to refer a child to CCS if there is sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS-eligible medical condition.

Regional Centers

- The Department of Developmental Services (DDS) is responsible for designing and coordinating a wide array of services for California residents with developmental disabilities. Regional Centers contract with DDS to help plan, access, coordinate and monitor these services and supports.

- California Health & Wellness members with intellectual or developmental disabilities, whose disability begins before the member's 18th birthday, and is expected to continue indefinitely and presents a substantial disability, may be eligible for living arrangements and support services.

Living Arrangements	Support Services	
Affordable Housing	In-Home Supportive Services	Companion Programs
Community Care Facilities	Respite (In-home) services	Independent Living Program
Family Home Agency	Transportation Services	Self- Determination Program
Foster Family Agency	Day Program Services	Work Services Program
Intermediate Care Facilities	Dental Services (Denti-Cal)	Supported Employment Services
Supported Living Services	Education Services	Work Activity Program Services
	Foster Grandparent and Senior	

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Physician's Responsibilities

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Key Responsibilities for PCPs

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PCPs are the cornerstone of our delivery system

PCP responsibilities include but are not limited to:

- Manage the medical and health care needs of members
- Educate members on maintaining healthy lifestyles and preventing illness
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide.
- Actively participate in quality initiatives and programs (e.g. HEDIS)
- Perform an Initial Health Assessment (IHA) within 120 days.
- Administer the Staying Healthy Assessment (SHA) or other approved Individual Health Education Behavioral Assessment (IHEBA) during the initial health assessment and at subsequent well care visits.
- For any members with mild to moderate substance use disorders, the provider should also complete an SABIRT (Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment) to members ages 11 years and older, including pregnant women to address specific conditions and future treatment recommendations.
- Additional PCP responsibilities are listed in the Provider Manual at **https://www.cahealthwellness.com/**

Initial Health Assessment (IHA) / Individual Health Education Behavioral Assessment (IHEBA)

Overview

Acronyms

IHA – Initial Health Assessment (see: DHCS Policy Letter 08-003) includes an IHEBA.

IHEBA – Individual Health Education Behavioral Assessment is a generic for the SHA or DHCS approved alternative assessment tool. IHEBA is a part of the IHA.

SHA – Staying Healthy Assessment is the Department of Health Care sponsored and approved IHEBA.

SABIRT – Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment

Requirements

DHCS requires providers to administer an IHEBA (e.g., Staying Healthy Assessment) to all Medi-Cal Managed Care patients as part of their IHA and well-care visits. For more information, please visit https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

Components of the Initial Health Assessment

(MUST be completed within 120 days of enrollment)

- a physical exam
- a physical and mental health history
- identification of high-risk behaviors
- assessment of need for preventive screenings or services and health education diagnosis
- and plan for treatment of any diseases
- identification of members whose health needs may require coordination with community resources and other agencies for services

Key Responsibilities for Specialist

The specialist provider responsibilities include:

- Maintain contact with the PCP
- Obtain authorization from California Health & Wellness's Medical Management Department (Medical Management) if needed before providing services.
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all California Health & Wellness quality initiatives and programs.

California Health & Wellness providers should refer to their contract for complete information regarding provider obligations and mode of reimbursement.

Access Standards

- The contract between DHCS and California Health & Wellness includes specific standards related to appointment times and wait times. These standards are based upon provider specialties.

- Compliance with these standards will be monitored by California Health & Wellness.

Type of Appointment	Scheduling Time Frame
Non-Urgent Primary Care	Within 10 business days of request
Urgent Care/No Prior Authorization Required	Within 48 hours of request
Urgent Care/Prior Authorization Required	Within 96 hours of request
Emergent	On demand service/24 hours a day, 7 days a week
Specialist	Within 15 business days of request
Non-Urgent/Ancillary Services for diagnosis or treatment of injury, illness or other health condition	Within 15 business days of request
First Prenatal Visit	Within two weeks of request
Clinical: Appointments for member for covered health care services shall be within the time period appropriate for their individual condition.	

Access Standards

Give Advance Notice for Provider Terminations or Practice Location Changes

All providers and delegated entities must give California Health & Wellness Plan (CHWP) sufficient advance notice of provider terminations in their network panel or of any service location changes.

Termination timeline

- Unless the stated effective date is further out, all termination notices to CHWP will be made effective on the first of the month approximately 60 days from the end of the month of receipt by CHWP
- (e.g., notice received January 10, termination will be effective April Providers and delegated entities must ensure access for Medi-Cal members remains available during that time.

Use any of these methods to submit prior notice:

- ❑ **Email:** CHWP_contracting@cahealthwellness.com
- ❑ **Online:** Complete the online form on the CHWP provider website at www.cahealthwellness.com under Provider > Provider Resources > Provider
- ❑ Data Reporting and Validation
- ❑ **Call or email:** Reach out to your provider relations & contracting specialist (PRCS)

Cultural, Linguistic & Disability Access

Provider Responsibilities:

- **Interpretation Services**
  a. **In all languages** (including American and Mexican Sign Language)
  b. **At all key points of contact** (medical and non-medical)
  c. **Over the phone** (24 hours a day, 7 days a week)
  d. **In-person** (upon a member's request) and 5 business days advance notice requested.
  e. **And through other formats** (e.g. relay, real-time captioning, or augmentative communication devices) **that ensure effective communication**.

- **Translated Member Materials**
  a. **In threshold languages**
  b. **In other languages** (through oral interpretation upon request)
  c. **In alternative formats** (upon request, e.g. Braille, large print, audio format)
  d. **Easy-to-understand** (6th grade reading level)
  e. **Includes print documents, signage, and multimedia materials** (e.g. websites).

Cultural, Linguistic & Disability Access (cont.)

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Provider Responsibilities

- **Reasonable Accommodations**
  a. That ensure equal access for members with disabilities to all services & facilities;
  b. Includes modifications of policies, practices, and procedures (e.g. to permit the use of service animals, to minimize distractions and stimuli).
  c. Provide physical accessibility in office and exam rooms.

- **Medical Care and Information on Treatment Options**
  a. Provided in a manner that is respectful of, and takes-into-account diverse cultural beliefs, health literacy rates, and disability access needs.

- **Connect Members with Cultural, Linguistic, and Disability-Related Community Resources**
  a. CH&W Member Connections Representatives, Member & Provider Services Representatives, and Care Coordination staff are available to assist.

Cultural, Linguistic & Disability Access (cont.)

Provider Responsibilities, Continued:

- **Inform, Facilitate, and Document**
  a. **Inform** members of these services, **facilitate** access to them, and **document** a request and/or refusal of services in the provider's data system

- **Staff Education & Training**
  a. **At least annually**
  b. **On policies/procedures** that describe these services & how to access them
  c. **On cultural, linguistic, and disability responsiveness** (aka cultural competency)

- **Provide Quarterly Updates**
  a. Ensure workforce is reflective of the cultural, linguistic, and disability diversity of the populations served
  b. Provide CH&W with quarterly updates on any changes in disability access and/or the language capabilities of staff for the Provider Directory

Cultural, Linguistic & Disability Access (cont.)

Provider Resources:

- Contact California Health & Wellness' Provider and Member Services department at **1-877-658-0305** (V/TTY) to request:
  - Assistance with any of these cultural, linguistic, or disability access services when serving a CH&W member;
  - A copy of the most recent CH&W Group Needs Assessment or Diversity & Disability Program Plan;
  - Education and training resources;
  - More information about CH&W's accountability requirements

CAHealthWellness.com:

- Section on Cultural Competency under Provider Resources section when you expand More Resource Topics.

Participation in Site Reviews

- Site visits are a part of the credentialing/re-credentialing process and will be conducted with providers before credentialing is finalized.
- Site visits are conducted to ensure all PCPs and certain high-volume specialists and ancillary providers are delivering quality healthcare services to our members.
- Site visits are performed in accordance with applicable and mandatory state requirements.

MHN
A Health Net Company℠

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Purpose: Delivers clinically based workplace solutions to improve productivity for its clients and enhance the lives of its members
Mission: To help people be healthy, secure and comfortable

- Providers may contact MHN at 1-800-647-7526 option 3 for Behavioral Health (BH) service inquiries or visit MHN Provider Portal at **www.mhn.com**
- For more inquiries or education & training providers may contact **MHN.ProviderServices@Healthnet.com**
- For claims DOS prior to July 1, 2019, contact CHWP Provider Services at phone number 1-877-658-0305.
- For claims DOS after July 1, 2019, contact MHN Customer Service at phone number1-800-444-4281.

Note: *Only if and when contracted under MHN directly must bill claims directly to MHN*
Attn: Claims, P.O. Box 14621, Lexington, KY 40512-4621
For electronical submissions use Payer ID 22771.

Network Partners

Envolve Pharmacy Solutions– Pharmacy Benefit Manager 1-877-277-0413 1-866-399-0929 (Fax) PA Requests BIN:008019
https://pharmacy.envolvehealth.com

MHN Services (Behavioral Health)
1-800-647-7526 option 3 or CHWP 1-877-658-0305
www.mhn.com

NurseWise (24/7 Availability)
1-877-658-0305
www.nursewise.com

National Imaging Associates (NIA)
(Hi-tech Radiology)
1-877-807-2363
www.RadMD.com

Envolve Vision
1-800-344-3937
1-877-940-9243 (Fax)
VIN: 56190
https://visionbenefits.envolvehealth.com

Claims

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Claims Submission

- Partnering Clearinghouses: Availity, Claim Remedi, Emdeon, Gateway, SSI (*Office Ally can still be used to file claims electronically*)

- Payer ID:
  Emdeon – 68047
  All Others – 68069

- Submit claims electronically using the secure Provider Portal at https://www.cahealthwellness.com/

- Submit paper claims to:

California Health and Wellness
Attn: Claims
P.O. Box 4080
Farmington, MO 63640-3835

Claims & Payment

- **Timely Filing -** First time claims and encounters not later than the sixth month following the month of service. Secondary claims not later than one year after the month of service. Non-par provider timely filing is 180 days.

- **Clean Claims -** 99% of clean claims are processed within 45 business days of receipt. It is our goal to process clean claims in less than 7 days.

- **Exceptions to a clean claim -** Claim for which fraud is suspected. Third Party Liability or other healthcare coverage.

Corrected Claims

- Corrected claims must be received within 365 days following the date of payment or the denial of the claim.

- Corrected claims may be submitted electronically through the secure web Provider Portal at https://www.cahealthwellness.com/ or mailed to:

California Health & Wellness
Attn: Corrected Claims
P.O. Box 4080
Farmington, MO 63640-3835

Provider Dispute Resolution (PDR) - Claim Disputes

- A claim dispute form titled Provider Dispute Resolution Request should be utilized when a provider has received an unsatisfactory response to a claim payment issue.

- Complete a Claims Dispute form located at https://www.cahealthwellness.com/ or right click on the form title above to Open hyperlink and mail the completed form to:

California Health & Wellness
Attn: Claim Dispute
P.O. Box 4080
Farmington, MO 63640-3835

Claim Disputes (con't)

- You should receive an acknowledgement within 5 business days
- All requests for reconsideration, appeal or dispute will be resolved within 45 business days of receipt.
- If a provider is not satisfied with the dispute review process, the provider may utilize the second level dispute process outlined in the Participating Provider Agreement.

PaySpan® Health

- Register at https://payspanhealth.com/nps for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
  - Free service and fast online enrollment
  - Improved cash flow through automated deposits
  - Access remittance data 24 hours a day
  - Access up to 18 months of historical remittance data
  - Ability to import payment data directly into the practice management systems
  - Mailbox functionality to automate the delivery of remittance data
  - Multi-payer solution
  - Webinars available

  - PaySpan Health Payer User Guide: https://www.payspanhealth.com/PaySpan/app/payspan/HelpFiles/PayerUserGuidePaySpanBrandingPDF.pdf

For more information contact PaySpan Health at: 1-877-331-7154

Prevention of Waste, Fraud & Abuse

- California Health & Wellness takes waste, fraud and abuse very seriously.
- California Health & Wellness, in conjunction with its parent company Centene Corporation, operates a Waste, Fraud and Abuse Unit.
- The Special Investigations Unit performs routine, retrospective audits as part of the Waste, Fraud and Abuse Detection Program.
- If you suspect or witness fraud, please call the Waste, Fraud and Abuse hotline at 1-866-685-8664. All calls are confidential.
- For more details, please see the Provider Manual at https://www.cahealthwellness.com/.

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Grievance and Appeals

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Grievance Process

A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the member's right to dispute an extension of time proposed by the plan to make an authorization decision.

- Provide Member with the ***Appeal or Grievance Form***: in office/facility or online https://www.cahealthwellness.com/members/medicaid/Appeals-and-Grievances.html or the Plan's toll free Member Services number: 1-877-658-0305.
- In addition, if the Provider is filing the Appeal or Grievance on behalf of the member an ***Authorized Representative Form*** must also be filled out and submitted: https://www.cahealthwellness.com/content/dam/centene/cahealthwellness/pdfs/CHW_Authorized_Representative_Form_ENG_060717.pdf
- The member, member's authorized representative or provider, may file a Grievance orally or in writing at any time.

For complete detailed information regarding the ***Appeal, Grievance, State Fair Hearing, and IMR*** processes, timelines, and guidelines, please refer to the Provider Manual.

Grievance Process

- The investigation of Grievances falls under the Quality Improvement Process at the plan. All contracted providers MUST participate in the Quality Improvement Process of the plan.

- For all member Grievances, Providers will receive a ***Provider Investigation*** letter from the Plan and a written response is required in **5 business days** from receipt of the letter.

- Grievances will be resolved in a timely manner that is appropriate for the complexity of the Grievance and the member's health condition: **(10) business days** of receipt or sooner but **not to exceed thirty (30) calendar d**ays, be it oral or in writing (exception: Expedited Grievances will be resolved within 72 hours after receipt).

- After completing the Grievance process, a member may submit the Grievance to the DMHC for review. For more information regarding the DMHC Grievance process and forms, direct the member to the DMHC website: https://www.dmhc.ca.gov/?referral=hmohelp.ca.gov or provide the member with the toll-free number: 1-888-HMO-2219

For complete detailed information regarding the ***Appeal, Grievance, State Fair Hearing, and IMR*** processes, timelines, and guidelines, please refer to the Provider Manual.

Appeal Process

An Appeal is a request for review of a Adverse Benefit Determination (ABD). The ABD is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service.

- To Appeal the Adverse Benefit Determination, provide Member with the ***Appeal or Grievance Form***: in office/facility or online https://www.cahealthwellness.com/members/medicaid/Appeals-and-Grievances.html

- In addition, if the Provider is filing the Appeal on behalf of the member an ***Authorized Representative Form*** must also be filled out and submitted: https://www.cahealthwellness.com/content/dam/centene/cahealthwellness/pdfs/CHW_Authorized_Representative_Form_ENG_060717.pdf

- The member, member's authorized representative, or provider, may file an Appeal with the Plan within 60 calendar days from the receipt of the Adverse Benefit Determination. The appeal must be filed with the plan first before a State Fair Hearing or Independent Medical Review may be filed with the regulators.

For complete detailed information regarding the ***Appeal, Grievance, State Fair Hearing, and IMR*** processes, timelines, and guidelines, please refer to the Provider Manual.

Appeal Process

- An ***Independent Medical Review (IMR)*** may also be requested **by the member only** within ***6 months*** of the Plan's written response to the member's Grievance. A member qualifies for an ***IMR*** only if they have not received a decision for a ***State Fair Hearing***. The ***IMR*** process resolves decisions that deny, modify or delay health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies.

- For more information regarding the ***State Fair Hearing*** or ***IMR*** process and forms, log onto the DMHC's website: https://www.dmhc.ca.gov/SearchResults.aspx?Search=IMR or call toll free 1-888-HMO-2219.

For complete detailed information regarding the ***Appeal, Grievance, State Fair Hearing, and IMR*** processes, timelines, and guidelines, please refer to the Provider Manual.

Authorization/Member Services

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Authorizations

- Some services require prior authorization from California Health & Wellness in order for reimbursement to be issued to the provider.

- Check to see if a pre-authorization is necessary by using our online tool: https://www.cahealthwellness.com/providers/preauth-check.html

- Standard prior authorization requests should be submitted for medical necessity review at least **five (5) business days before the scheduled service delivery date** or as soon as the need for service is identified.

- **Emergent and post-stabilization services do not require prior authorization.** **Urgent/emergent admissions require notification within one (1) business day following the admit date.*

Authorizations

Services provided by an “Out of Network” provider require prior authorization.

High Tech Imaging Services (CT, MRI, PET) require authorization by National Imaging Associates at https://www1.radmd.com/radmd-home.aspx

Authorization can be submitted via:

- ✓ Fax
- ✓ Telephonic
- ✓ Secure web portal

If we need additional clinical information or the case needs to be reviewed by the Medical Director, it may take up to 14 calendar days to be notified of the determination.

Case Management

Disease Management

California Health & Wellness works with Nurtur to give disease management services to our members for the following conditions:

- Asthma
- Diabetes
- Congestive Heart Failure
- Hypertension
- Smoking Cessation
- Weight Management
- Low Back Pain

Care Coordination

This service is for members who have complex medical conditions. Conditions may include:

- Diabetes
- Sickle Cell
- Multiple Sclerosis
- Kidney or Renal Disease
- HIV/AIDS
- Hemophilia
- Brain Injury

Providers, members, health plan staff can refer a member potentially in need for Care Management Programs or Services by contacting the Call Center at 1-877-658-0305 or completing the Care Management Referral Form posted at www.CAHealthWellness.com or right click the title of the form to open the hyperlink.

Value Added Services

California Health & Wellness offers programs to assist members with access of additional services and medical questions/concern.

The programs are:

- NurseWise, call: 1-866-896-8443 or e-mail: info@nursewise.com
- Start Smart for Your Baby
- Member Connections Program
- Non-emergency Transportation and Non-Medical Transportation

  For NEMT -A provider must complete a Physician Certification Statement (PCS) form

- Babylon Telehealth services, call: 1-800-475-6168

Provider Relations

A vital part of CH&W's Provider Relations Department philosophy of service is direct personal communication at the PCP level. We offer routine face-to-face visits with physicians to offer personal administrative and operational support.

Services:

- Routine face-to-face visits
- Operational Support
- Liaison to internal departments
- Assist with triaging operational issues
- Provider Training, Orientation, and Education
- Educational Tools and Resources
- HEDIS/Care Gap Reviews
- Conducting JOC Meetings

For inquiries related to the above services you may contact Provider Relations at CHWP_Provider_Relations@Centene.com for all other inquiries contact Provider Services at 1-877-658-0305.

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Quality Improvement
HEDIS, CAHPS & CalAIM

Provider Training Guide

HEDIS – Incentive Program

California Health and Wellness offers incentive payments to qualifying primary care providers in recognition for their efforts to improve quality of care for Health Net Medi-Cal members.

- PCPs are awarded for care gaps closed in various HEDIS measures
- FQHC/RHC/IHS providers are awarded for meeting the minimum performance level (MPL) and having a certain % of improvement (1% for providers meeting MPL and 2% for providers below MPL) in various HEDIS measures.
- All 12 counties statewide with active W-9 on file
- Other eligibility requirements exist!

A useful tool to maximize your HEDIS incentive is Cozeva Portal
Providers have support in the following areas when they sign up on Cozeva Portal

- Track measure rates using the Registries scorecard
- View patient-level detail on gaps in care
- Track estimated/potential incentive payments
- Print face sheets to facilitate pre-visit planning
- Close data gaps instantly by uploading records
- More frequent incentives (quarterly vs. semiannual)

More timely and secure e-payments through PayPalHyperwallet®

- https://www.cahealthwellness.com/providers/quality-improvement/hedis-measure-specifications.html

For HEDIS related questions go to https://www.cahealthwellness.com/providers/quality-improvement/hedis-measure-specifications.html

CAHPS - Consumer Assessment of Healthcare Providers & Systems

- CAHPS Surveys are designed to capture accurate & reliable information from members about their experiences with health care.
- Survey results are reported as part of HEDIS data collection.
- Survey results are used by health plans for internal quality improvement and by NCQA for accreditation decisions.
- Survey vendors are monitored by NCQA

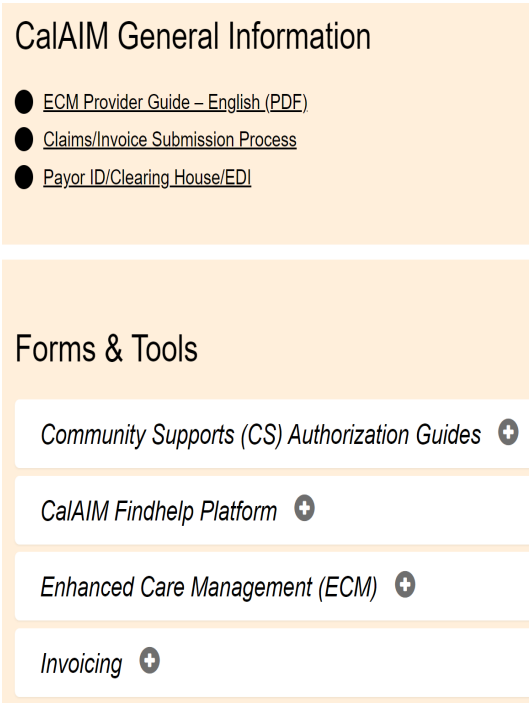
CalAIM

CalAIM (California Advancing and Innovating Medi-Cal) is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.
We have developed a thorough optional training program designed to ensure the successful deployment of CalAIM.

The trainings includes the following topic:

1. General managed care 101 overview and how it impacts CalAIM
2. Member engagement and data sharing process with our plan for Enhanced Care Management (ECM)
3. Referrals, Authorization, and Claims process for ECM and Community Supports (CS)
4. And more

You can access CalAIM Webinar Recordings in the following Link:
https://www.cahealthwellness.com/providers/resources/calaim-resources.html



Web Portal / Demo

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Website & Secure Provider Portal

www.CAHealthWellness.com

- Check member eligibility
- Provider Manual/ Billing Manual
- Provider Information for Medical Services
- Prior Authorization Code Checker
- Operational forms
- Clinical Practice Guidelines
- Provider Newsletters and Announcements
- Find a Provider
- Find Community Resources
- Krames Staywell Health Library: Health Sheets

Through Secure Provider Web Portal Participating Providers can:

- Register Free and Easy
- Check member eligibility & PCP Information
- Submit Prior Authorization requests
- View InterQual SmartSheets
- View assigned membership
- Submit, view and adjust claims
- View payment history
- Secure Messaging option to communicate with health plan
- Secure Provider Website Instructional Guide

Questions