POLICY AND PROCEDURE	
Policy # and TITLE: Legal Claims and Judicial Review	
Primary Policy owner: Compliance	**POLICY #:** CMP30
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☒All Departments 2) ☐Behavioral Health (BH) 3) ☐Benefits Administration (BA) 4) ☐Care Management (CM) 5) ☐Claims (CLMS) 6) ☐Community Marketplace & Member Engagement (MAR) 7) ☐Compliance (CMP/HPA) 8) ☐Configuration (CFG) 9) ☐Provider Contracting (CONT) 10) ☐Cultural & Linguistics (CL) 11) ☐Customer Service (CS)	12) ☐Facilities (FAC) 13) ☐Finance (FIN) 14) ☐Human Resources (HR) 15) ☐Information Technology / Core Systems (IT) 16) ☐Pharmacy (PH) 17) ☐Provider Networks (PRO) 18) ☐QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☐ Utilization Management (UM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** N/A

I. PURPOSE

This policy is written to set forth the process for the presentation of claims to the San Joaquin County Health Commission ("Commission"), operating and doing business as Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan"), in compliance with this Policy, Division 3.6 of Title 1 of the California Government Code (CGC), and all applicable statutes and regulations. Section 1094.6 of the California Code of Civil Procedure (CCCP) shall govern cases involving judicial review.

II. POLICY

A. **General:** As a public agency, the Health Plan is subject to Division 3.6 of Title 1 of the California Government Code, pertaining to claims against public agencies. Any claims against the Health Plan for money or damages, which are not governed by any other statutes or regulations expressly relating thereto, shall be presented in accordance with Title 1, Division 3.6, Part 3, Chapter 1 (commencing with Section 900) and Chapter 2 (commencing with Section 910) of the CGC, prior to initiating suit thereon.

B. **Claims Presentation:** Except as provided in Section II.A, claims presented to the Health Plan shall be handled in accordance with this Policy. These written claims include but are not limited to Verified Claims, Notice of Intent to Sue, Summons and Complaints, and all documents that have the potential to meet the criteria for a claim against a public entity as defined in CGC Sections 910 and 910.2. The written claim contains sufficient information so the Health Plan can conduct a thorough investigation. Claims shall be submitted to the Health Plan's Standards and Compliance at 7751 S. Manthey Road, French Camp, CA 95231.

C. **Excepted Claims:** In accordance with the authority set forth in CGC Section 935, the claims procedures for those claims against the Health Plan for money or damages, which are excepted from the claims presentation requirement by CGC Section 905 and not governed by other statutes or regulations expressly relating thereto, are governed by the procedures set forth in this Policy. Notwithstanding any exceptions contained in Section 905 of the CGC, no action based on a claim or demand for money or damages shall be brought against the Health Plan, or any of the Health Plan's Commission members, officers, employees, or agents, unless presented to, and acted upon by, the Commission, as provided herein.

D. **Timeliness:** All claims are presented within the time limitations and in the manner prescribed by Sections 910 through 915.2 of the CGC. Such claims are further subjected to the provisions of Section 945.4 of the CGC relating to the prohibition of suits in the absence of presentation of claims and action thereon by the Health Plan's Health Commission.

E. **Late and Insufficient Claims:**
   1. If the Chief Executive Officer (CEO), or his or her designee upon the CEO's unavailability, determines that a claim fails to comply substantially with the presentation requirements of CGC 910 and 910.2, or with the requirements of a form provided under CGC Section 910.4 if a claim is presented thereto, the designee may give written notice of its insufficiency in accordance with CGC 910.8 and 915.4.
   2. When a claim is not presented within the time limits prescribed in CGC Section 911.2, the CEO or his or her designee upon the CEO's unavailability, is authorized to return the claim without further action, in accordance with CGC Section 911.3 for claims required to be filed within six (6) months or reject the claim in accordance with CGC Section 913 for all other claims.
   3. Timely filing of a proper claim in accordance with this policy and procedure is a condition precedent to the maintenance of any action against the Health Plan.

F. **Small Claims:** In the cases of small claims actions brought against the Health Plan which personally name an individual who has no personal knowledge of the claim, it is permissible to substitute a representative with more personal knowledge of court appearances.

G. **Delegated Functions of the Health Commission and Settlement Authority**
   1. Claims Against the Health Plan
      a. The CEO, or his/her designee upon the CEO's unavailability, is authorized to perform the functions of the Health Commission

which are specified in Part 3 of Division 3.6 of Title 1 of the CGC.

b. Such delegation includes the rejection and the allowance, compromise, or settlement of any claims if the amount to be paid from the Health Plan's treasury does not exceed the amount as specified in CGC 935.4 in effect at the time of decision. Notwithstanding the foregoing, any allowance, compromise, or settlement of any claim in which the amount to be paid from the Health Plan's treasury exceeds the department executive signing authority, as specified in CGC 935.4 in effect at the time of decision, shall be approved personally by the CEO, rather than his or her designee.

2. Actions Against the Health Plan: Consistent with Sections 913 of Part 3 and 949 of Part 4 of Division 3.6 of Title 1 of CGC:
   a. The CEO, with the assistance of legal counsel(s), is authorized to compromise any pending action if the amount to be paid from the Health Plan's treasury does not exceed the CEO signing authority as specified in CGC 935.4 in effect at the time of decision.
   b. The Health Commission may on a case-by-case basis authorize its CEO, with the assistance of legal counsel, to compromise any pending action where the amount to be paid from the Health Plan's treasury exceeds the CEO signing authority amount as specified in CGC 935.4 in effect at the time of decision.
   c. The CEO or his/her designee shall report settlements to the Health Commission, at a minimum, once per year.

H. **Judicial Review**: In compliance with Section 1094.6 of the CCCP, petitions for judicial review of any decision made by the Health Plan are filed within ninety (90) days after the action is final.

I. **Claim Form**: In accordance with CGC Section 910.4, the Health Plan maintains and provides a claim form for the public's use, which form is attached here to as Exhibit A. All claims presented to the Health Plan

must be submitted on the Health Plan's claim form pursuant to CGC Section 910.4, or in a form that substantially complies with the claims filing requirements of CGC Sections 910 and 910.2. The CEO has the authority to revise the claim form from time to time as s/he deems necessary.

J. **Exhaustion of Administrative Remedies**: Nothing herein is intended to diminish, eliminate, or waive any legal or contractual obligation to exhaust the Health Plan's administrative remedies prior to the presentation of a claim pursuant to this Policy.

III. PROCEDURE

A. Follow all applicable procedures outlined in the California Code of Civil Procedure, Section 1094.6 and California Government Code, Title 1, Division 3.6.

IV. ATTACHMENT(S)

A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
B. Glossary of Terms Link
C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

A. California Code of Civil Procedure, Section 1094.6
B. California Government Code, Title 1, Division 3.6, Sections 900-915.2, 935, 935.4, 945.4, and 949, 28 and all applicable statutes and regulations.

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
000	Previous Revision Dates: 10/21, 06/22, 07/23, 10/23	N/A
001	Policy Moved to new template	12/17/2023

002		
003		
Initial Effective Date: 11/1/2021		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	001	12/7/2023
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review	001	11/15/2023
Quality and Utilization Management		
• Quality Operations Committee		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	N/A	N/A	N/A
Department of Managed Care (DMHC)	N/A	N/A	N/A

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy