Health Plan of San Joaquin

Mountain Valley Health Plan

2026 Medi-Cal Provider Manual

DUALPM2026

TABLE OF CONTENTS

SECTION 1: INTRODUCTION

ABOUT HEALTH PLAN OF SAN JOAQUIN/MOUNTAIN VALLEY HEALTH PLAN

Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") is pleased to have you as part of our provider network. We recognize that the strength of our health care programs depends upon strong collaboration and communication with our Providers and their staff.

Health Plan, a not-for-profit health plan initiative for San Joaquin County, has been serving Members and the community since 1996. Health Plan is the leading Medi-Cal Managed Care Plan in San Joaquin and Stanislaus counties. As of January 1, 2024, our service area includes Alpine and El Dorado counties and our extensive referral network extends well beyond these local areas and includes facilities and providers in other parts of the Central Valley, the Bay Area, and the Greater Sacramento Area. As a result, when we refer to both entities throughout this document, we will use the designation "Health Plan."

We currently have three conveniently located offices to serve members and providers. For more information, visit our website at www.hpsj-mvhp.org. Our friendly staff looks forward to serving you!

SAN JOAQUIN COUNTY	STANISLAUS COUNTY	EL DORADO/ALPINE COUNTY
7751 S. Manthey Road French Camp, CA 95231-9802 Phone: 1-888-936-PLAN (7526)	1025 J Street Modesto, CA 95354-0803 Phone: 1-888-936-PLAN (7526)	4327 Golden Center Drive Placerville, CA 95667 Phone: 1-888-936-PLAN (7526)

SECTION 1: INTRODUCTION

MISSION, VISION, AND VALUES

Our Vision

Healthy communities with equitable access to quality care.

Our Mission

Provide high quality healthcare for our members through community partnerships.

Our Values

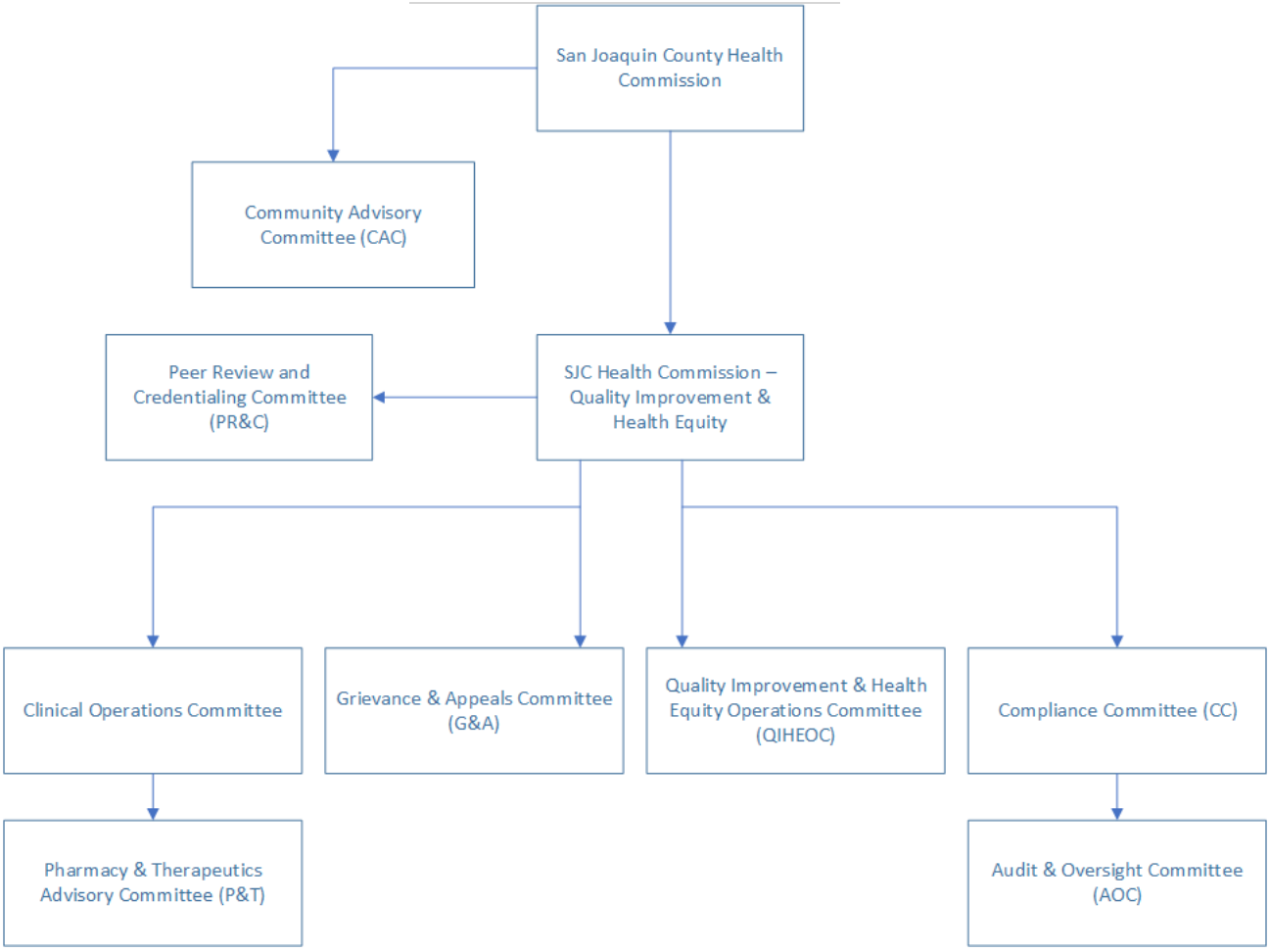
Accountability	Diversity, Equity, and Inclusion (DEI)	Partnerships	Excellence	Stewardship	Teamwork
We are accountable to members, providers, our communities, and each other.	We believe in promoting a foundation of compassion and respect for diversity, equity, and inclusion strengthening our organization and community by embracing opportunities for growth and leveraging the uniqueness of individual ideas, thoughts, and cultures.	We actively engage in community partnerships to advance quality care and health equity.	We act with integrity and aim for excellence in all we do.	We serve as a responsible steward of entrusted resources.	We demonstrate teamwork in all our interactions.

GOVERNANCE AND COMMITTEES

Health Plan is governed by the San Joaquin County Health Commission (Commission), a thirteen member commission appointed by the San Joaquin County (SJC) Board of Supervisors. It is comprised of the SJC Director of Health Care Services, the Hospital Council Regional Vice President, the Chief Assistant Director of El Dorado County Health and Human Services Agency, Stanislaus County Behavioral Health Director, SJC County Administrator, St. Joseph's Hospital Chief Executive Officer, Doctors Medical Center Modesto Chief Medical Officer, Friends Outside Executive Director, community physicians, and local representatives of San Joaquin, Stanislaus, and Alpine County.

Health Plan leadership is accountable to this governing entity. Within this structure is Health Plan's operations and administration:

Health Plan Quality Management Committees



SECTION 1: INTRODUCTION

INTENT OF THE PROVIDER MANUAL

The Provider Manual is an extension of the Agreement that Providers entered into with Health Plan. Providers must abide by the conditions set forth in their Agreement and in the Provider Manual. Certain sections and provisions of this Manual may not apply to all Agreements and lines of business or products.

Health Plan may, from time to time, be required to make material changes to the Provider Manual to comply with:

- Federal and/or State laws
- Regulations of government agencies governing Benefit Plans covered by their Agreement
- Regulations of accreditation organizations
- Changes in Health Plan policies and/or procedures

Should Health Plan determine that a change to the Provider Manual is required, Health Plan shall provide Providers with forty-five (45) business days prior written notice of said changes to Provider Manual unless a shorter time frame is required by a State law, Federal law, government regulations or an accreditation organization.

Such changes shall become effective upon the expiration of forty-five (45) business days. If a Provider believes that such changes shall have a material impact on the Provider, then Provider shall notify Health Plan in writing prior to the effective date of the change and the Provider and Health Plan shall confer and/or negotiate in good faith regarding the change. If Health Plan agrees that such changes shall have a material impact on Provider, and Provider and Health Plan are unable to reach agreement regarding the change within forty-five (45) business days of Provider's notice to Health Plan, then the Provider may elect to terminate their Agreement pursuant to the "Termination without Cause" provision in their Agreement. The change to which the Provider objected shall not be in effect during the termination notice period.

If there are conflicts between this Manual and current State and Federal laws and regulations governing the provision of health care services, those laws and regulations will supersede this Manual.

The Provider Manual is intended to be used as a reference guide for Providers and their office staff. It includes:

- Operational Procedures
- Key Contacts
- Links to Resources
- Compliance Information

SECTION 1: INTRODUCTION

HOW TO USE THE PROVIDER MANUAL

The Provider Manual has been designed to be easy to search for and access through our website. Providers can go to www.hpsj-mvhp.org and access the Manual directly online. You can also download it by section or in its entirety. To obtain a copy, go to our online portal Doctor's Referral Express (DRE) or call our customer service line at 1-888-936-7526.

SECTION 2: BENEFIT PROGRAMS

HEALTH PLAN MEDI-CAL MANAGED CARE (HMO)

Medi-Cal is California's Medicaid health care program serving children and adults with limited or no income. People eligible for coverage include families, seniors, people with disabilities, children in foster care, pregnant women and childless adults who meet certain income and eligibility requirements. Health Plan provides high quality, accessible and cost-effective health care to Medi-Cal Members through our managed care delivery system which is structured as a health maintenance organization (HMO). Our Medi-Cal product in San Joaquin, Stanislaus, Alpine and El Dorado counties provides a full range of medical benefits and Covered Services.

A primary advantage for Medi-Cal individuals enrolling in Health Plan is the opportunity to develop ongoing relationships with Primary Care Physicians (PCP) and other Participating Providers (Providers) in a Group or clinic that can support preventative as well as acute care. The primary benefit to Providers is the ability to better coordinate and more efficiently manage Member care by working with a local managed care plan.

OBTAINING COVERAGE AND EXCLUSIONS INFORMATION

Health Plan covers, at a minimum, those medically necessary core benefits and services specified in the agreement with the California Department of Health Care Services (DHCS). Excluded services will not be reimbursed by Health Plan. To ensure that the services provided to Members are covered, please review the *Medi-Cal Combined Evidence of Coverage and Disclosure Form* for the appropriate year. This document can be found on Health Plan's website www.hpsj-mvhp.org.

If you are not currently part of Health Plan's Provider network, you can still access *Health Plan's Medi-Cal Combined Evidence of Coverage and Disclosure Form* on our website. You can also obtain information from the DHCS Medi-Cal Benefits Division at www.dhcs.ca.gov or visit the Medi- Cal website at www.medi-cal.ca.gov.

SERVICES COVERED BY HEALTH PLAN

Covered Services refers to the health care services and items Health Plan provides to its Members through its health care programs. Health Plan's health care programs currently include Medi-Cal and Medicare Dual Special Needs Plan (D-SNP) HMOs, but may also include other health care programs and/or products that Health Plan may offer to individuals or other entities.

SERVICES NOT COVERED BY HEALTH PLAN

Non-Covered Services typically refer to the following health care services and items:

- Health care services and items which are not the financial responsibility of Health Plan but are covered on a fee-for-service basis by the Medi-Cal Program
- Health care services and items which are not covered by the Medi-Cal program
- Health care services and items which are not covered under any other Health Plan health care program (excluded services)

For excluded services for Health Plan's Medi-Cal HMO program, please review

the *Medi-Cal Evidence of Coverage, Benefits and Services,* which is available on the website at www.hpsj-mvhp.org.

ENHANCED CARE MANAGEMENT (ECM)

California Advancing and Innovating Medi-Cal (CalAIM) is an initiative led by DHCS that aims to improve the quality of life and health outcomes of Medi-Cal beneficiaries. Enhanced Care Management (ECM) and Community Supports are part of CalAIM.

Enhanced Care Management (ECM) is a Medi-Cal managed care benefit that addresses clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management.

ECM Populations of Focus include:

- Individuals and Families Experiencing Homelessness
- Individuals At Risk for Avoidable Hospital or ED Utilization Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Adults Transitioning from Incarceration
- Adults Living in the Community and at Risk for LTC Institutionalization
- Adult Nursing Facility Residents Transitioning to the Community
- Birth Equity (Adults and Youth)
- Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness
- Children and Youth at Risk for Avoidable Hospital or ED Utilization
- Children and Youth with Serious Mental Health and/or SUD Needs
- Children and Youth Transitioning from a Youth Correctional Facility
- Children and Youth Enrolled in CCS or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition
- Children and Youth Involved in Child Welfare

ECM Providers who are contracted with Health Plan to provide ECM services must adhere to the following provider terms and conditions in accordance with their contract and requirements as set forth in this provider manual.

Providers of Enhanced Care Management (ECM) are required to:

- Be community-based entities, with experience and expertise providing intensive, in-

person care management services to individuals in one or more of the populations of focus for ECM.

- Comply with all applicable state and federal laws and regulations and all ECM program requirements.
- Have capacity to provide culturally appropriate and timely in-person care management activities, including accompanying Members to critical appointments when necessary.
- Deliver care in culturally and linguistically appropriate and accessible ways.
- Have formal agreements and processes in place to collaborate and coordinate care with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, including community support providers.
- Use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the Member care plan.
- Enroll as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters, including Provider Credentialing/Recredentialing and Screening/Enrollment (APL 22-013), if a state-level enrollment pathway exists. DHCS All Plan Letters (APLs) may be found here, www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
- Comply with Health Plan's process for vetting the provider, which may extend to individuals employed by or delivering services on behalf of the provider, to ensure it can meet the capabilities and standards required to be a provider of ECM if APL 22-013 does not apply to a provider.
- ECM providers outreach potential members to offer ECM program and have 30 days to engage the members before requesting authorization to avoid or delay member care. HPSJ/MVHP requires ECM referral form for initial authorization and a care plan for extension of services beyond 12 months.
- Provider should immediately alert Health Plan if it does not have the capacity to accept an ECM referral.
- Provider should ensure assignments are conducted in an equitable and non-discriminatory manner.
- Upon initiation of ECM, ensure each Member assigned has a lead care manager who interacts directly with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), specialty mental health services, drug Medi-Cal organized delivery system services, and any community supports and other services that address social determinants of health (SDOH) needs, regardless of setting.
- Advise the Member on the process of switching providers, which is permitted at any time. Provider should conduct due diligence to notify Health Plan if the Member wishes to change Providers.

- Maintain adequate staff to ensure its ability to carry out responsibilities for each assigned Member, consistent with contractual obligations and any other related DHCS guidance.
- Be responsible for conducting outreach and engagement to each assigned Member into ECM, in accordance with Health Plan's policies and procedures. Providers should prioritize those with highest level of risk and need for ECM.
- Outreach should be conducted primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.
- Provider should use the following modalities, as appropriate and as authorized by the member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: Mail, Email, Texts, Telephone Calls, and Telehealth.
- Comply with non-discrimination requirements set forth in State and Federal law and the agreement with Health Plan.
- Obtain, document, and manage Member authorization for the sharing of personally identifiable information between Health Plan and ECM, Community Supports, and other providers involved in the provision of Member care to the extent required by federal law.
    - Member authorization for ECM-related data sharing is not required for the provider to initiate delivery of ECM unless such authorization is required by federal law.
    - When federal law requires authorization for data sharing, provider should demonstrate that it has obtained Member authorization for such data sharing back to Health Plan.
- Provider shall notify Health Plan to discontinue ECM in a timely manner (no greater than 10 business days) under the following circumstances:
    - The Member has met their care plan goals for ECM.
    - The Member is ready and consents to transition to a lower level of care.
    - The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
    - Contact with the Member has been unsuccessful despite multiple documented attempts.
- When ECM is discontinued, or will be discontinued for the Member, the provider is responsible for sending a closure of case management notice to the Member with a copy to Health Plan
- Providers should document and submit a report of the Members who have declined/opted out of ECM services, or remain unable to reach for each month, no later than the 15th of the following month.
- Provider should communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).

- When ECM is discontinued, or will be discontinued for the Member, Health Plan is responsible for sending a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA.
- Providers of ECM should ensure:
    - The ECM approach is delivered in a person-centered, goal oriented, and culturally appropriate manner.
    - Each Member receiving ECM has a lead care manager.
    - Each Member has a written, prioritized, culturally relevant individualized care management plan.
    - Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources.
    - Alert Health Plan and follow Health Plan instructions to ensure non-duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources.
    - To collaborate with area hospitals, primary care providers, behavioral health providers, specialists, dental providers, providers of services for LTSS and community support providers to coordinate member care.
- Provider shall provide all core service components of ECM as noted below to each assigned Member, in compliance with Health Plan's policies and procedures:
    - Outreach and engagement of Health Plan members into ECM.
    - Provider shall make five (5) attempts over the course of 30 days.
    - Comprehensive assessment and care management plan, which shall include, but is not limited to:
        a. Engaging with each Member authorized to receive ECM primarily through in- person contact
        b. When in-person communication is unavailable or does not meet the needs of the Member, the provider should use alternative methods (including telehealth) to provide care.
        c. Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and as may be needed to inform the development of an individualized care management plan.
        d. Develop a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.
        e. Incorporate into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary

community based and social services, and housing;
f. The care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the care management plan; and
g. The care management plan is reviewed, maintained, and updated under appropriate clinical oversight.

- Enhanced Coordination of Care, which shall include, but is not limited to:
  a. Organizing patient care activities, as laid out in the care management plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the member's care management plan.
  b. Maintaining regular contact with all providers, that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of member goals and needs.
  c. Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed.
  d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment.
  e. Communicating the Member's needs and preferences timely to the Member's multi- disciplinary care team in a manner that ensures safe, appropriate, and effective person- centered care; and
  f. Ensuring regular contact with the Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.
- Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b) and shall include, but is not limited to:
  a. Working with Members to identify and build on successes and potential family and/or support networks.
  b. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- Comprehensive Transitional Care, which shall include, but is not limited to:
  a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM.

b. For Members who are experiencing, or who are likely to experience, a care transition, ensuring these transitions are effective by completing the following:
    i. Developing and regularly updating a transition of care plan for the Member.
    ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges.
    iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;
    iv. Coordinating medication review/reconciliation; and
    v. Providing adherence support and referral to appropriate services especially with regard to ensuring follow-up appointments are made and kept, and that Transitional Care Services continue until Members are connected to all needed services and supports.

- Member and family Supports, which shall include, but are not limited to:
    a. Documenting a Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and Health Plan.
    b. Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws.
    c. Ensuring the Member's provider serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s).
    d. Identifying support needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services.
    e. Providing for appropriate education of the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the member; and,
    f. Ensuring that the Member and the primary care provider has a copy of their care plan and information about how to request updates.
- Coordination of and Referral to Community and Social Support Services which shall include, but are not limited to:
    a. Determining appropriate services to meet the needs of Members, including services that address Social Determinants of Health (SDOH) needs, including housing, and services offered by Health Plan as community supports; and,
    b. Coordinating and referring Members to available community resources and

following up with members to ensure services were rendered (i.e., "closed loop referrals").

- In addition to all ECM and community support requirements noted, providers should
  - Participate in all mandatory, provider-focused ECM training and technical assistance provided by Health Plan including in-person sessions, webinars, and/or calls, as necessary.
- Accept and consume data associated with ECM. Health Plan will follow DHCS guidance for data sharing where applicable.
- Health Plan will provide to provider the following data for ECM:
  - Member assignment files, defined as a list of Medi-Cal members authorized for ECM and assigned to the provider.
  - Encounter and/or claims data.
  - Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned members; and
  - Reports of performance on quality measures and/or metrics, as requested.

COMMUNITY SUPPORTS

Community supports are flexible wraparound medical or social services that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. They are provided as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. Examples include housing navigation, recuperative care, and meals/medically tailored meals. These services are optional for the plan to offer and beneficiary to accept.

DHCS has preapproved 15 community supports as part of CalAIM. Plans, such as Health Plan, may elect the community supports they will provide and may elect to add or remove after the implementation. Health Plan offers the following community supports for San Joaquin, Stanislaus, Alpine and El Dorado counties.

- Housing Navigation and Transition Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post Hospitalization Housing
- Recuperative Care
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation
- Environmental Accessibility Adaptations (Home Modifications)
- Day Habilitation Programs
- Personal Care and Homemaker Services
- Respite Services
- Assisted Living Facility (ALF) Transitions

- Community or Home Transition Services
- Transitional Rent

Providers of community supports are required to:

- Be community-based medical and social service providers with experience and/or training in providing one or more of the community supports approved by DHCS.
- Enroll in Medi-Cal, pursuant to DHCS APLs, including APL 22-013, Credentialing/ Recredentialing and Screening/Enrollment, if a State-level enrollment pathway exists. If APL 22-013 does not apply to a community support provider, the community support provider will comply with Health Plan's process for vetting the community support provider, which may extend to individuals employed by or delivering services on behalf of the community support provider.
- The community support provider shall have the capacity to provide the community support in a culturally and linguistically competent manner.
- If the community support provider subcontracts with other entities to administer its functions of community supports, the community support provider shall ensure agreements with each entity bind each entity to applicable terms and conditions.
- Deliver contracted community support services in accordance with DHCS service definitions and requirements.
- Maintain staffing that allows for timely, high-quality service delivery of the community supports that it is contracted to provide.
- Accept and act upon Member referrals from Health Plan for authorized community support unless the community support provider is at pre-determined capacity.
- Follow Health Plan community support authorization guidelines.
- Conduct outreach to the referred member for authorized community support as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment.
- Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week.
- Coordinate with other providers in the Member's care team, including ECM Providers, other community support providers and Health Plan.
- Comply with cultural competency and linguistic requirements required by Federal, State and local laws, and in contract(s) with Health Plan; and

- Comply with non-discrimination requirements set forth in State and Federal law and the contract with Health Plan.
- When federal law requires authorization for data sharing, community support provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to Health Plan.
- Member authorization for community supports-related data sharing is not required for the community support provider to initiate delivery of community supports unless such authorization is required by federal law. Community support providers will be reimbursed only for services that are authorized by Health Plan. In the event of a Member requesting services not yet authorized by Health Plan, community support provider shall send prior authorization request(s) to Health Plan, unless a different agreement is in place (e.g., if Health Plan has given the community support provider authority to authorize community supports directly).
- If a community support is discontinued for any reason, community support provider shall support transition planning for the Member into other programs or services that meet their needs.
- Community support provider is encouraged to identify additional community supports the Member may benefit from and send any additional request(s) for community supports to Health Plan for authorization.
- As part of the referral process, Health Plan will ensure community support provider has access to:
    - Demographic and administrative information confirming the referred Member's eligibility for the requested service.
    - Appropriate administrative, clinical, and social service information the community support provider might need in order to effectively provide the requested service; and
    - Billing information necessary to support the community supports provider's ability to submit invoices to MCP.
- ECM and Community Supports Claims/Billing:
    - ECM and community support providers that have capabilities to submit claims should submit to Health Plan via CMS 1500, UBO4 form or submitted Electronic Data Interchange (EDI) in accordance with ECM and Community Supports coding guidance.
    - The Department of Health Care Services (DHCS) requires Medi-Cal Managed Care Health Plans (MCP) to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates. For ECM and Community Supports, plans will be required to submit encounter data for these services through the existing encounter data reporting mechanisms for all covered services.
    - Providers are required to submit claims/encounters for adequate data collection and in accordance with the reporting requirements of their contract. ECM and

Community Supports providers must use the Healthcare Common Procedure Coding System (HCPCS) codes for ECM services. The HCPCS code and modifier combined define the service as ECM.

  - DHCS Coding Guidance for ECM and Community Supports www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

- ECM Claims/Billing Guidelines
  - One unit represents a 15-minute interval.
  - One claim per Member per month (PMPM) should be submitted. From and through dates should equal the month of service provided.
  - ECM outreach should be billed with respective HCPCS codes and will be reimbursed at specified rate.

If an ECM service is provided through telehealth, an additional modifier of GQ must be used.

- Community Supports Claim/Billing
  - Providers should bill with applicable HCPCS codes for the Community Support they will be providing as per the designated HCPCS codes.
  - If Community Supports is provided through telehealth, an additional modifier of GQ must be used.
  - Housing services such as housing tenancy and sustaining services and housing transition navigation services are paid on a PMPM basis and should include the appropriate HCPCS code and modifier combination on the first line of the claim.
- Please Note: These guidelines are intended for educational purposes only and are subject to change.

Please refer to the DHCS CalAIM, Enhanced Case Management and Community Supports website for proper billing guidelines at www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

Community Health Workers (CHWs)

Health Plan covers community health worker (CHW) benefits for individuals when recommended by a physician or other licensed practitioner to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. CHW services are considered preventative care services and Medi-Cal covered benefits.

Services may include:

- Health education and training, including control and prevention of chronic or infectious diseases; behavioral, perinatal and oral health conditions; and injury prevention
- Health promotion and coaching, including goal setting and creating action plans to address disease prevention and management
- Screening and assessment that does not require a license to assist Members to obtain services to improve their health
- Individual support and advocacy

CHWs are required to meet minimum provider requirements and qualifications through training

and experience as specified by DHCS, including having life experience with the population they are serving and can connect members with health and social services.

CHWs are required to have a supervising provider who should be a licensed provider, a hospital, an outpatient clinic or a local health jurisdiction (LHJ) or a community-based organization (CBO). CHWs must demonstrate, and Supervising Providers must maintain evidence of minimum qualifications through one of the pathways outlined in APL 24-006 and as determined by the Supervising provider. DHCS All Plan Letters (APLs) may be found here, www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Licensed provider should ensure that the Member meets eligibility criteria before recommending CHW services, as defined by DHCS. No prior authorization is required. For Members who may need ongoing CHW services or continued CHW services, a written plan of care may be required.

Street medicine Providers can also be reimbursed for providing State Plan benefits, including the use of CHW services as defined in 42 CFR 440.130(c) and APL 22-016. Health Plan is responsible for ensuring non-duplication of services provided by a CHW and any other covered benefit, program, and/or delivery system.

For any questions regarding the referral process for CHW services please contact your Provider Services Representative or Health Plan's Utilization Management Department at 1-888-936-7526.

Electronic Visit Verification (EVV) for In-Home Visits

EVV is required for personal care services (PCS) and home health care services (HHCS) for in-home visits by a Provider. This includes PCS and HHCS delivered in the Members' homes as part of a Community Based Adult Services (CBAS), Community Supports or any other Medi-Cal benefit.

Providers rendering Medi-Cal services subject to Electronic Visit Verification (EVV) must comply with the requirements established by DHCS.

Health Plan monitors compliance with these requirements. Non-compliance with these requirements can result in corrective action, denial of payment and/or reassignment of members.

Registering for Electronic Visit Verification (EVV)

In California, Electronic Visit Verification (CalEVV) is a telephone and computer-based solution that electronically verifies when in-home service visits occur for Personal Care Services (PCS) and Home Health Care Services (HHCS).

Health Plan providers and subcontractors that provide in-home visits, in accordance with the DHCS guidelines, must sign up with DHCS's EVV system.

Provider agencies and individual nurse providers (INPs) who provide PCS and HHCS are required to register in the Provider Self Registration portal.

More information can be found on the DHCS website:
www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx

All Plan Letter 22-014 provides additional guidance regarding the implementation of federally mandated Electronic Visit Verification (EVV) requirements. DHCS All Plan Letters (APLs) may be found here, www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

For submitting claims for Personal Care Services (PCS) and Home Health Care Services (HHCS) for In-Home Visits, see Section 10 – Claims Submission.

MAJOR ORGAN TRANSPLANT

Transplants for Children Under Age 21

State law requires children who need transplants to be referred to the California Children's Services (CCS) program to see if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for the transplant and related services. If the child is not eligible for CCS, prior authorization should be requested from Health Plan. If appropriate, Health Plan will refer the child to a qualified transplant Center of Excellence (COE) for evaluation. If the transplant center confirms the transplant would be needed and safe, Health Plan will cover the transplant and related services.

Transplants for Adults Age 21 and Older

If you identify a Health Plan member who needs a major organ transplant, you should request prior authorization from Health Plan. As appropriate, Health Plan will refer the member to a qualified transplant COE facility for an evaluation. If the COE confirms a transplant is needed and safe for their medical condition, Health Plan will cover the transplant and other related services.

Transplants are covered under Health Plan if:

1. The transplant is performed at COE facility
2. The Member meets patient selection criteria for the transplants below.

Transplant and services covered by Health Plan are:

- Bone marrow
- Heart
- Heart/Lung
- Kidney/Pancreas
- Liver
- Liver/Small bowel
- Lung
- Pancreas
- Small bowel

Other Transplants covered by Health Plan:

- Autologous Islet Cell
- Cornea
- Kidney

Please contact Health Plan's Case Management team at 1-209-942-6352 if you need further assistance.

MEDI-CAL RX TRANSITION

Under guidance of California Governor Gavin Newsom's Executive Order N-01-19, DHCS has transitioned all outpatient pharmacy dispensing services from the managed care (MC) plans to Medi-Cal Rx. This was to provide standardization of the Medi-Cal pharmacy benefit statewide, under one pharmacy benefit manager. Doing so allowed improvement of Medi-Cal beneficiary access to pharmacy services with a pharmacy network that includes approximately 94% of the state's pharmacies.

Additional resources and information can be found at https://medi-calrx.dhcs.ca.gov/provider/

SECTION 3: CREDENTIALING

CREDENTIALING

Credentialing is an important function of the Quality Improvement and Health Equity (QIHE) Department. Health Plan's credentialing program has been developed in accordance with the standards of the National Committee for Quality Assurance (NCQA), the California Department of Health Care Services (DHCS), California Department of Managed Health Care (DMHC), and all other State and federal requirements. Health Plan initially credentials most health care Providers seeking to participate in the network and recredentials them at least every three (3) years. Credentialing information submitted to Health Plan is reviewed and primary source verified, as applicable using NCQA and DHCS approved sources. To verify information, Health Plan uses the same sources and processes for initial credentialing and recredentialing.

In order to ensure the highest quality health care delivery system and to maintain compliance with regulatory and accreditation agencies, Health Plan credentials or oversees the credentialing of the following types of Providers:

- Physicians (MD)
- Osteopathic Practitioners (DO)
- Podiatrists (DPM)
- Nurse Practitioners (NP)
- Chiropractors (DC)
- Dentists (DMD)/Oral Surgeons that provide services under the medical benefit
- Physician Assistants (PA)
- Nurse Midwives (NMW)
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities and have an independent relationship with Health Plan
- Locum Tenens practitioners including physicians, dentists, chiropractors, optometrists, social workers, and psychologists after 90 calendar days of continuous service.
- Practitioners who are hospital-based but who see members as a result of their independent relationship with Health Plan including, but not limited to:
    - Anesthesiologists with pain management practices
    - Cardiologists
    - University faculty who are hospital-based and who also have private practices.

In addition, Health Plan also credentials the following allied health professional Providers:

- Psychologists
- Optometrists
- Physical Therapists
- Chiropractors
- Speech/Hearing Therapists
- Telemedicine Providers
- Audiologists
- Mental Health and Substance Use Disorder Provider
- Addiction Specialists
- Occupational Therapists
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage Family Therapists (LMFT)
- Clinical Nurse Specialists
- Other allied providers as deemed necessary
- Street Medicine Providers
- Clinical Nurse Specialists
- Board Certified Behavioral Analysts (BCBA)

In accordance with Health Plan policies and procedures, the credentialing process typically takes between 60 and 90 days. Within 120 days of receipt of a provider application, Health Plan shall complete the enrollment process and provide the applicant with written determination.. For Mental Health and Substance Use Disorder Providers, Health Plan will notify them within seven (7) business days of receipt of a credentialing application to: 1) verify receipt; and 2) inform the Provider whether the application is complete. The information gathered during this process is confidential and disclosure is limited to parties who are legally permitted under State and federal law to have access to this information.

In order to maintain health care quality standards, Members may not be assigned to Providers until credentialed, however we do refer members to specialists and locum providers and they can see members without credentialing for 90 days.

OBTAINING A CREDENTIALING APPLICATION

For New Contract Opportunities or for Existing Contracted Providers, contact the Contracting Department by visiting www.hpsj.com/provider-contract-request

A Contracting Coordinator or Network Manager will screen Provider for Medi-Cal Fee for Service Enrollment or submission prior to contacting the Credentialing Department to send out the Electronic Credentialing application.

REQUIREMENTS FOR NETWORK PARTICIPATION

Requirements for Physicians

Health Plan will ensure that at a minimum, physicians considered for network participation and continued participation are in good standing (through Primary Source Verification, as applicable), the sources and processes used at initial credentialing and re-credentialing to verify information are the same and meet the following criteria before being accepted in the network:

- Valid, unrestricted, and current California State license
- Medi-Cal Fee for Service or Ordering, Prescribing, and Referring (ORP) Enrollment
- Clinical privileges at a Hospital or coverage arrangements with another physician for Members who require hospitalization (if applicable)
- Current and valid federal Drug Enforcement Agency (DEA) registration or Controlled Dangerous Substance (CDS) certificate for the State
- Graduation from an approved medical school and completion of an appropriate residency or specialty program
- Board certification (if required)
- Work history of the preceding five (5) years acceptable to Health Plan
- Current professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Professional liability claims history acceptable to Health Plan
- Absence of Office of Inspector General (OIG) exclusions
- Absence of State sanctions against licensure
- National Practitioner Data Bank (NPDB) query results acceptable to Health Plan
- Absence of Medicare and Medi-Cal/Medicaid sanctions
- Absence of Quality of Care and service issues
- Facility Site Review (FSR) findings acceptable to Health Plan, if an office site visit is conducted

For recredentialing, acceptable findings from quality reporting are required. This may include but is not limited to a review of:

- Member and Provider complaints
- Results of access and satisfaction surveys
- Grievance reports
- Potential Quality Incident (PQI) reporting

Requirements for Non-Physician Providers & Non-Physician Medical Practitioners

Health Plan shall ensure, at a minimum, that non-physician Providers and Non-Physician Medical Practitioners considered for network participation and continued participation are in good standing (through primary source verification, as applicable) and meet the following criteria before being accepted in or continue participation in the network:

- Valid, unrestricted, and current State license
- For prescribing practitioners, current, valid federal Drug Enforcement Agency (DEA) registration or Controlled Dangerous Substance certificate for the State

- Work history of the preceding five (5) years acceptable to Health Plan
- Current professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Graduation from an approved professional school
- Board certification, if applicable
- Hospital clinical privileges, if applicable
- Professional liability claims history acceptable to Health Plan
- Absence of Office of Inspector General (OIG) exclusions
- Absence of State sanctions against licensure
- National Practitioner Data Bank (NPDB) query results acceptable to Health Plan
- Absence of Quality of Care and service issues

THE CREDENTIALING PROCESS

During the credentialing process, the information on the Provider's electronic credentialing application is reviewed and verified for correctness, and then reviewed through government verification sources which will include, but not be limited to:

- National Practitioner Data Bank (NPDB)
- Office of Inspector General (OIG)
- State licensing boards for California and other states if applicable

In addition to providing documentation, a Facility Site Review (FSR) may be required for Primary Care Physicians (PCP). Providers will be contacted by Health Plan's FSR Team to schedule and coordinate the FSR.

Completed electronic credentialing applications will then be presented to the Peer Review & Credentialing Committee (PR&CC) which currently meets every other month. The PR&CC reviews each credentialing application to determine if the Provider meets the initial credentialing or recredentialing criteria and then makes the decision to either accept or reject a Provider's application.

All credentialing applications approved by the PR&CC are submitted to the San Joaquin County Health Commission for review and final approval. The Commission meets monthly and once the Commission grants approval, Health Plan can offer or complete an Agreement with the Provider.

INITIAL CREDENTIALING

The Provider data that is examined during the credentialing and recredentialing process includes:

- California State licensure
- Medi-Cal Fee for Service or Ordering, Referring, and Prescribing (ORP) Enrollment
- Current professional liability insurance or self-insurance
- Provider's primary admitting hospital, if appropriate
- Exclusions, suspensions, or ineligibility to participate in any State or federal health care program

- National Provider Identification (NPI) number
- Valid California Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate, if applicable
- Education and training, including board certification (if the Provider states on the application that he or she is board certified)
- American Medical Association (AMA) screening for Education Commission for Foreign Medical Graduates (ECFMG)
- Work history
- History of professional liability claims
- National Practitioner Data Bank
- Licenses of any mid-level Providers employed under the Provider, as well as verification of liability insurance coverage for the mid-level Provider.

RECREDENTIALING

Health Plan re-credentials all Providers at least every three (3) years but may re-credential Providers more often if it is deemed necessary. The same information that is reviewed during the initial credentialing process is usually reviewed during the recredentialing process with the exception of the Provider's educational credentials and work history. In addition, Health Plan will review Provider contact logs to assess any Quality-of-Care issues.

The recredentialing process requires a timely response from all Providers. Providers will receive an electronic recredentialing link five (5) months in advance of the three (3) year anniversary of the last credentialing date. Providers are required to complete identified areas of the application and verify that the information provided on the application is current. Electronic Recredentialing packets are sent to practitioners at least every thirty-six (36) months or sooner.

The practitioner has 15 business days to send the recredentialing materials to Health Plan. If materials are not received within that timeframe, the Credentialing Specialist sends a second request on the 16th day. If the recredentialing materials are not received 15 business days after the second notice, on the 16th day, a THIRD AND FINAL notice is sent to the practitioner via email by the Contracting Department.

If the recredentialing materials are not received within 15 business days of the final notice, on the 16th day, the Credentialing Specialist notifies the Contracting Department. The Contracting Department attempts to obtain the materials. If unable to do so, the Contracting Department notifies the practitioner that he or she will receive an Administrative Termination via Certified Mail as the recredentialing appointment date has expired.

A practitioner may reapply for participation however the full initial credentialing process will be required.

PROVIDER'S RIGHTS DURING THE CREDENTIALING PROCESS

Review of Credentialing Files

Providers have the right to review the information in their credentialing files that have been

obtained in order to evaluate their credentialing application. This includes the application, attestation, and Curriculum Vitae (CV), and information from outside sources. Credentialing information that is not available for review includes references, recommendations, or other peer-review protected information as this information is used by the Chief Medical Officer and/or PR&CC to determine initial network participation and/or contract continuance.

Requests to review this file must be made in writing to the Chief Medical Officer, and the Chief Medical Officer will be present at the time of review.

Notification of Errors in Credentialing Submissions

Providers have the right to be notified in the event that credentialing information obtained by Health Plan varies substantially from that provided by the Provider on the application materials, Health Plan Credentialing Specialists will notify the Provider by letter, telephone, or fax. If the notification is conducted by telephone, the date, time, and the person initiating the call and obtaining the information along with the response will be documented and the documentation retained in the credentialing file.

The notification to the Provider will include the following:

- A description of the discrepancy
- A request for a written explanation and/or correction of the discrepancy
- The name and telephone number of the Credentialing Specialist to whom the response should be submitted
- Notification that a written response is due no later than sixty (60) calendar days from the date of the letter
- Notification that failure to respond within the sixty (60) calendar days will result in, for initial application, closure of the file for lack of response
- For recredentialing Providers, notification that the file will be presented to the Peer Review and Credentialing Committee without benefit of explanation or correction of the discrepancy

The Credentialing Specialist will review the response, sign and date the response, and then notify the Provider that the response has been received. The Credentialing Specialist will also document the receipt and notification to the Provider of the receipt of the information in the credentialing file. Health Plan staff members are not required to reveal to a Provider the source of the information if the information is not obtained to meet Health Plan's credentialing verification requirements, or if law prohibits disclosure.

Correction of Erroneous Information

Providers have the right to correct erroneous information they may have provided within 14 business days, or which has been submitted by another party in the course of the credentialing process. If information provided on the application is inconsistent with information obtained via Primary Source Verification in the credentialing or recredentialing process, the Credentialing Specialist will send the Provider a written notification of the discrepancy and request formal written clarification.

This letter will include a summary of the information in question and a request to have the Provider's written response to the information returned within fourteen (14) business days. This letter will be sent electronically or via certified mail marked as "Confidential" with return receipt requested.

Providers do not have the right to correct an application already submitted and attested to be correct and complete. Providers have the right to correct erroneous information prior to the notification of decision and for applications that have not yet been attested to be correct and complete. However, they may submit an addendum to correct erroneous information they may have provided, or which is submitted by another party. This can be sent to the Credentialing Specialist via electronic or certified mail. If preferred, the Provider may add an explanation for the erroneous information on their application, include a signed and dated statement attesting to the accuracy of the information provided, and then return the information to the Credentialing Specialist who initiated the query.

Application Status and Notification on Decision

Providers have the right to receive information about the status of their application or reapplication and may contact the Credentialing Department at any time to request this information. Upon request, the Credentialing Specialist will provide information regarding the current stage of the application process, such as in progress/pending or awaiting additional information or clarification. The Credentialing Department will respond to these requests in writing no later than 60 days after receipt of request.

Health Plan will notify Providers in writing of their approval no later than sixty (60) calendar days from the Peer Review and Credentialing Committee's (PR&CC) approval date. Any Provider who is denied participation, approved with conditions, pended or terminated, will be notified in writing within sixty (60) days of the PR&CC's action and given the reasons for the decision.

Notification of Provider Rights

Health Plan notifies Providers of these rights through a number of methods, which includes notifications in the credentialing application or reapplication cover letter, written and web-based Provider Manual, and other publications distributed to Providers.

CREDENTIALING A NEW GROUP PROVIDER

To ensure that there is no disruption in obtaining services requiring prior authorization and to avoid claims being denied, it is imperative that any new Provider who joins a Group in Health Plan's Provider network is approved by the PR&CC prior to providing Covered Services to Members.

Before a Provider can be added to a Group contract the new Provider must receive notification from the Credentialing Department that all credentialing requirements have been met. In addition, Providers must receive official notice from the Contracting Department as to the effective date upon which they can provide Covered Services to Members. The Provider Services Department should be contacted as soon as possible when new Providers are joining a Group.

ECM Providers

Health Plan will ensure all ECM Providers for whom a state-level enrollment pathway exists enroll in Medi-Cal (www.dhcs.ca.gov/provgovpart/Pages/PED.aspx), pursuant to relevant DHCS All Plan Letters (APLs), including APL 22-013 (Provider Credentialing/Recredentialing and Screening/Enrollment) and any subsequent APLs. If APL 22- 013 and other subsequent APLs do not apply to an ECM Provider, HPSJ will verify qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. HPSJ will ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.

Credentialing Provider Organization Certification

Health Plan may obtain Credentialing Provider Organization Certification (POC) from the NCQA. Health Plan may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.

Site Review Process

When appropriate and at the sole discretion of the health plan credentialing & re-credentialing may be delegated:

- **Facility Site Review (FSR):** a formal review of primary care sites that occurs prior to the practice accepting Medi-Cal Managed Care Members, and then every three (3) years thereafter.
- **Medical Record Review (MRR):** A review of selected medical records to determine compliance in the documentation of clinical care
- **Physical Accessibility Review Survey (PARS):** A review to determine physical accessibility for seniors and people with disabilities
- **Focused Review:** A focused review is a targeted review of one or more specific areas of the FSR or MRR. The Plan must not substitute a focused review for a site review. The Plan may use focused reviews to monitor Providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions. Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to the Corrective Action Plan (CAP) timelines.

All new primary care sites must undergo an initial full scope site review and attain a minimum passing score of eighty percent (80%) on both the FSR and on MRR surveys. Initial full scope site reviews will be performed at sites that have not previously had a FSR, PCP sites that have not had a FSR within the past three (3) years, and PCP sites that are returning to Medi-Cal Managed Care and have a passing score but were previously terminated for cause and non-compliance with their CAP.

There are additional scenarios that require Health Plan to conduct an initial site review. Examples of these scenarios include, but are not limited to, instances when:

- A new PCP site is added to the Plan's network.
- A newly contracted Provider assumes a PCP site with a previous failing FSR and/or MRR

score within the last three years.

- A PCP site is returning to the Medi-Cal managed care program and has not had a passing FSR in the last three years.
- There is a change of ownership of an existing Provider site.
- A PCP site relocates.

When a PCP site relocates, Health Plan must:

- Complete an initial FSR within 60 days of notification or discovery of the completed move.
- Allow assigned Members to continue to see the Provider.
- Not assign new Members to Providers at the site until the PCP site receives passing FSR and MRR scores.
- The reviewer will also complete a PARS during the initial site.

The FSR can be waived by Health Plan for a pre-contracted Provider site if the Provider has documented proof that a current FSR with a passing score was completed by another health plan within the past three (3) years if an memorandum of understanding (MOU) is in place between Health Plan and the collaborating MCP. Health Plan may review sites more frequently if it is determined necessary.

Non-Compliance or Failure on FSR

Pre-contractual Providers

A pre-contractual Provider who scores below 80% on the full scope site review survey shall not be counted as a network Provider. Prior to being contracted with Health Plan, a non-passing Provider must be re-surveyed and pass the Full Scope Site Review Survey at 80% or higher. After achieving a score of 80% or higher, a CAP shall be completed as specified under CAP steps. If the Provider fails the site review after the second attempt, the Provider will need to reapply to the MCP after six months from the date of the second attempt. Health Plan reserves the right not to contract with any Provider who does not pass the pre-contractual Site Review Survey.

Contracted Providers

Contracted Providers must also pass the FSR every 3-years at a score of eighty (80%) or higher. Non-passing Providers shall be notified of the survey score, all cited deficiencies, and CAP requirements at the time of the non-passed survey. Health Plan shall have the right to remove any Provider with a non-passing score from the Provider network.

Failed Audit Scores

When a PCP site receives a failing score on an FSR or MRR, the Health Plan will notify the PCP site of the score, all cited deficiencies, and all CAP requirements. The Health Plan may choose to remove any PCP site with a failing FSR or MRR score from its Network. If the Health Plan allows a PCP site with a failing FSR or MRR score to remain in its Network, the Health Plan will require and verify that the PCP site has corrected the identified deficiencies within the CAP timelines established in this policy. The Health Plan will not assign new Members to Network PCP sites that receive a failing score on an FSR or MRR until the Health Plan has verified that the PCP site has corrected the deficiencies, and the CAP is closed.

If the PCP site fails the FSR or MRR on its third consecutive attempt, despite the Health Plan's ongoing monitoring and assistance, the PCP site will not have an opportunity to complete a CAP and must be removed from the Health Plan's Provider Network. Impacted Members must be reassigned to other Network Providers, as appropriate and as contractually required. If a PCP site is removed from one Health Plan's Network due to three consecutive failing scores, all other Health Plans must also remove the PCP site from their Networks.

FSR/MRR CAP Noncompliance
Any network Provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and Members shall be appropriately re-assigned to other network Providers. Health Plan shall provide affected Members with a 30-day notice that the non-compliant Provider is being removed from the network. In addition, Provider sites that score below 80 percent in either the FSR or MRR for two consecutive reviews must score a minimum of 80 percent in the next site review in both the FSR and MRR (including sites with open CAPs in place). Sites that do not score a minimum of 80 percent in both the FSR and MRR despite Health Plan's ongoing monitoring, must be removed from the network and Members must be appropriately reassigned to other network Providers. Health Plan must provide affected Members with 30-day notice that it will remove the noncompliant Provider from the network.
Site *Review and Medical Record Review Requirements for Street Medicine:*
Street medicine Providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.

For street medicine Providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, Health Plan must conduct the full review process of the street medicine Provider and affiliated facility in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review, as stated in APL-24-001.

For street medicine Providers serving as an assigned PCP, and that are not affiliated with a brick-and mortar facility or mobile unit/RV, Health Plan must conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine Provider to ensure Member safety as per the limited/condensed (as shared by DHCS) FSR and MRR requirements that would apply only to a street medicine Provider under this scenario. (APL-24-001)

General FSR/MRR Scoring

	Exempted Pass	Conditional Pass	Fail
FSR	• Score of 90% and above with no deficiencies in critical elements, infection control, or pharmacy • CAP not required	• Score of 90% and above with deficiencies in critical elements, infection control, or pharmacy • Score of 80% to 89% regardless of deficiencies • CAP required	• Score of 79% or below • CAP required
MRR	• Score of 90% and above, with all section scores at 80% and above • CAP not required	• Score of 90% and above with one or more section scores below 80% • Score of 80% to 89% • CAP required	• Score of 79% or below • CAP required
Health Plan may require a CAP regardless of score for other findings identified during the survey that require correction.			

Corrective Action Plans for Deficiencies

All sites that receive a Conditional Pass, which is defined as eighty-to-eighty nine percent (80–89%), or ninety percent (90%) and above with deficiencies in critical elements, pharmaceutical services, or infection control, will be required to establish a CAP that addresses each of the noted deficiencies. CAP documentation must identify:

- Specific deficiency
- Corrective action(s) needed
- Re-evaluation timelines/dates
- Responsible person(s)
- Problems in completing corrective actions
- Education and/or technical assistance provided by Health Plan
- Evidence of the correction(s)
- Completion/closure dates
- Name/title of reviewer

Timelines for CAP

Providers will be informed of non-passing survey scores, critical element deficiencies, other deficiencies that require immediate corrective action, and the CAP requirements for these

deficiencies.

Below is the timeline for correction and reporting:

CAP Timeline	CAP Action(s)
FSR and/or MRR Completion Day	Health Plan must provide the PCP site a report containing: • The FSR and/or MRR scores. • Any critical element findings, if applicable; and discussion of the CE CAP and this initiates the CAP timeline for CE • A formal written request for CAPs for all critical elements, if applicable.
Within 10 business days of the FSR and/or MRR	• The PCP site must submit a CAP and evidence of corrections to the MCP for all deficient critical elements, if applicable. • Health Plan must provide a report to the PCP site containing Non-FSR and/or MRR findings, along with a formal written request for CAPs for all non-critical element deficiencies. This starts the non-CE CAP timeline • Health Plan must provide educational support and technical assistance to PCP sites as needed.
Within 30 calendar days from the date of the completed FSR and/or MRR (Audit date)	• Health Plan must conduct a focused review to verify that CAPs for critical elements are completed. • Providers can request a definitive, time-specific extension period to correct CE deficiencies, and to be granted at the discretion of the MCP, not to exceed 60 calendar days from the date of the FSR.
Within 30 calendar days from the date of the FSR and/or MRR Report (10 days after the issuance of the CAP)	• The PCP site must submit a CAP for all non-CE (FSR/MRR) deficiencies to the MCP • Health Plan must provide educational support and technical assistance to PCP sites as needed.

CAP Timeline	CAP Action(s)
Within 60 calendar days from the date of the FSR	• For those sites that were granted an extension for CE CAPs, the MCP must verify that all CE CAPs are closed.
Within 60 calendar days from the date of the FSR and/or MRR report	• The MCP must verify that non-critical CAPs are completed. • Health Plan must review, approve, or request additional information on the submitted CAP(s) for non-critical findings. • Health Plan must continue to provide educational support and technical assistance to PCP sites as needed.
Within 90 calendar days from the date of the FSR and/or MRR report	All non-critical CAPs must be closed. • Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 calendar days from the date of the FSR and/or MRR Report	• Under extenuating circumstances, MCPs can request from DHCS a definitive, time-specific extension period to allow for 1) the PCP site to complete the CAP and/or 2) the MCP to verify CAPs have been completed. • The MCP must conduct a focused FSR and/or MRR, as applicable, within 12 months of the original FSR and/or MRR date(s).

SECTION 3: CREDENTIALING

FACILITY AND ANCILLARY ASSESSMENT AND VERIFICATION

Facilities and Ancillary Providers seeking to contract with Health Plan must first fill out an application to verify they meet all regulatory and plan criteria for acceptance into the network. Application submission is not a guarantee of acceptance. The criteria for participation and continued participation may vary depending upon the types of Medi-Cal covered services provided and network need/adequacy. The minimum criteria are as follows:

Facility Providers

- Valid California state license
- Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Medicare/Medi-Cal Certification
- Accreditation by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or another accreditation body acceptable to Health Plan, if applicable
- Absence of Office of Inspector General (OIG) exclusions

Ancillary Providers

- Valid business license
- Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Medicare/Medi-Cal certified and/or participating, as appropriate
- Clinical Laboratory Improvement Amendment (CLIA) certificate if applicable
- Accreditation for Radiology/Imaging, if applicable
- Absence of Office of Inspector General (OIG) exclusions

For more information regarding specific requirements for participation, please contact the Provider Contracting Department at 1-888-936-7526.

FACILITY AND ANCILLARY ASSESSMENT AND VERIFICATION

Facilities and Ancillary Providers seeking to contract with Health Plan must first fill out an application to verify they meet all regulatory and plan criteria for acceptance into the network. Application submission is not a guarantee of acceptance. The criteria for participation and continued participation may vary depending upon the types of Medi-Cal covered services provided and network need/adequacy. The minimum criteria are as follows:

Facility Providers

- Valid California state license
- Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Medicare/Medi-Cal Certification
- Accreditation by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or another accreditation body acceptable to Health Plan, if applicable
- Absence of Office of Inspector General (OIG) exclusions

Ancillary Providers

- Valid business license
- Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Medicare/Medi-Cal certified and/or participating, as appropriate
- Clinical Laboratory Improvement Amendment (CLIA) certificate if applicable
- Accreditation for Radiology/Imaging, if applicable
- Absence of Office of Inspector General (OIG) exclusions

For more information regarding specific requirements for participation, please contact the Provider Contracting Department at 1-888-936-7526.

SECTION 4: PROVIDER CONTRACTING

BECOMING A PARTICIPATING PROVIDER

Health Plan Provider Contracting Department is responsible for recruiting providers. It is also responsible for negotiating financially sound contracts with physicians, medical groups, hospitals, ancillary providers, and other health professionals in order to maintain a comprehensive provider network.

The Department of Healthcare Services (DHCS) requires all Medi-Cal managed care plan providers, including facility and ancillary providers, to be enrolled in Medi-Cal Fee-For-Service (FFS), unless excluded.

Health Plan is required to ensure that all contracted providers are enrolled in Medi-Cal FFS. This requirement is consistent with federal regulations. The provider or their affiliated medical group is responsible for his/her own enrollment process directly with DHCS and must show evidence of current/active Medi-Cal enrollment. Please note while you are required to be Medi-Cal enrolled, you are not required to accept Medi-Cal FFS beneficiaries in your practice.

For a list of excluded or exempted provider types, please visit www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx

Ordering, Referring or Prescribing (ORP) providers must enroll either as a Medi-Cal billing provider, rendering provider, or as an ORP only (non-billing) provider

Providers who are in a medical group and do not bill Health Plan directly for services can have an ORP enrollment only. This means that if the provider intends to bill Health Plan directly, they must be enrolled with Medi- Cal.

Once Medi-Cal enrollment is confirmed, Health Plan can begin the credentialing and contracting process

To begin the contracting process, providers should first review the Credentialing Section of this Manual to determine the credentialing requirements for becoming a Provider. Once the credentialing requirements are determined to be applicable, Providers will need to complete a credentialing application on our website at www.hpsj.com/providers, or call 1-888-936-7526 to speak with a Contracting Representative.

Once the application and all required pre-contractual forms are submitted and reviewed, and the credentialing process is initiated, the Contracting Department will be in contact with the Provider to review the contracting process and address any needed questions. Providers will not be able to accept assigned Members or referrals until credentialing and Commission approval is completed and network acceptance is documented.

Please review the Credentialing Section of the manual for details.

ADDING A NEW PROVIDER TO AN EXISTING CONTRACT

When adding a new provider to an existing medical group contract, please provide at least ninety (90) days prior written notice to Health Plan's Provider Services Department. Notification to add new providers can be delivered by fax to 1-209-461-2565, or by mail to:

Health Plan of San Joaquin/Mountain Valley Health Plan
Attn: Provider Services
7751 S. Manthey Road
French Camp, CA 95231-9802

To ensure there is no disruption in obtaining authorizations, and to avoid claims denials, it is imperative that a new provider joining a medical group (that is not delegated for credentialing) is approved by Health Plan Credentialing Department prior to providing services to Members.

TERMINATING A CONTRACT

Individual providers and/or groups must give Health Plan at least ninety (90) days advance written notice of any provider leaving the practice or medical group for any reason. In addition, providers or medical groups must comply with the specific termination provisions and notice periods outlined in their contracts.

CONTINUITY OF CARE OBLIGATIONS OF TERMINATING PROVIDERS

When Providers terminate from Health Plan network for reasons other than medical disciplinary cause, fraud, or other unethical activity, they must work with Health Plan to ensure continuation of medical care to the Members assigned to them or under their care.

Providers must continue to provide Covered Services to Members who are hospitalized for medical or surgical conditions or who are under their care on the date of termination. Providers must also continue to provide Covered Services to Members until the Covered Services are completed, or until alternate care can be arranged with another provider.

Providers must ensure an orderly transition of care for case-managed Members, including but is not limited to the transfer of Member medical records.

FACILITY AND ANCILLARY CONTRACTING

Facility and ancillary providers seeking to contract with Health Plan should contact Health Plan's Contracting Department at 1-888-936-7526 and speak with a Contracting Representative. Facility and ancillary providers will be provided with the necessary applications and documents needed in order to move forward with credentialing.

SECTION 5: PROVIDER SERVICES

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

Health Plan values its relationship with Providers and Providers have the right to know what they can expect from Health Plan. Providers' Rights include but are not limited to the following:

- **Communication with Members:** The right to freely communicate with Members about their treatment, including medication treatment options, regardless of benefit coverage limitations.
- **Review of Credentialing Information:** The right to review information Health Plan has obtained to evaluate the Provider's individual credentialing application, including attestation, credentialing verification (CV), and information obtained from any outside source (e.g., malpractice insurance carriers, State licensing boards), with the exception of references, recommendations, or other peer-review protected information. Health Plan is not required to reveal the source of information if the information is not obtained to meet Health Plan credentialing verification requirements or if disclosure is prohibited by law.
- **Correction of Credentialing Information:** The right to correct erroneous information when credentialing information obtained from other sources varies substantially from information submitted by the Provider. The correction of erroneous information submitted by another source is detailed in the Credentialing section of this Provider Manual.
- **Credentialing Updates:** The right to be informed of a Provider's credentialing application status upon request to Health Plan.
- **Staying Informed:** The right to receive information about Health Plan, including but not limited to available programs and services, its staff and their respective titles, operational requirements, and contractual relationships.
- **Coordination of Care:** The right to information on how Health Plan coordinates its interventions with treatment plans for individual Members.
- **Health Plan Support:** The right to receive support from Health Plan in making decisions interactively with Members regarding their health care.
- **Health Plan Contact Information:** The right to receive contact information for staff responsible for managing and communicating with the Provider's Members.
- **Health Plan Communications:** The right to expect and receive communication from Health Plan staff regarding complaints, issues, or concerns relating to Provider rights and responsibilities and their staff.
- **Grievance and Appeals**: The right to receive policies and procedures about the grievance and appeals process.
- **Telehealth**: All Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Member choice. To preserve a Member's right to access Covered Services in-person, a Provider furnishing services through video synchronous interaction or audio-only synchronous interaction must offer those same services via in-person and or face-to-face contact. Providers must arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

Providers are also required to explain the following to Members:

- The Member's right to access Covered Services delivered via Telehealth in-person.
- That use of Telehealth is voluntary and that consent for the use of Telehealth can be withdrawn at any time by the Member without affecting their ability to access Medi-Cal Covered Services in the future.
- The availability of Non-Medical Transportation to in-person visits.
- The potential limitations or risks related to receiving Covered Services through Telehealth as compared to an in-person visit, if applicable.

PROVIDER DIRECTORY MAINTENANCE RESPONSIBILITY

In order to assure Members of timely and accurate information on the Providers available in Health Plan's network, it is important that Providers comply with Health Plan's policies regarding Provider Directory maintenance. Health Plan has a regulatory responsibility to publish an accurate Directory of all Providers. This Provider Directory will be maintained and updated in accordance with State and federal law, including but not limited to Section 1367.27 of the Health and Safety Code. Health Plan is required to have a current Provider Directory to reflect the following changes:

- Provider is no longer accepting new Members
- Provider was previously not accepting new Members but is now open to new Members
- Provider is no longer contracted with Health Plan (contract termination has occurred)
- Provider has moved to a different location
- Provider has added a location
- Provider has changed its office hours
- A change in languages spoken in the office
- As a result of an error identified through a Member complaint
- Any other information affecting the accuracy of the Provider Directory

Provider Demographic Information

This Directory will include, but not be limited to, the following demographic information for each Provider as required by Section 1367.27(h) of the Health and Safety Code and by Section 438.10(h) of the California Code of Regulations:

• Provider's Name	• National Provider Identification Number (NPI)
• Practice Address(s) and Site or Clinic Name, if applicable	• California License Number
• Telephone Number	• Name of Affiliated Medical Group or Clinic and NPI, Address, Telephone Number

• Whether the provider offers appointments via Telehealth	• Office Email Address, if available
• Office Hours and Days Open	• Admitting privileges at hospitals contracted with Health Plan, if any, for physicians and surgeons
• Whether the Provider is accepting new patients	• Cultural and Linguistics Capabilities, including whether non-English languages and American Sign Language are offered by the Provider or a skilled medical interpreter at the Provider's office,
• Type of Practitioner	• Board certification if any
• Area of Specialty	• Accessibility to accommodate Members with physical disabilities
• For ECM or Community Supports Indication of the Population of Focus the Provider serves, whether the Provider serves adults, youth, or both	• Identification of Network Providers or sites that are not available to all or new Members
• Enhanced Care Management Provider organization name, mailing address, contact information for new referrals and telephone and email, contact information for existing patients and telephone and email (if different than contact information for new referrals)	• Whether the provider offers gender-affirming services(voluntary)

Provider Directory Audits

Health Plan will send a written notification to all contracted Providers at least once a year, and as frequent as every six (6) months, to verify the accuracy of the information on file. The following are key timelines and process points:

- Providers must respond to Health Plan within thirty (30) business days to confirm that the information is correct or provide changes needed to update the Directory.
- If no response is received from a Provider within the thirty (30) business days, Health Plan will send a second written notice.
- Provider must respond to Health Plan within fifteen (15) business days of the second notice to confirm the accuracy of the information or provide changes needed to update the Directory.

- If Health Plan does not receive a response from the Provider by the end of the 15 business days, and Health Plan cannot verify the Provider's information, Health Plan sends a third notice to give the Provider ten (10) business days prior notice of removal from the Provider Directory.
- Non-responsive Providers are removed from the Directory at the next required update.
- Failure to respond to the notices for Directory confirmation or changes may result in the delay of claims payment or Capitation Payments pursuant to HSC §1367.27. Please refer to the Provider Payment section in this manual for more information on payment delays.

PROVIDER COMMUNICATION

At Health Plan, we value our relationship with our Provider network and believe that prompt and effective communication is critical to ensure that you are receiving the information and support you need from us. Throughout the year, Health Plan is notified by regulators and accreditation agencies as to changes or clarifications that impact Members, billing, or other administrative processes. In order to keep you up to date, we have several communications strategies that we employ:

Provider Alerts

The primary method of communication is a *Provider Alert*. *Provider Alerts* are typically condensed documents providing valuable updates, information, and action requests. They are sent by fax and email to the contact information provided by the practice, and they are provided during meetings, visits, and programs. *Provider Alerts* often contain time sensitive information, so they should be a priority for review and response, if necessary. To ensure receipt of these important *Provider Alerts* on a timely basis, it is essential that Health Plan is provided with accurate and current practice information including contact information for receipt of these notices. Current, as well as past, *Provider Alerts* are also available on Doctor's Referral Express (DRE) and on the website, www.hpsj-mvhp.org.

Provider Alerts generally address the following types of issues:

- Changes to Health Plan policies, procedures, and processes
- Important regulatory or legislative changes
- Upcoming meetings or events beneficial to Providers to support Members
- Training opportunities and requirements
- Health Plan company announcements
- Health Plan initiatives requesting Provider input and/or feedback
- Changes in the Provider network that may impact the practice
- New programs and/or products in development where your input is requested
- New programs, products or Member benefits

Provider Webinars

Health Plan provides webinars to update Providers with important information. Providers will be notified in advance of upcoming webinars via *Provider Alerts*, through DRE, and through updates on the website, www.hpsj-mvhp.org.

SECTION 5: PROVIDER SERVICES

Provider Newsletters

On a quarterly basis, Health Plan publishes a Provider newsletter called *PlanScan*. *PlanScan* is made available electronically to all Providers including contracted Facilities. Both current and back issues of *PlanScan* are available on Health Plan's website, www.hpsj-mvhp.org. This publication can be emailed to Providers by request.

Provider Feedback

Provider Satisfaction Surveys

Health Plan performs satisfaction surveys on an annual basis in order to gain perspective on the level of service provided to Providers and office staff and to determine the overall satisfaction of Health Plan from the Provider perspective. Providers are encouraged to complete these satisfaction surveys since the information gathered will be used to help improve services.

Focus Groups

Health Plan may conduct focus groups with Providers in order to gain feedback on how services can be enhanced. Providers invited to participate in a focus group will be contacted by Health Plan's Provider Services Department. Providers that agree to participate in the focus group may be compensated for their participation.

For more information or to provide feedback as to how Health Plan can enhance our service to Providers and improve satisfaction, please contact Health Plan at 1-888-936-7526.

PROVIDER EDCUATION AND TRAINING

Health Plan provides training opportunities to Providers based on operational relevance and regulatory requirements. Some training topics include:

New Provider In-Service

Within ten (10) business days of a Provider becoming effective in Health Plan's network, a Provider Services Representative (PSR) will meet with Provider or designated office staff to start a detailed orientation (i.e., in-service). This in-service includes, but is not limited to, the following:

- Overview of Health Plan
- Fraud, Waste & Abuse State-mandated training information and Attestation
- Cultural Competency & Sensitivity State-mandated training information and Attestations
    - Health Plan Cultural Competency & Diversity
    - Seniors and Persons with Disabilities (SPD) Awareness and Sensitivity
- Health Insurance Portability and Accountability Act (HIPAA) State-mandated training information and Attestation
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) State-mandated training information and Attestation
- Emergency Preparedness
- Review of information contained in the Provider Manual, including the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) Timely Access standards and After-hours requirements
- Explanation of Doctors Referral Express (DRE)

- Assistance in setting up DRE access
- Guidance on electronic claims submission and online Authorization
- Guidance on coordinating preventive services (HEDIS) and standards, if applicable
- Members' Rights and Responsibilities, including Advanced Directives, including the Member Grievance and Appeals Process
- Provider Rights and Responsibilities, including the Provider Dispute Process
- Answers to any questions you may have regarding working with us The In-Service is completed within thirty (30) business days.

On-Going Provider In-Services

Health Plan's Provider Services team conducts follow-up visits as necessary in order to assess the Provider's experience working with Health Plan and to address any additional questions or concerns. Health Plan staff is also available to conduct follow-up trainings to review or address any topic necessary to support Providers in performing their duties and functions. The goal is to ensure that working with Health Plan is a positive experience for Providers, their office staff and Members.

Regional Centers

Regional Centers identify and support individuals with developmental disabilities throughout their life span. Providers can receive outreach and education to identify and manage Members living with disabilities and behavioral health needs. Alta California Regional Center and Valley Mountain Regional Center are two out of 21 Regional Centers serving the counties listed below.

Regional Center	Contact	Counties Served
Alta California Regional Center	1-916-978-6400 *Multiple Locations www.altaregional.org	**Alpine**, Colusa, **El Dorado,** Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba
Valley Mountain Regional Center	1-209-473-0951 *Multiple Locations www.vmrc.net	Amador, Calaveras, San **Joaquin, Stanislaus**, and Tuolumne

Bold = Health Plan Service Areas

Other Training Opportunities

Health Plan also offers Providers and office staff the opportunity to attend trainings in either in-person setting during the day, as well as evening training on various operational and quality related topics. Topics could include, but not be limited to:

- Doctor's Referral Express (DRE) Refresher Training
- How to Successfully Pass a Facility Audit (FSR)
- How to Successfully Pass a Chart Audit
- California Children's Services (CCS)

- Improving HEDIS performance
- Fluoride Varnish Treatment Training

DOCTORS REFERRAL EXPRESS (DRE)

One of the most beneficial resources to help in providing efficient service to Members is Doctors Referral Express (DRE). DRE is the HIPAA-compliant secure Provider portal that is available 24/7 to Providers. DRE also has a mobile application compatible with both iPhone and Android devices. This service is provided at no cost to the Provider and will assist in managing medical care for Members. Throughout this Provider Manual, there are references to DRE that indicate the use of this tool to accomplish several administrative tasks such as:

- Member eligibility verification
- Obtaining PCP Member rosters
- Sending emails to Health Plan departments
- Checking claims status
- Submitting Provider Dispute Resolution (PDR) and checking status
- Reviewing *Milliman Care Guidelines*
- Accessing HEDIS "Gap Reports"
- Accessing the Patient Benefit Dossier
- Obtaining/Status checking Authorization and referrals
- Obtaining Member coverage and benefits information
- Accessing Member utilization history
- Billing Code Finder (CPT, HCPCS)
- Provider Lookup Tool
- Accessing Forms and Data
- Download Remittance Advice – RA
- Download PHDP Reports

Doctor's Referral Express (DRE) Portal Access

To receive access to Doctor's Referral Express (DRE), Providers and their authorized users must have an active contract with Health Plan. Each Provider office user (physician, medical assistant, office employee, biller, authorization clerk, etc.) is required to have their own unique access to DRE that is approved by the Provider office administration. Sharing log-in and password information is prohibited.

For security purposes, the user will be required to validate that an online account will be set up in their name and will be required to attest to the on-line Health Plan Confidentiality Statement. Upon receiving the application and completing the online attestation, each user will receive a confirmation e-mail from Health Plan providing them the resolution of the DRE access request. All fields must be completed in the online application before DRE Provider portal access will be activated. The Practice/Clinic NPI and Tax ID# will be required during the registration process.

Once the registration is completed, the user will be able to access DRE at Health Plan's website:

www.hpsj-mvhp.org. A Provider Services Representative will contact all new Provider offices connecting to DRE to schedule training. To be compliant with Health Plan security standards, all DRE users will be required to validate their account on a quarterly basis. For questions regarding DRE access and training, please call the Provider Services department at 1-888-936-7526.

DRE access can be obtained by linking to Health Plan's on-line web page www.hpsj.com/providers.

Non-contracted providers are able to obtain access to DRE to view and download their Remittance Advice. You may call Health Plan's Customer Service Department at 1-888-936-7526 and request to speak to a Provider Services Representative for assistance.

SECTION 6: ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

MEDI-CAL ELIGIBILITY

Under Medi-Cal, Health Plan offers a managed care plan (Medi-Cal HMO) for low-income adults, children, seniors, and persons with disabilities. This program is regulated under the provisions of Title 22 of the California Code of Regulations and the Department of Health Care Services (DHCS). Under this oversight, Health Plan's Medi-Cal HMO program must comply with federal and State requirements. Health Plan's Medi-Cal HMO program provides general acute and preventative medical services required by the federal government under the federal Medicaid program as well as the State Medi-Cal program. Some services are carved out and not managed by Health Plan.

Eligibility for Medi-Cal is month-to-month so Members participating in this program must re-certify their eligibility annually. Because of this, Members may lose Medi-Cal eligibility and then regain it later or become effective for services retroactively. Please be aware that not all Medi-Cal beneficiaries participate in Health Plan's Medi-Cal HMO plan. Those patients who are not affiliated with Health Plan may be participating through another Medi-Cal HMO or be Medi- Cal fee-for-service (FFS).

MEMBER IDENTIFICATION CARDS

Health Plan issues all new Members an Identification Card that must be presented to Providers at the time Covered Services are requested. Please note that Health Plan's Identification Card (ID Card) alone should not be considered verification of Member eligibility with our health care programs. The ID Card is issued for identification purposes only and does not guarantee eligibility. All Providers must verify eligibility on the date that the service is rendered. A referral or Authorization is also not enough to guarantee that the patient is eligible on the date of service.

VERIFICATION OF ELIGIBILITY

There are several ways to verify eligibility with Health Plan. The methods listed below will provide various levels of detail about Members including, but not limited to:

- Name
- Health Plan identification number
- Birth date
- Gender (female or male)
- Language preference
- Eligibility status (eligible or termed) and effective dates
- PCP name and phone number
- PCP assignment effective date

Interactive Voice Response System (IVR)

IVR is another tool that is available 24/7 to verify Member eligibility. To use IVR, please call 1-209-942-6303 and provide the Member's 9-digit Health Plan identification number. A confirmation number will be provided which should be maintained to document the verification of eligibility.

Customer Service Department

Eligibility can also be verified by calling the Customer Service Department. Representatives are available to assist with eligibility verification inquiries Monday through Friday from 8:00 a.m. to 5:00 p.m. To contact Customer Service, call 1-888-936-7526.

HealthReach Advice Nurse Line

Health Plan's Advice Nurse **HealthReach** is available 24/7 to assist you with eligibility inquiries and to assist in triaging Members in need of Covered Services. To access **HealthReach**, please call 1-800-655-8294.

Medi-Cal Automated Eligibility Verification System (AEVS)

You can access the State of California's AEVS by calling 1-800-427-1295.

Edifecs

Health Plan leverages Edifecs for its X12N 270/271 Health Care Eligibility Request and Response, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Type 3 and Errata (also The X12N 270/271 version of the 5010 Standards for Electronic Data Interchange Technical Report referred to as Implementation Guides) for the Health Care Eligibility Request and Response Transaction has been established for eligibility status inquiry and response compliance. This document has been prepared to serve as a Health Plan specific companion guide to the 270/271 Transaction Sets. This document supplements but does not contradict any requirements in the 270/271 Technical Report, Type 3. The primary focus of the document is to clarify specific segments and data elements that should be submitted to Health Plan on the 270/271 Health Care Eligibility Status Request and Response Transaction. This document will be subject to revisions as new versions of the 270/271 Transaction Set Technical Reports are released. This

document has been designed to aid both the technical and business areas.

For more information to implement the X12N 270/2721, please refer to www.hpsj.com/wp-content/uploads/2024/07/HPSJ-MVHP_-270271-electronic-eligibility-verification-companion-guide-07232024E.pdf.

PRIMARY CARE PHYSICIAN (PCP) ASSIGNMENT AND CHANGE

PCPs are the primary Provider of Covered Services for Members. They play a central role in coordinating care. For this reason, the selection or assignment of each Member to a PCP is of critical importance. The PCP is the center of a multidisciplinary team and coordinates all medical care for their assigned Members while acting as their key contact and advocate.

The first and most important decision that a Member makes is the selection of a PCP. Health Plan encourages individual PCP selection because it creates a better opportunity for a Member to develop a one-on-one relationship with a physician who can personally engage with them in coordinating their care. This relationship creates continuity and improved quality and helps avoid confusion and duplication of services. Members can find available PCPs on Health Plan's website and are directed to choose PCPs for themselves and for each family Member. If a member does not select a PCP, one will be automatically assigned to them.

Members can change PCPs by using the Member portal on Health Plan's website or by calling the Customer Service Department at 1-888-936-7526. Providers can also submit Member PCP selections to Health Plan by using the PCP Selection Form Request via secure Provider portal (DRE).

- PCP change requests made from the first (1st) through the fifteenth (15th) of the month will become effective the first (1st) day of the month of the request if the Member has not accessed care with their current PCP during month of the request.
- PCP change requests made from the sixteenth (16th) through the end of the month of the request will become effective the first (1st) day of the following month.
- PCP changes requests made after the fifteenth (15th) of the month can become effective the first (1st) day of the month of the request if:
    - The Member has not seen their current PCP in the month of the request, and the Member is ill and need immediate medical attention
    - The Member does not approve of a previous auto-assignment
    - The Member previously requested a change, and it was not administratively processed

GROUP/CLINIC ASSIGNMENT

Health Plan Members can be assigned to either an individual PCP within a Group or clinic, or directly to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

PRIMARY CARE PHYSICIAN (PCP) AUTO-ASSIGNMENT

Upon Enrollment with Health Plan, Members are notified that they have thirty (30) days to select a

PCP. In the event Members fail to respond with a selection, the Member will be assigned to a PCP by Health Plan. In making an auto-assignment, Health Plan will take several factors into consideration, including but not limited to:

- Language, age and gender of Member
- Language, age and gender restrictions for potential PCPs
- Current report of PCPs accepting new Members
- Panel capacity of current PCPs
- Geographic accessibility (travel time and distance) based on Member's zip code
- Availability of traditional safety net PCPs
- Culture and ethnicity of Member and PCPs
- PCPs with whom Member has had a previous relationship

Health Plan will notify the Member of the auto-assignment. They will have the option of changing PCPs if they do not wish to receive care from the auto-assigned PCP.

PCPs are notified of newly assigned Medi-Cal Members on the monthly roster, which is available through the secure Provider portal (DRE) on Health Plan's website, www.hpsj-mvhp.org.

MEMBER DISENROLLMENT

Health Plan does not make Medi-Cal eligibility determinations for Members. The responsibility for the determination of Medi-Cal eligibility resides with the State and the County Human Services Agency; it is subject to retroactive adjustment in accordance with the terms and conditions of coverage described in the *Medi-Cal Combined Evidence of Coverage and Disclosure Form*. Providers must verify eligibility on the date that the service is rendered (see section 6-1).

- Disenrollment is effective on the 1st day of the 2nd month following receipt by Department of Health Care Services (DHCS) of all documentation necessary to process the disenrollment – provided disenrollment was requested at least thirty (30) calendar days prior to that date.
- During this time period, the Member remains active and Covered Services should be continued until the effective date of disenrollment.
- Administering disenrollment requests is the responsibility of Health Plan's Utilization Management Department.

Voluntary Disenrollment

Members can elect to discontinue participation in Health Plan's Medi-Cal plan as often as monthly. This disenrollment decision can be made for any reason. If a Member requests disenrollment, the Customer Service Representative (CSR) will refer Member to HCO for further assistance.

However, if a reason is given, Health Plan may be able to resolve the situation by explaining how participation with Health Plan works, facilitating appointments or resolving service issues.

Involuntary Disenrollment

Under certain circumstances, Health Plan may request the disenrollment of a Member under

specific guidelines set by DHCS. In addition, Health Plan Providers may, under specific circumstances, request that Health Plan review a given Member situation for possible disenrollment consideration. Please note that final disenrollment decisions are handled entirely by DHCS. Members can be disenrolled for any of the reasons stated in 22 CCR section 53891, including the following:

- Member moves outside of Health Plan's Service Area
- Member no longer qualifies for Medi-Cal benefits as determined by DHCS
- Member has changed to a Medi-Cal Aid Code which is not covered under Health Plan
- Member is (or will be) incarcerated for more than one (1) month
- Member becomes enrolled in one of the following forms of other health coverage, except when dual enrollment is permitted per 22 CCR section 53845(f):
    - Medicare HMO
    - TRICARE or Tricare Prime HMO
    - Kaiser HMO
    - Any other HMO/prepaid health plan in which the enrollee is limited to a prescribed panel of Providers for comprehensive service

SECTION 7: PROVIDER-MEMBER RELATIONSHIP

MEMBER RIGHTS AND RESPONSIBILITIES

Health Plan Members have specific rights and responsibilities outlined under Title 22, California Code of Regulations Section 72527 and in the *Medi-Cal Combined Evidence of Coverage and Disclosure Form* for the appropriate year. This information can be found via the following link Health Plan Evidence of Coverage Section 7 and can also be found on Health Plan's website, www.hpsj.com/rights-responsibilities.

In addition, Health Plan recognizes the specific needs of Members and strives to maintain a mutually respectful relationship. Under the plan's rights and responsibilities statement, for Providers and practice staff, this means Members must:

- Be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of their Protected Health Information (PHI) and Private Information (PI)
- Be provided with information about the plan, its practitioners and Providers, all services available to members, and member rights and responsibilities.
- Be able to choose a primary care doctor within Health Plan's network unless the PCP is unavailable or is not accepting new patients
- Participate in decision making with Providers regarding their own health care, including the right to refuse treatment
- Be able to have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Be able to submit grievances, either verbally or in writing, about the organization, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination
- Be able to request an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and how to continue benefits during the appeal process through the State Fair Hearing, when applicable
- Be able to request a State Fair Hearing, including information on the circumstances under which an expedited State Fair Hearing is available
- Receive no-cost interpretation services and written translation of critical informing materials in their preferred threshold language, including oral interpretation and American Sign Language (ASL)
- Be able to have a valid Advance Directive in place, and an explanation of what an Advance Directive is
- Be able to disenroll from Health Plan and change to another health plan in the county upon request
- Be able to access minor consent services
- Get no-cost written member informing materials in other formats (such as braille, large-size print no smaller than 20-point font, audio, and accessible electronic formats) upon request and 45 CFR sections 84.52(d), 92.202, and 438.10.

- Be free from any form or restraint or seclusion used as means of coercion, discipline,
- convenience or retaliation.
- Have access to and get copies of their medical records, and request that they be amended or corrected, as specified in 45 CFR sections §164.524 and 164.526.
- Make recommendations regarding these member rights and responsibilities.
- Have freedom to exercise these Member rights without retaliation or any adverse conduct by Health Plan, their Providers or the State.
- Have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, and sexually transmitted infection services from Provider of their choice without referral or Prior Authorization, inside or outside of the network. Also, to have Emergency Services provided in or outside Health Plan's network pursuant to the federal law.
- Have a responsibility to supply information, to the extent possible, that the organization and its practitioners and Providers need to provide care.
- Have a responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- Have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ADVANCE DIRECTIVES

Health Plan recognizes the Members' rights to formulate Advance Directives, including the right to be informed of State law in respect to Advance Directives and receive information regarding any changes to that law.

Health Plan notifies Members of their right to formulate an Advance Directive at the time of initial enrollment and annually thereafter through the Combined Evidence of Coverage and Disclosure Form. PCPs and Specialists providing care should assist adult Members over eighteen (18) years of age and older in receiving additional information and understanding their right to execute Advance Directives. Below are key actions that should be taken to assist Members.

- At Member's first PCP visit, office staff should ask if they have executed an Advanced Directive and the Member's response should be documented in the medical record.
- If the Member has executed an Advance Directive, a copy should be included as a part of the Member's medical record.
- Providers should discuss the potential medical situations with the Member and any designees named in the Advanced Directive. This discussion should be documented in the medical record.
- If possible, a copy of the Advance Directive should be placed in the Member's chart.

SECTION 7: PROVIDER-MEMBER RELATIONSHIP

ROLE OF PRIMARY CARE PROVIDERS (PCPs)

The PCP is the central relationship that all Health Plan Members are encouraged to develop to ensure personal attention, quality care, and efficient services. When Health Plan assigns a Member to a selected PCP, it is with the expectation that the PCP will provide most of the Covered Services. It is the PCP's responsibility to coordinate the services of specialists and ancillary Providers or coordinate with Health Plan if out-of-network services are required.

Participating PCPs are contracted to either perform a number of key activities, or to coordinate them. These include, but are not limited to, the following activities:

- Provide appropriate medical care within their scope of practice for Members, including preventive care, acute care, and care for chronic conditions

Be available for, or provide, on-call coverage through another source twenty-four (24) hours a day for the management of Member care

- Coordinate necessary health assessments as required by Health Plan or other regulatory agencies
- Provide referrals to other Providers for Covered Services outside of the PCP scope of practice and follow Health Plan guidelines for out-of-network services
- Maintain continuity of Member's care through coordination and follow up with other Providers as well as Health Plan when appropriate
- Ensure that care is provided in a safe, culturally responsive, and timely manner
- Provide Members with educational information on maintaining healthy lifestyles and preventing serious illness
- Provide screenings, health assessments, and other activities in accordance with Health Plan policies, DHCS requirements, and other public health initiatives
- Conduct behavioral health screenings based upon a Provider assessment to determine whether a Member requires behavioral health or substance abuse services and refer for services, if needed (for more information, please see Section 15 on Behavioral Health)
- Meet and maintain the access standards as outlined in this section under "Timely Access to Care"
- Cooperate with Health Plan's Case Management and Quality programs
- Maintain complete and accurate medical records for Members in a confidential manner,
- including documentation of all services and referrals provided to Members by the PCP, Specialists, and any ancillary Providers.
- May establish new patient relationships via synchronous video Telehealth visits.
- May establish new patient relationships via audio-only synchronous interaction only when one or more of the following criteria applies:
    a. The visit is related to sensitive services in accordance with California Civil Code Section 56.06(n).
    b. The Member requests an audio-only modality.
    c. The Member attests they do not have access to video.
- FQHCs, including Tribal FQHCs, and RHCs may establish new patient relationships

through an asynchronous store and forward modality, as defined in BPC section 2290.5(a), if the visit meets all the following conditions:

a. The Member is physically present at a Provider's site, or at an intermittent site of the Provider, at the time the Covered Service is performed.
b. The individual who creates the patient's Medical Records at the originating site is an employee or Subcontractor of the Provider, or other person lawfully authorized by the Provider to create a patient Medical Record.
c. The Provider determines that the billing Provider can meet the applicable standard of care.
d. A Member who receives Covered Services via Telehealth must otherwise be eligible to receive in-person services from that Provider.

ROLE OF NON-PHYSICIAN MEDICAL PRACTICIONERS (NPMPs)

Non-Physician Medical Practitioners (NPMPs) provide a wide variety of medical care depending upon their licensure, certification, and experience. This category includes physician assistants (PAs), nurse practitioners (NPs), and certified nurse midwives (CNMs). To provide Covered Services to Members, these Providers must be credentialed by Health Plan.

Consistent with Health Plan and Medi-Cal guidelines, NPMPs must perform services under the general supervision of a Provider. The supervising Providers must be available to the NPMP either in person or through electronic means to provide:

- Supervision as required by State professional licensing laws
- Necessary instruction in patient management
- Consultation
- Referral to Specialists or other licensed professionals

Supervision Limits of NPMPs

In accordance with Medi-Cal regulations, an individual physician may not supervise more than four (4) PAs (full-time equivalents). While there is no limit on the number of NPs or CNMs that a single physician may supervise, if the NPs or CNMs order drugs or devices, a single physician cannot supervise more than four (4). Supervising Providers are required to develop and document a system of collaboration and supervision with each NPMP they supervise. This document must be kept on file at the Provider's office and available for review by either Health Plan or DHCS.

Member Awareness of Care from NPMPs

Providers who employ or use the services of NPMPs must ensure that Members are clearly informed that their services may be provided by NPMPs.

ROLE OF SPECIALISTS

While the PCP provides the central relationship with the Member, the role of the specialist is also important to ensure appropriate care is provided for any given medical need. For this reason, it is important that Health Plan specialists communicate frequently with PCPs in coordinating care and maintain adequate documentation of care provided.

Specifically, specialists should:

- Provide all appropriate services within their scope of practice
- Follow Health Plan referral and authorization guidelines in coordinating services with other Providers
- Provide the PCP with consult reports and other appropriate records

Maintain the confidentiality of medical information

- Cooperate with Health Plan's Case Management and Quality Programs
- Meet and maintain the Access Standards as outlined in this Section 7 under "Timely Access to Care"
- Maintain complete and accurate medical records for Members in a confidential manner, including documentation of all services and referrals provided to the Member

SUPPORTING MEMBERS IN SELF-CARE

Providing quality health care to Health Plan Members includes supporting Members not only in remaining compliant with their medication and treatment protocols, but also supporting them in making important changes in their health behaviors. This includes providing information and education to prevent disease and illness.

PCPs are expected to engage frequently with Members to encourage preventive strategies such as improving diets, exercising, taking medications appropriately, and actively managing complex health conditions. Providers should ensure that clinicians and staff communicate with Members about health choices and preventative actions.

Health Education Services

Health education services are covered services and are available to Members at no cost. These services are designed to assist and support Providers in promoting self-management and healthy behaviors for Members. The Health Education Department is part of Health Plan's Medical Management Department. The Health Education Department is dedicated to the promotion and empowerment of healthy lifestyles. The goal is to help Members be engaged and informed so they can be active participants in their care and in the care of their children. Many of the services provided below are provided in English, Spanish, Khmer, and Vietnamese (the threshold languages for Health Plan).

Health Plan's Health Education Department –

1. Ensures that the health education services are provided directly by Health Plan or through subcontracts or formal agreements with other Providers specializing in health education services
2. Conducts targeted outreach to promote optimal program use and participation by Members, and ensures these programs are available and accessible upon self-referral or referral by contracted medical Providers. All programs are available to Members at no charge.
3. Distributes appropriate health education notices and information through, but not limited to:
    a. Member handbook

   b. FOCUS YOUR HEALTH, the Member newsletter
   c. Special mailings
   d. Provider offices
   e. Community outreach activities
4. Provides Members' access to an Audio Library, available through the Advice Nurse/Physician Line
5. Health Plan's multidisciplinary health education program includes intervention such as:
   a. Self-care techniques and/or self-care publications
   b. Public service announcements (PSAs) to reinforce healthy behaviors
   c. Billboards (outdoor advertising) identifying health risks/healthy behaviors, etc.
   d. Health/patient education materials (development and distribution)
   e. Advice Nurse information and audio library promotions
   f. Participation in community organizations promoting healthy behaviors
   g. Community health education program development and referral
   h. Outreach to target populations, utilizing community-based organizations, the faith communities, neighborhood groups, etc.
   i. Trainings/seminars for Provider staff to support their work with Health Plan patients

Health Plan provides health education through health promotion activities including, but not limited to:

   a. Participating in community coalitions and meetings to understand the needs of our members in organic settings.
   b. Finding, planning, facilitating, and/or participating in community events (e.g., health fairs, annual Black Family Day, Health Plan Walks for Health, etc.)

Health Education Materials

Health Plan has health education materials available at no cost to Providers and Members. These materials are provided at no cost to Providers and Members.
Topics include, but are not limited to:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Parenting
- Colds & flu
- Chronic disease or health conditions
- Prenatal care and unintended pregnancy
- Prevention of sexually transmitted diseases
- Alcohol and drug use
- Comprehensive tobacco cessation
- Nutrition

- Physical activity
- Congestive heart failure
- Pregnancy

New materials are developed as needed. We welcome suggestions for additional health education materials; please contact the Health Plan at 1-888-936-7526.

Other Educational Resources

Health education services are also provided to Members through:

- **HealthReach**– 24-Hour Advice Nurse/Physician Line – In addition to Advice Nurse services, HealthReach has an audio library with over 1500 health topics recorded in English and Spanish; if necessary, the Advice Nurse can connect Health Plan Member with a physician
- **Your Health Matters**, a quarterly newsletter that is mailed to Health Plan Members which includes health education and local resources
- **Community Events & Health Fairs** – Health Plan participates in health fairs and community events to promote personal health awareness and preventive health care to Members and the community

SOCAL SERVICES SUPPORT FOR MEMBERS

Health Plan Social Work Services team conducts Member needs assessments to help Members obtain necessary services that could positively impact their overall health care efforts. Based on findings from the assessment, this team will help coordinate necessary services. These services could include, but are not limited to:

- Food Resources (i.e., food banks)
- Utility Resources

For questions or printed information about Social Services or community resources, please call 1-209-942-6320 or 1-888-936-7526.

PARTICIPATING IN COMMUNITY INITIATIVES

Health Plan participates in a variety of workgroups and coalitions that convene to identify and develop health education interventions on important health issues.

PROVIDER PANEL CAPACITY

All Health Plan Providers are considered open to serve new and established Members unless there is written notice on file of any panel capacity limitations. Since the goal is to maintain maximum access for Members, capacity limitations and/or restrictions are discouraged unless necessary.

Health Plan is responsible for monitoring PCP availability and capacity on an annual basis as required by DHCS and State regulations. Availability ratio standards for PCPs and Non-Physician Medical Practitioners (Ns) are defined below:

- PCPs 1:2,000 Members

- NPMP's 1:1,000 Members

PCPs have an enrollment limit of 2,000 Members. Health Plan's policies are in accordance with these standards. All Participating PCPs are encouraged to accept a minimum potential enrollment of 200 Members.

If there is a change in panel capacity, Providers must provide written notice to the Provider Services Department via fax 1-209-461-2565, or by mail to 7751 S. Manthey Road, French Camp, CA 95231-9802.

OPEN AND CLOSED PANEL STATUS

PCPs are expected to maintain an "open" status for Health Plan Members consistent with their availability to patients of other health care plans and programs. PCPs must notify Health Plan within five (5) business days of closing their practice(s) to new Members. The five (5) business day notice also applies to reopening a practice that has been previously closed.

If a Provider is contacted by a Member or potential Member and the Provider is officially "closed" to new Members, it is important that Members or potential Members be directed to contact Health Plan so that they can be assisted in obtaining another Provider, and if necessary, correct any errors in the Provider Directory.

TIMELY ACCESS TO CARE

Under California law, Health Plan is obligated to provide or arrange for timely access to care. Contracted Providers must follow the limits on how long members wait to get health care appointments.

Contracted Providers or members can contact Health Plan to obtain assistance if they are unable to obtain a timely referral to appropriate Providers by calling the Customer Service Department at 1-888-936-7526

You may also call the DMHC Help Center at 1-888-466-2219 TDD 1-877-688-9891 or at www.HealthHelp.ca.gov for assistance.

If Health Plan is not able to help with a timely referral, you or the member may file a complaint. *See additional information at www.hpsj.com/grievances-appeals.*

Timely Access Standards apply to all counties. Time and Distance standards vary depending on county size.

DHCS County Categories by Size

- Alpine County – Rural
- El Dorado County – Small
- San Joaquin County – Medium
- Stanislaus County – Medium

SECTION 7: PROVIDER-MEMBER RELATIONSHIP

PCPs should be located within ten (10) miles or thirty (30) minutes from the Member's residence, when applicable.

San Joaquin, Stanislaus, El Dorado, Alpine Counties PROVIDER TYPE	**TIME or DISTANCE**
Primary Care (Adult and Pediatric)	10 Miles or 30 Minutes
Obstetrics/Gynecology (OB/GYN) - Acting as a PCP	
Hospitals	

Specialists and other Providers should be located within the time or distance below from the Member's residence, when applicable.

San Joaquin and Stanislaus Counties (Medium) PROVIDER TYPE	**TIME or DISTANCE**
^Specialty Care (Adult and Pediatric)	30 Miles or 60 Minutes
OB/GYN Specialty Care	
Substance Use Disorder *Outpatient Services*	
Substance Use Disorder *Opioid Treatment Programs*	

El Dorado County (Small) PROVIDER TYPE	**TIME or DISTANCE**
^Specialty Care (Adult and Pediatric)	45 Miles or 75 Minutes
OB/GYN Specialty Care	
Non-Specialty Mental Health Providers *Outpatient Services Mild to Moderate* (Adult and Pediatric)	
Substance Use Disorder *Outpatient Services*	60 Miles or 90 Minutes
Substance Use Disorder *Opioid Treatment Programs*	45 Miles or 75 Minutes

Alpine County (Rural) PROVIDER TYPE	**TIME or DISTANCE**
^Specialty Care (Adult and Pediatric)	60 Miles or 90 Minutes
OB/GYN Specialty Care	
Non-Specialty Mental Health Providers *Outpatient Services Mild to Moderate* (Adult and Pediatric)	
Substance Use Disorder *Outpatient Services*	
Substance Use Disorder *Opioid Treatment Programs*	

^Time or Distance Standards apply to core Specialists as determined by DHCS.

Timely Access Standards	
Health Plan Telephone Wait Times	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
Average Speed of Telephone Answer: The maximum length of time for Customer Service Department staff to answer the telephone	10 minutes
After Hours Calls	**Telephone triage shall be available 24 hours a day, seven days a week. Telephone triage or screening wait time shall not exceed 30 minutes.** **Automated system or live attendant:** • Must provide emergency instructions • Offer a reasonable process to contact the PCP, covering physician or other "live" party • If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner for both urgent and non-urgent calls. **Professional exchange staff:** Must have access to practitioner for both urgent and non-urgent calls.

Health Plan is committed to providing Timely Access to health care for Members. Below are the standards for appointments and wait times for:

- Call Service Standards
- Preventative Care Appointment Standards
- Routine Primary Care Appointment Standards (Non-Urgent)
- Urgent Care Services Appointment Standards
- Specialty Care Practitioner Appointment Standards

PRIMARY CARE PROVIDER (PCP) and SPECIALIST Telephone Wait Times	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
Telephone answer time during business hours	Not to exceed 10 minutes
Call return time for urgent message or triage time during business hours	30 minutes
Call return for non-emergency and non-urgent messages during business hours	Within 24 hours and no later than the next business day

PRIMARY CARE PROVIDER (PCP) After Hours Access	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
Telephone access after hours	• Telephone access must be available 24 hours a day/7 days a week. • The phone message or live person must provide emergency instructions, such as calling 911 or going to the nearest emergency room or urgent care. • The phone message or live attendant must provide instructions on how to contact or reach a physician for urgent care. • Triage or return call must be within 30 minutes of the call.

PRIMARY CARE PROVIDER (PCP) Preventive Care Appointment Standards	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
First Prenatal Visit	• Within 14 calendar days of request
Newborn Visits after discharge from the Hospital	• Within 48 hours for infants discharged in less than 48 hours of life after delivery • Within 30 days from the date of birth if the infant was discharged more than 48 hours of life after delivery

SECTION 7: PROVIDER-MEMBER RELATIONSHIP

PRIMARY CARE PROVIDER (PCP) Preventive Care Appointment Standards	
Child physical exam and wellness checks with PCP	Within 14 calendar days of request or in alignment with American Academy of Pediatrics Bright Futures Guidelines.
Initial Health Assessment (Member's aged 18 months and older)	Completed within 120 calendar days of Enrollment

PRIMARY CARE Routine (Non-Urgent) Services	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
In-Office wait time for scheduled appointment	Not to exceed 45 minutes
Non-urgent appointments (PCP Regular and Routine) Excludes physicals and wellness checks	Within 10 business days of request.*
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Within 15 business days of request.*
PRIMARY CARE Urgent Care Services	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
Urgent Access to PCP or designee	24 hours a day, 7 days a week Appointment availability during business hours from 8:00 a.m. – 5:00 p.m. and after hours on call access.
Urgent Care Services (Includes appointment with any physician, Nurse Practitioner, Physician Assistant)	Within 48 hours of request*

SPECIALTY CARE Urgent and Non-Urgent Appointment Standards	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
In-Office wait time for scheduled appointment	Not to exceed 60 minutes

Non-urgent Appointments	Within 15 business days of request*
Urgent Care Services (Includes appointment with any physician, Nurse Practitioner, Physician Assistant)	Within 48 hours of request*
Urgent Care Services (Specialist and other) that require prior Authorization	Within 96 hours of request*
BEHAVIORAL HEALTH CARE **Urgent and Non-Urgent Appointment Standards**	
APPOINTMENT TYPE	**TIME-ELAPSED STANDARD**
Non-Urgent Care Services with a - Non-Physician Mental Health Provider	Within 10 business days of the request*
Urgent Care Services	Within 48-hours*
Follow-up appointment with non-physician mental health care Substance Use Disorder Provider for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition	10 business days from the prior appointment *
Access to care for non-life-threatening Emergency Services	Within 6 hours
Access to follow-up care after hospitalization for mental illness	Must Provide Both: • One follow-up encounter with a mental health Provider within 7 calendar days after discharge, and • One follow-up encounter with a mental health Provider within 30 calendar days after discharge
***Substance Use Disorder - Outpatient services**	Within 10 business days

***Substance Use Disorder- Opioid Treatment Program** ***Substance Use Disorder services are the responsibility of the County Mental Health Program**	Within 3 business days
LONG-TERM SERVICES AND SUPPORTS (LTSS) Access Standard	
Skilled Nursing Facility and Intermediate Care Facility/Developmentally Disabled (ICF-DD) (San Joaquin and Stanislaus Counties)	Within 7 business days of the request
Skilled Nursing Facility and Intermediate Care Facility/Developmentally Disabled (ICF-DD) (El Dorado and Alpine Counties)	Within 14 business days of the request
PREVENTATIVE CARE Non-Urgent/Routine Appointment Standards**	
Preventative Services	Within 30 business days of the request

ANCILLARY SERVICES Standards	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business day of the request

* The waiting time may be extended if the referring or treating Provider, or the clinician providing triage or screening, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

**Preventative care services and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be

scheduled in advance consistent with professionally recognized standards of practice as determined by the treatment Provider acting within the scope of their practice.

PROVIDER REQUEST FOR MEMBER REASSIGNMENT OR DISMISSAL

Providers can file a grievance regarding a Health Plan Member and request member reassignment or dismissal. PCPs must submit a request for member reassignment in writing and must include the reason(s). The Provider Services Department will forward all requests for PCP reassignment to Customer Service.

Health Plan Providers have the right to request a member reassignment or dismissal. To assist you with this process, here are some best practices to ensure your request in process promptly.

1. A 30-day or more prior notice of dismissal/reassignment letter must be mailed to the member via United States Postal Service mail. The letter must include the following:
    a. Date
    b. Dismissal/Reassignment effective date
    c. Member Name
    d. Health Plan ID Number
    e. Reason for dismissal/reassignment such as:
        i. Disruptive behavior
        ii. Our office will no longer be able to provide you with patient care services due to break down in doctor-patient relationship
        iii. Non-compliance with our office policy regarding multiple missed appointments
2. Please ensure the letter is addressed to the member. If you are dismissing a minor, address letter to parent/legal guardian
3. A copy of the dismissal letter sent addressed to member must be faxed or emailed to Health Plan at providerservices@hpsj.com
4. A dismissal letter must be received for each member
5. Please remember that you are still required to see the member, prescribe medications or provide refills for up to 30 days or up to the effective date of dismissal, whichever is more, after requesting reassignment or dismissal.

A member dismissal may be granted with less than 30-day notice to the member under certain circumstances, such as a danger to the Provider or practice.

INTERPRETER SERVICES

Health Plan offers qualified interpreter services 24/7 to assist Providers and staff in communicating with Members. These services can be provided in person, over-the-phone, or via video remote interpreting. During regular business hours, bilingual Customer Service Representatives are available by phone, in person, or through a TTY/TDD line for the deaf and hard-of-hearing.

In-Person Interpreter Services

To schedule an in-person interpreter for medical appointments, contact the Customer Service Department at 1-888-936-7526, TTY 711. This service must be scheduled five (5) business days prior to the scheduled appointment for spoken languages, and ten (10) business days prior for sign language or captioning services.

Remote Interpreter Services

For interactions where an in-person interpreter is unavailable or the in-person component not required, **Remote Interpreting Services** are available at no cost through phone over-the phone interpretation OPI) and video remote interpreting (VRI) modalities. Health Plan's Cultural and Linguistic Services department assists Providers with establishing these services in their clinics or units as needed. For Providers who do not currently have a dedicated remote interpreting service established, either by themselves or through Health Plan, over-the-phone interpreters are available 24/7 and may be accessed by calling 916-249-9593, Access Code: 20696850. The call will be handled in a three-way conversation through the over-the-phone service. Video interpreting devices may also be available in your clinic or unit for 24/7, on-demand, spoken and sign language interpreting services. If you are interested in acquiring these services, Provider Relations can connect you with the Cultural and Linguistic Services department at Health Plan for consultation.

Alternative Format Selection

Alternative format selection (AFS) is a way of communicating with members who are visually impaired. Health Plan provides alternative formats such as Braille, audio CD, large print, and electronic format for easy reading. Health Plan members have the right to request member informing materials in an alternative format at no cost.

If a member selects an electronic format, such as an audio or data CD, the information will be provided encrypted (i.e. password protected). However, the member can request to receive the information unencrypted (not password protected). Unencrypted materials may make the information more vulnerable to loss or misuse.

Providers can call Health Plan's Customer Service Department at 1-888-936-7526 with Alternative Format Requests or requests for auxiliary aids.

Updating Member Preferences

When members need to update or change their preferred language and/or alternative format, Health Plan network providers and subcontractors should support members by referring them to BenefitsCal, Covered California, or their local county office to make or update their alternative format preferences. DHCS collects members' most recent alternative format preference from these sources and informs Health Plan of members' preferences.

Health Plan uses member preference data to provide materials in the member's requested format. Health Plan also shares the data with subcontractors and network providers, as appropriate. Network providers and subcontractors should use this data to determine which language and/or format to use when communicating with members.

SECTION 7: PROVIDER-MEMBER RELATIONSHIP

HEALTHREACH 24-HOUR NURSE/PHYSICIAN ADVICE LINE

Health Plan provides a 24/7 advice nurse and physician consult service through **HealthReach**.

This service is available to all Members at no cost. Members may call and speak to a registered nurse or access the audio health library for recorded messages on hundreds of health topics. If the advice nurse concludes a physician contact is needed, the nurse will connect the Member. Contact **HealthReach** at 1-800-655-8294.

TRANSPORTATION SERVICES

Health Plan can arrange medical transportation for members who qualify. Non-medical transportation (NMT) is available upon request to members for medically necessary visits.

Call Health Plan's Customer Service Department at 1-888-936-7526 to determine eligibility and schedule service.

Triage or Screen Members to Assess Urgency of Need of Care

Appropriately licensed personnel for triaging the health concerns of a Health Plan member includes:

1. Licensed physician,
2. Registered nurse (RN),
3. Certified nurse midwife (CNM),
4. Nurse practitioner (NP),
5. Physician assistant (PA), and
6. Other licensed personnel acting within their scope of practice to screen patients.

Unlicensed Personnel Are Not Eligible to Triage or Screen Medical Patients

Unlicensed personnel who process patient phone calls or unscheduled office visits may ask questions on behalf of appropriately licensed health care personnel for the purpose of determining a patient's condition. However, unlicensed personnel shall not use a patient's responses to assess, evaluate, or determine the urgency of the patient's need for care.

Please refer to Provider Alert: Provider Education: Only Licensed Personnel May Triage Medi-Cal Patients (hpsj.com) for examples.

SECTION 8: UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT PROGRAM OVERVIEW

Health Plan has Utilization Management (UM) policies and procedures that support the provision of quality and equitable health care services. The goal of UM is to provide Members with the right care, in the right place, within the most appropriate timeframe. The UM program staff can provide guidance to Providers to help support care in all clinical settings and situations including hospital admissions (both medical and psychiatric diagnoses), Long Term Acute Care, emergency situations, ancillary support, and Long-Term Care.

The key objective of Health Plan's UM Program is to improve access to care, maintain the highest quality, and create healthy outcomes, while providing the most cost-effective care possible considering the Member's needs.

COUNSELING MEMBERS ON TREATMENT OPTIONS

Every Provider has the responsibility of counseling Members as to the course and options in medical treatment regardless of whether it is a covered benefit or not. The UM Department will assist and provide care coordination, case and/or disease management services for Members at risk for substantial ongoing care. The UM Department will also assist in establishing whether the Member is eligible for other medical programs available through the State or in the local community.

AVAILABILITY OF MEDICAL REVIEW CRITERIA

The UM department conducts timely prospective, concurrent, and retrospective review of requested care and services. Licensed clinical staff evaluate treatment requests ensuring that services are medically necessary and congruent with evidence-based, nationally recognized clinical guidelines. At any time, a Provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling Health Plan at 1-888-936-7526. Appropriately licensed professionals supervise and monitor all authorization decisions. Only a physician with appropriate training, experience, and certification by the American Board of Medical Specialties, or a licensed pharmacist may defer, modify or deny a request for services based on medical necessity.

INPATIENT CARE

Health Plan uses nationally recognized, evidence-based clinical guidelines, including but not limited to MCG, to guide medical necessity review for admission, length of stay and treatment options. It is imperative that the Facility team and Health Plan work together for the clinical benefit of the Member, discharge planning and transitions of care coordination, and for clarity in claims processing.

At any time, a Provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling Health Plan at 1-888-936-7526. Appropriately licensed professionals supervise and monitor all authorization decisions. Only a physician with appropriate training, experience, and certification by the American Board of Medical Specialties, or a licensed pharmacist may defer, modify, or deny a request for services based on medical necessity.

HOSPITAL CARE

Planned (elective) admissions

The admitting physician or hospital must obtain authorization from Health Plan prior to the Member's admission. Prior authorization requests are processed within 5 business days of receipt of all information necessary to make a determination, but not to exceed 14 Calendar Days of receipt of the request. Urgent or expedited requests a decision is made within 72 hours of receipt of the request and documentation. If additional information is needed, the decision may be deferred, and the time limit extended an additional 14 calendar days. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. Requests may be submitted online through the Provider Portal Doctor's Referral Express (DRE) at www.hpsj.com/providers, or by fax at 1-209-942-6302. See section 8, page 5 of this manual for additional information.

Observation

If a patient is seen in the ER and held for observation (not admitted), observation services are paid per the contracted rate for up to 24 hours. Observation services beyond 24 hours require notification and clinical documentation to support medical necessity, which should be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 1-209-762-4702. See section 8, page 6 of this manual for additional information.

Emergency Admissions

If a patient is seen in the ER and admitted for stabilization and further treatment, no authorization is required for services required to stabilize the Member. The hospital must, within one business day after admission, notify and provide clinical documentation to support medical necessity of ongoing inpatient services, which should be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 1-209-762-4702.

Post Stabilization

California Health and Safety Code 1262.8, includes various provisions regarding emergency and post-stabilization care. Post-stabilization care is defined as medically necessary care provided after an emergency medical condition has been stabilized as defined by subdivision (j) of Section 1317.1.

Health Plan is required to provide specific health plan contact information and 24-hour access to request prior authorizations for post-stabilization care when a Health Plan Member receives emergency medical care from any hospital regardless of contract status.

If treating a Health Plan patient with an emergency medical condition, as defined by 1317.1, a prior authorization is required from Health Plan for post-stabilization care. The stabilizing hospital should conduct the following:

i. The hospital shall contact **Health Plan UM at the following phone number 1-209-461- 2205** to obtain timely authorization for post-stabilization care

Health Plan requests the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary to make a decision in authorizing post-stabilization care or to assume management of the patient's care by prompt transfer. Health Plan shall not require a hospital representative or a physician and/or surgeon to make more than one telephone call to the number provided in advance by Health Plan. The representative of the hospital may be but is not required to be a physician and/or surgeon.

When Health Plan is contacted by a stabilizing hospital and within 30 minutes from the time of the initial contact, Health Plan shall conduct either of the following:

ii. Authorize post-stabilization care

iii. In case of a potential transfer, inform the hospital that it will arrange for the prompt transfer for the enrollee to another hospital.

Admitting facility should fax admission face sheet and clinical documentation to the Inpatient Department fax, 1-209-762-4702. Assigned Concurrent Review Nurse will collaborate with the facility in discharge planning.

A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for post-stabilization care rendered to the enrollee if any of the following occur:

i. The health care service plan authorizes the hospital to provide post-stabilization care.

ii. The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize post-stabilization care or to promptly transfer the enrollee within the timeframe noted above. The request shall be deemed authorized.

iii. There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires post-stabilization care.

An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

Continued Stay (Concurrent) Review

If a Member requires additional inpatient services beyond the approved length of stay, the hospital must provide updated clinical documentation to support the medical necessity of continued inpatient care. Requests may be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 1-209-762-4702. The requests are processed within 72 hours from receipt of the request and supporting clinical documentation reasonably necessary to make a decision.

*A patient is stabilized, or stabilization has occurred when, in the opinion of the treating Provider, the patient`s medical condition is such that, within reasonable medical probability, no material deterioration of the patient`s condition is likely to result from, or occur during, the release or transfer of the patient. California Health And Safety Code Section 1317.1, Section (j)

Retrospective Authorizations

A network Provider or Practitioner may request retrospective authorization for Covered Services rendered to a member when the request is made 1) within thirty **(30) calendar days** after the initial date of service, *and* 2) if one of the following conditions apply:

a. The Member has Other Health Coverage (OHC);
b. The Member has a retrospective eligibility segment; or
c. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, and/or HPSJ eligibility at the time of service.
d. Any request for Non-Emergency Medical Transportation (NEMT) provided. The request must include a completed Health Plan Physician Certification (PCS) form validating the need for this type of service.

Out-of-network/non-contracted providers are not eligible to request retrospective authorizations.

If while doing an Outpatient procedure, the MD notices that another procedure is necessary but has not been authorized, it is ok to submit a retrospective authorization ASAP, but within 30 calendar days of the service being rendered.

Retrospective Eligibility Segment: This occurs when a member who is seen by a provider to receive services but does not have Medi-Cal eligibility or it has changed. DHCS will grant eligibility retrospectively and we would honor that as part of this protocol. For example, a member is seen in your office January 5, 2024, and DHCS retrospectively determines the member to be eligible and provides notification in February that the member is eligible from January 1 and forward.

Decision and Notification Requirements: All requests for retrospective review are required to be determined and a notification to the member and requesting provider within 30 Calendar Days of receipt of all information necessary to make a decision.

Submission Requests: When submitting your retrospective authorization request, please include a completed authorization request form with the Retrospective Review box checked and all clinical information demonstrating medical necessity of the request.

Please direct questions to your Provider Services Representative who will work with Utilization Management to address your questions.

UTILIZATION MANAGEMENT STAFF AVAILABILITY

Providers are encouraged to contact Health Plan's Utilization Management Staff and the Medical Directors to discuss referrals, case management services for specific Members, or other areas of concern.

UM Staff Availability during Normal Business Hours

Health Plan's UM staff Members are available Monday through Friday from 8:00 a.m. to 5:00 p.m. pacific time to receive and respond to inquiries regarding UM issues from Members and Providers. UM staff Members can be reached at 1-888-936-7526. Providers can also contact the Intake Processor of the Day (IPOD) located on the Provider Portal who can assist with

Authorizations or questions. The phone number to reach the Medical Director regarding an UM issue is 1-209-942-6431.

UM Staff Availability After Hours

Hospitals who need urgent authorization for admission may call 1-209-461-2205, 24 hours/day, 7 days/week. Providers who need assistance with routine matters may leave a secure voice mail message after normal business hours at 1-888-936-7526. Voice mail messages are retrieved each business day at 8:00 a.m. by a Customer Service Representative who responds to the call or routes the message to the appropriate UM staff Member. Responses to voice mails are returned no later than the next business day.

REFERRALS TO IN-NETWORK/OUT-OF-NETWORK PROVIDERS

Health Plan maintains a wide network of Providers to ensure that most health care needs can be provided within the Service Area. These Network Providers are best prepared to accept referrals and operate within the guidelines established by Health Plan. These Providers also meet the standards for timely and geographic access for our Members. If Providers are experiencing difficulty in locating a local Provider that can meet the Member's medical needs, they should contact the UM Department at 1-888-936-7526.

In some cases, Health Plan may have exclusive contracts with specialty Providers. In these instances, referrals must be directed to these Providers. Currently all laboratory, and some vision and durable medical equipment services are contracted through specific vendors. For more information on referral to Providers please contact the UM Department at 1-888-936-7526.

If Covered Services are needed from an out-of-network Provider, the UM Department should be contacted at 1-888-936-7526 to obtain approval for the referral. Health Plan's Contracting Department will contact Providers that may be available to meet the clinical needs of the Member.

CONTINUITY OF CARE

Health Plan provides continuity of care for Members when their Provider is no longer part of the network or when the Member is transitioning from Medi-Cal fee-for-service (FFS) to Health Plan or from another managed care plan to Health Plan, upon request. Health Plan Members can continue to see their non- contracted Provider for up to 12 months from effective date with Health Plan when:

- Member has an existing relationship with the Provider
- Provider accepts Health Plan's reimbursement rate or Medi-Cal FFS rate
- Provider is in good standing and does not have any disqualifying quality of care issues
- Provider is a California State Plan Provider
- Provider supplies Health Plan all relevant treatment information

Continuity of Care does not apply for services not covered by Medi-Cal, or DME, transportation, other ancillary services, or carved-out service Providers.

If you are a non-contracted Provider providing services to a Health Plan Member, you may initiate a request for continuity of care by submitting a Medical Authorization Form available on Health

Plan's website at www.hpsj-mvhp.org. or by contacting Customer Service at 1-888-936-7526.

OBTAINING A SECOND OPINION

Health Plan honors the Member's right to obtain a second opinion from another Provider when indicated. To coordinate this, the Member should be directed to an in-network Provider. If an in-network Provider is unavailable, Authorization for an out-of-network second opinion should be requested. The UM Department will notify the requesting Provider in writing of the result of the authorization request and assist the member with making arrangements for the second opinion upon request.

Health Plan will allow a second opinion to Members by an appropriately qualified healthcare professional, if requested by a Member or a participating Provider who is treating the Member. An authorization is not needed for a second opinion with an in-network Provider. If the Provider is out of network, an authorization is needed. Health Plan will also arrange transportation if needed for the second opinion.

COVERED SERVICES THAT DO NOT NEED PRIOR AUTHORIZATION/REFERRAL

Health Plan permits a member to obtain some Covered Services without a referral or Prior Authorization. A complete list of these Covered Services can be found on the Provider Portal and should be regularly reviewed for changes. Basic prenatal care with an-in network provider does not require a referral or prior authorization.
However, the following Covered Services never need a referral or authorization from Health Plan. Members may choose an in-network Provider or an out-of-network Provider for:

- Emergency
- Services
- Certain preventative services (Access the Provider Portal for more information)
- Basic prenatal care in-network
- HIV testing
- Minor Consent Services
- Outpatient Hospice
- Family Planning
- Treatment and diagnosis of sexually transmitted diseases (STDs)
- Sensitive services for both men and women
- Well women health service

SECTION 8: UTILIZATION MANAGEMENT

STANDING/EXTENDED REFERRALS

Health Plan's Primary Care Providers (PCP) may request a standing or extended access referral to a non-network Specialist for a Member who has ongoing specialty care needs. Health Plan will refer Members to contracted specialists unless there is no specialist within the plan network that is appropriate to provide treatment to the Member, as determined by the primary care physician in consultation with the planned medical director as documented in the treatment plan. When a standing or extended access referral is medically necessary and there is no appropriate network specialist to provide treatment to the Member, the standing or extended referral will be approved to an out of network Specialist for up to 12 months.

Conditions necessitating a standing or extended access referral and/or the development of a treatment plan are interpreted broadly as a "condition or disease that requires specialized medical care over a prolonged period of time and as life threatening, degenerative or disabling" and could include but are not limited to the following:

- Hepatitis C
- Lupus
- HIV/AIDS
- Cancer
- Potential transplant candidates
- Severe and progressive neurological condition
- Renal failure
- Cystic fibrosis
- Acute leukemia
- High risk pregnancy

Affirmative Statement on Incentives

Health Plan's UM decision making is based solely on appropriateness of care, service, and existence of coverage. Health Plan does not specifically reward any Provider or other individuals for issuing denials of coverage. Financial incentives for UM decisions do not in any way encourage decisions that result in underutilization.

SUBMITTING REQUESTS FOR AUTHORIZATIONS

Providers must verify a Member's eligibility before submitting a referral for Authorization for Covered Services. Eligibility may be verified through the Provider Portal located in the Provider area of the Health Plan website (www.hpsj-mvhp.org). Alternate methods to verify eligibility are detailed in this Manual under "Eligibility Verification, Member Enrollment, and Customer Service." The list of services that require Prior Authorization, and the Authorization Request Form are located in the Provider Portal, and on the Provider page of Health Plan's website.

ADVANTAGES OF SUBMITTING AUTHORIZATIONS ONLINE

Providers can submit referrals online through the portal or by fax at 1-209-942-6302. Online is the preferred mode of submission, with the following advantages for Providers:

- Immediate access to the status of the referral (not available for faxed requests)
- Direct communication with Health Plan staff via the Provider Portal regarding any aspect of the Authorization status

The following information is required for Authorization Requests:

- Member's demographic information (name, date of birth, etc.)
- Request type (Office Based or Facility)
- Requester
- Requester affiliation or "Pay to Service"
- Provider's National Provider Identifier (NPI) (only required for paper submissions)
- Provider Group's NPI (if there is a Group NPI; only required for paper submissions)
- Provider's tax ID number (only required for paper submissions)
- Location where services will be provided
- Requested service/procedure, including specific CPT/HCPCS codes and quantity requested
- Member diagnosis (ICD code and description)
- Signature of requesting Provider Modifiers, if applicable
- Fax back number
- Clinical indications necessitating service or referral
- Pertinent medical history and treatment
- Medical records and/or other documents supporting the request
- Supporting clinical documentation (Clinical information can be scanned and uploaded directly into the Provider Portal along with the Authorization request.)

TURNAROUND TIME FOR PRIOR AUTHORIZATION

The turnaround time for a prior Authorization depends on the status of the request:

- **Expedited Request**: Within seventy-two (72) hours of receipt of Authorization request
- **Standard Request:** Within five (5) Working Days of receipt of information to make a determination and, not to exceed fourteen (14) calendar days of receipt of the request.
- Prompt Authorization determinations are made in accordance with the guidelines when all supporting clinical information that supports medical necessity is submitted along with the Authorization request.

EMERGENCY/URGENT CARE SERVICES

Emergency and Urgent Care Services are available at any time without Authorization. Health Plan does not deny claims for Emergency Services including screening (triage) even when the condition does NOT meet the medical definition of "Emergency Services". Hospitals, urgent care centers, and professional services (including labs, ancillary services, etc.) cannot bill, charge, or collect money from any Member for any Emergency or Urgent Care Services. PCPs should council Members if they are using hospital Emergency Services for routine, non-Emergency medical conditions.

As appropriate, Members should use urgent care facilities for urgent non-Emergency conditions. Health Plan has contracted with urgent care centers throughout the Service Area and they offer both convenient hours and, in most cases, shorter waiting times than Emergency Rooms.

Observation Stay

Certain Health Plan hospital service agreements contain a provision for an observation stay. An observation stay means a period of up to 24 hours when continuous monitoring, on an out-patient basis, is required to evaluate a Member's medical condition or determine the need for an inpatient admission.

An observation stay is only covered when ordered by a physician and meets medical necessity criteria. No Authorization is required for an observation stay lasting 0-24 hours.

The following is a list of conditions that may be appropriate for an observation stay.

Condition or Symptom	Purpose of Observation
Abdominal Pain	Rule out and manage pain
Chest Pain	Rule out and manage pain
Back Pain	Rule out and manage pain
Syncope	Rule out, stabilize and treat
Seizures	Rule out, stabilize and treat
Fever of unknown origin	Rule out, stabilize and treat
Asthma	Stabilize and treat
Bronchitis	Stabilize and treat
Bronchitis (pediatric only)	Stabilize and treat
Cellulitis	Culture, sensitivity test and plan of care
Concussion	Stabilize and observe
Croup (pediatric only)	Stabilize and treat
Dehydration	Stabilize and treat
Drug overdose	Stabilize, Manage and refer
Gastroenteritis	Stabilize and treat
Migraine headaches	Manage pain
Neurological deficit (pediatric only)	Rule out, stabilize and treat
Phlebitis	Rule out and stabilize
Pneumonia	Rule out and give first dose(s) of agent(s)
Renal colic/calculus	Stabilize and treat
General malaise and fatigue	Rule out, stabilize and treat

INPATIENT ADMISSIONS

All non-emergency (elective) admissions to Acute Care, Acute Rehabilitation, Long-Term Acute Care, and Long-Term Care facilities require Prior Authorization. Providers are also required to admit Members only to Hospitals contracted with Health Plan. Elective admissions to out-of-network facilities will require prior Authorization.

Long-Term Care

Health Plan covers long-term care services for Members who need out-of-home placement in a long-term facility due to their medical condition.

Types of Long-Term Care Facilities

Medi-Cal covered long-term care services include placement in the following types of facilities:

- Nursing Facility Level A (NF-A) and Level B (NF-B)
- Subacute Care Facilities – both adult and pediatric facilities
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Intermediate Care Facilities for the Developmentally Disabled Habilitative (DD-DH)
- Intermediate Care Facilities for the Developmentally Disabled Nursing (DD-N)

Health Plan coordinates placement in a health care facility that provides the appropriate level of care based on Member's medical needs.

Criteria for Admission

The Medi-Cal long-term care benefit has specific criteria for admission to each type of long-term care facility based upon the Member's diagnosis, physical limitations, and medical treatment needs. If a Provider intends to refer a Health Plan Member to a nursing facility, it is important to understand Medi-Cal's facility-specific criteria. Providers can use the following link to find the long-term care admissions criteria for each type of facility: www.medi-cal.ca.gov

Referring a Member to a Nursing Facility

Here are several important reminders for physicians who intend to refer a Health Plan Member to a nursing facility:

1. To refer a Member to a nursing home, the physician must order the admission and provide the following information:
    a. The Members' medications, diet, activities, and medical treatments, such as wound care and labs.
    b. A current history and physical
    c. Diagnosis/diagnoses
    d. Indication of whether the physician will be following the Member once admitted to the facility
2. In making the referral, the physician must identify the facility of admission. The Member and/or the Member's authorized representative may also seek the physician's counsel in determining an appropriate facility.
3. The admitting facility is responsible for obtaining authorization from Health Plan. The admitting facility will present medical justification for the level of care requested. If the authorization request is not approved or is modified, the Member, physician, or facility has an option to appeal the determination.

Trauma Care

Certain Health Plan contracted hospital service agreements contain a provision for trauma care. The hospital must be a designated trauma facility to receive reimbursement for trauma care. Trauma care is defined as inpatient or outpatient services provided during one uninterrupted admission or outpatient service initiated in a hospital emergency department of a Member who is treated directly by the hospital trauma-based care team. The Member's condition must meet the trauma triage protocol adopted by the American College of Surgeons committed on trauma or the

hospital's specific emergency medical services criteria.

Trauma activation is defined as an on-site active participation of Members of the trauma team including trauma surgeon, in the care of the Member from admission in the hospital emergency department, in accordance with the applicable triage guidelines and criteria and in response to the pre-arrival notification.

1. The initial evaluation of the Member must take place within 30 minutes of the Member arriving to the emergency department; this evaluation must take place within 8 hours of the traumatic event should the Member be transferred from another facility.
2. The hospital's contracted trauma reimbursement rate will not be paid if the initial evaluation of the Member does not take place within 30 minutes of the Member arriving in the emergency department or within 8 hours of the traumatic event if the Member is transferred from another facility.
3. The activation of the trauma team must be in response to the notification of key hospital personnel by pre-hospital caregivers.
4. A Member who dies prior to arriving at the hospital cannot be charged the trauma team activation rate regardless of whether the pre-hospital caregiver notification was provided to the receiving hospital.
5. A Member who dies within 24 hours of arriving in the Emergency Department can be charged the outpatient trauma rate.

Health Plan requires the following documentation be submitted to the Utilization Management (UM) Department to allow trauma charges:

1. A trauma activation sheet completed at the time of the Emergency Department assessment and documentation submitted.
2. Documentation the nurse triage responded to the patient immediately upon arrival.
3. Documentation that the physician responded with a patient assessment within 15 minutes (Level1) and within 30 minutes (Level 2 and 3).

Trauma triage protocol per local county EMS agency includes the Member meet at least one of the criteria listed below in order for a valid trauma activation and subsequent trauma charge:

1. Anatomic Criteria
    a. All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee
    b. Flail chest
    c. Two or more proximal long-bone fracture
    d. Crushed, degloved or mangled extremity
    e. Amputation proximal to wrist and ankle
    f. Pelvic fractures
    g. Open or depressed skull fracture
    h. Paralysis
2. Physiologic Criteria
    a. Glasgow coma scale (GCS) of < 14

b. Systolic blood pressure (SBP) of < 90 mm HG; or
c. Respiratory rate of < 10 or > 29 breaths per minute (< 20 in infant aged < 1 year)

3. Mechanism Criteria
   a. Falls
      i. Adults: fall > 20 feet (one story = 10 feet)
      ii. Children aged < 15 years: fall 10 feet or two to three times child's height
   b. High-risk auto crash
      i. Intrusion: > 12 inches to the occupant site or > 18 inches to any site
      ii. Ejection (partial or complete) from automobile
      iii. Death in same passenger compartment
      iv. Vehicle telemetry data consistent with high-risk or injury;
      v. Auto versus pedestrian/bicyclist thrown, run over or with significant (> 20 mph) impact; or
      vi. Motorcycle crash > 20 mph

A copy of the criteria used for evaluating trauma is available upon request.

Administrative Day

Certain Health Plan contracted hospital service agreements contain a provision for administrative days. An administrative day means an authorized inpatient day for a Member who no longer meets medical necessity criteria for inpatient service at an acute care hospital, is unsafe for discharge and is pending placement in a nursing home or other subacute or post-acute care.

Authorization from Health Plan's Utilization Management (UM) Department is required for an administrative day. The inpatient facility requesting the administrative day must submit daily documentation of the Member's condition, type of services received and documented reasonable five (5) attempts of placement efforts in a nursing home or other subacute or post-acute care. The hospital must continue daily placement attempts in a nursing home or subacute or post-acute care during the Member's administrative day stay.

INPATIENT CONCURRENT REVIEW

To ensure quality and cost-effective inpatient care, Members must receive the appropriate level of care while they are in the inpatient setting. Health Plan's goal is a safe, efficient Member discharge transition to the most appropriate and least restrictive setting that meets the Member's needs. Upon admission to an inpatient facility, a Concurrent Review Registered Nurse (CCRN) reviews the facility clinical documentation to ensure the Member is receiving quality care at the appropriate intensity regardless of whether the care is delivered in an acute, rehabilitation, skilled, or other inpatient setting. Clinical information should be submitted within 24 hours.

Health Plan's physicians and other licensed clinical staff apply national standards of care (*MCG*) to determine the medical necessity for the inpatient stay and the level of care, namely, acute medical-surgical, telemetry, intermediate or intensive care unit level of care. If the medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the inpatient stay or for the level of care requested, the inpatient stay will be

denied by the Medical Director.

The Facility and Provider are provided the reason for the denial and the appeal rights. If the level of care that is delivered to the Member is deemed inappropriate, the level of care billed by a facility is subject to denial.

Health Plan's CCRN leverages a team approach with facility staff to successfully coordinate medical care and plan for post-discharge needs. Updated clinical information which includes facility CM contact information should be submitted daily or as requested. The CCRN or Medical Director may need to contact the Attending Physician to address complex issues or problems that arise.

INITIAL HEALTH APPOINTMENTS

Within one hundred twenty (120) days of the date of Enrollment or change of PCP, PCPs must perform an Initial Health Appointment (IHA) for all Members. For Members less than 18 months of age, IHA must happen within 120 calendar days of enrollment or within periodicity timelines established by the AAP Bright Futures for age 2 and younger, whichever is sooner.

An IHA must be provided in a way that is culturally and linguistically appropriate for the Member and must be documented in the Member's medical record.

An IHA must include ALL of the following:

- A history of the Member's physical and mental health.
- An identification of risks.
- Dental screening and oral health assessments for children under age three (3) years old, including a referral to a dental Provider if needed.
- Immunizations including documentation of all age-appropriate immunizations in the Member's medical record.
- An assessment of need for preventive screens or services.
- Health education; and
- The diagnosis and plan for treatment of any diseases.

An IHA is not necessary if the PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months.

For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. IHA must include age-appropriate childhood screenings including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and SUD.

For adults, PCPs should continue to provide all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all these elements to be completed during the initial appointment, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.

ADULT PREVENTIVE GUIDELINES

Health Plan of San Joaquin | Mountain Valley Health Plan

When it comes to patient care, HPSJ/MVHP is on your team. We understand that preventive health care is about improving quality of life. This quick reference guide is here to help you reach those goals with your patients.

Screening Recommendations	21 to 39	40 to 49	50 to 65	65 and Older
Initial Health Visit	Within 120 days of enrollment			
History and Physical Exam	Every Year			
Blood pressure, Weight, and Height Check	With Every History and Physical			
Alcohol misuse screening and counseling	Recommended			
Drug misuse screening and counseling	Recommended			
Depression and Anxiety Training	Recommended			
Obesity	Recommended			
Tobacco Use Screening	Recommended			
HIV Infections	Recommended			If at risk
Syphilis	If at risk			
Tuberculosis	Screen all and test at risk			
BRCA Gene Screening	Talk to Doctor about risks (e.g. family history of breast or ovarian cancer)			
Chlamydia and Gonorrhea	Screening in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection			
Intimate Partner Violence	Childbearing-aged women			
Cervical Cancer	Pap smear every 3 years, or every 5 years with HPV co-testing starting at age 30			
Abnormal Glucose/Diabetes		Recommended		
Hepatitis C Screening	If at risk			
Colorectal Cancer		Recommended		
Breast Cancer		Biennial Screening		
Lung Cancer Screening			If at risk	
Osteoporosis		If at risk		
Abdominal Aortic Aneurysm				If an "ever smoker"
Preventive Therapies				
Primary Prevention of Breast Cancer	If at risk			
Folic Acid Supplementation	If capable of conceiving			
Statins for Primary Prevention of CVD	If at risk			
Aspirin for Primary Prevention of CVD and Colorectal Cancer		If at risk		
Fall Prevention in Community-dwelling Older Adults			If at risk	
Immunizations				
Influenza and COVID-19	One dose annually			
Tetanus, diphtheria, pertussis (TDAP)	1 dose Tdap, the Td booster every 10 years			
Shingles (Zoster)			2 doses	
Pneumococcal Conjugate			1 dose	
Meningococcal B	If at risk			
Meningococcal A, C, W, Y	If at risk			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			
HPV (Female)	2 or 3 doses depending on age at initial vaccination 19-26 yrs			
HPV (Male)	2 or 3 doses depending on age at initial vaccination 19 -21 yrs			
Chickenpox (Varicella)	2 doses (if born in 1980 or later)			
Hepatitis A	If at risk			
Hepatitis B	If at risk			
Hepatitis C (HCV)	If at risk			
Haemophilus influenza type b (Hib)	If at risk			
RSV for pregnant people	If at risk			
Counseling Recommendations				
Sexually Transmitted Infection	If at risk			
Diet/Activity for CVD*	If at risk			
Skin Cancer	If at risk			
Weight		BMI 18.5 - 29.9 kg/m²		

Recommended for Women Only | Recommended for Men Only | Recommended for all Adults

* CVD=Cardiovascular Disease

For full guidelines visit www.uspreventiveservicestaskforce.org

Sources: USPSTF Recommended Adult Preventive Health Care Schedule Grade A and B 2024, CDC Recommended Adult Immunizations 2024

ANNUAL COGNITIVE HEALTH ASSESSMENT

In accordance with APL 22-025, Health Plan provides coverage for annual cognitive health assessments for Members who are 65 years of age or older who do not have Medicare coverage. DHCS All Plan Letters (APLs) may be found here, www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

This assessment may be performed by any licensed health care professional contracted with Health Plan who is enrolled as a Medi-Cal Provider, is acting within their scope of practice, and is eligible to bill Evaluation and Management (E&M) codes.

Contracted Providers must complete the following steps to bill and receive reimbursement for these annual assessments:

- Complete the DHCS Dementia Care Aware cognitive health assessment training prior to performing the assessments.
- Administer the assessments as part of E&M visits.
- Create required documentation.
- Use appropriate CPT codes.

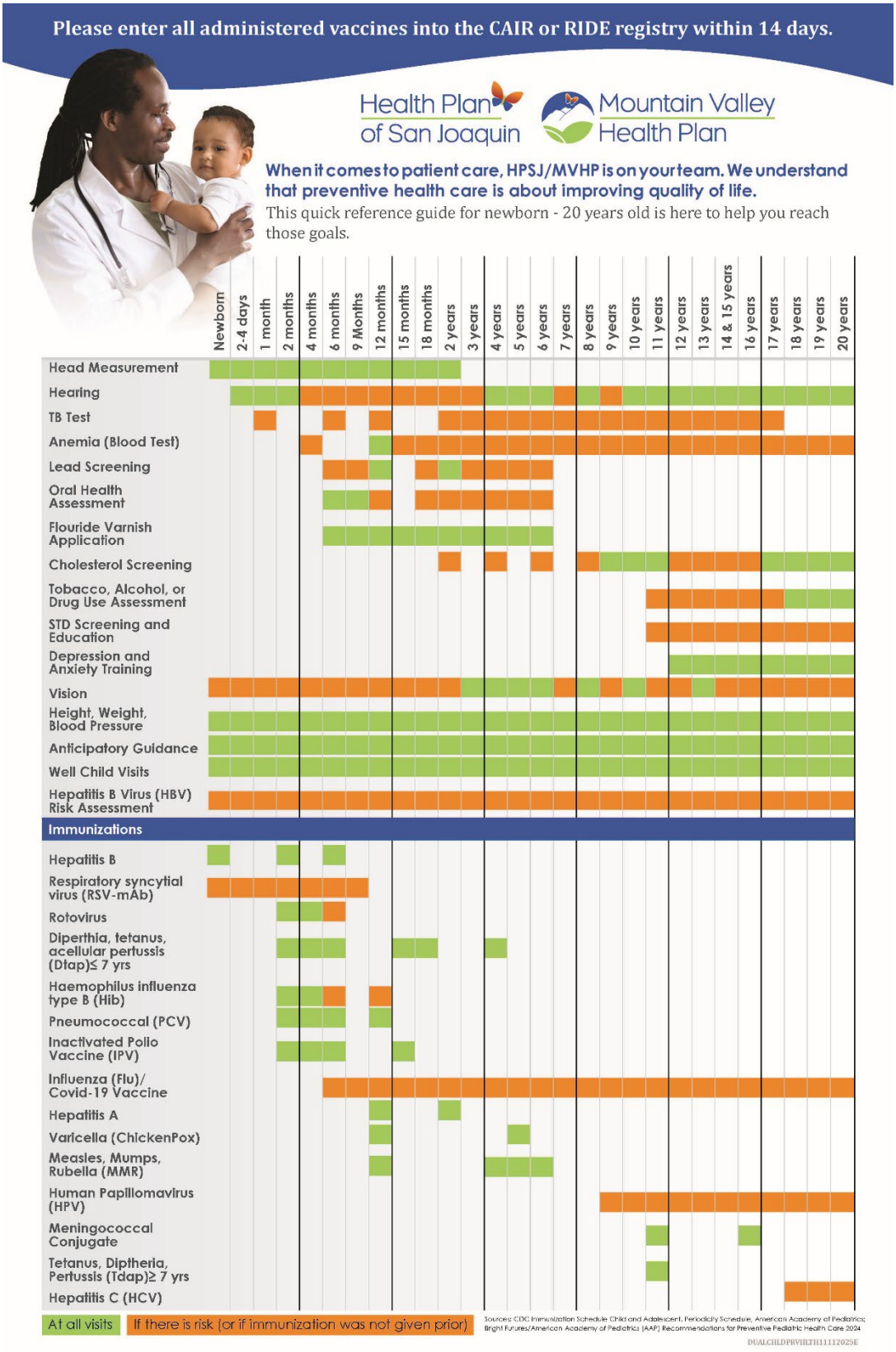
Providers must use at least one of the required cognitive assessment tools:

- General Practitioner Assessment of Cognition (GPCOG)
- Mini-Cog
- Eight-item Informant Interview to Differentiate Aging and Dementia
- Short Informant Questionnaire on Cognitive Decline in the Elderly

Providers are advised to continue to provide assessments, referrals and treatments as needed to Members under 65 years of age who show or report symptoms of cognitive decline.

For questions about the Annual Cognitive Health Assessment, please contact your Provider Relations representative.

PEDIATRIC PREVENTIVE GUIDELINES



BLOOD LEAD SCREENING OF YOUNG CHILDREN

All Providers who perform Periodic Health Assessments (PHAs) on child Members between the ages of six months to six years (i.e. 72 months) must comply with current federal and state laws, and industry guidelines for health care Providers issued by the California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB), including any future updates to these guidelines.

Guidelines specific to lead screening are as follows:

1. Provide oral or written anticipatory guidance to the parent(s) or caregiver(s) of a child Member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. Anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.
2. Order or perform blood lead screening tests. Blood lead screening tests may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. Testing must be performed on all child Members in accordance with the following:
    a. At 12 months and at 24 months of age.
    b. When the network Provider performing a PHA becomes aware that a child Member who is 12 to 24 months of age has no documented evidence of a blood lead screening test performed at 12 months of age or thereafter.
    c. When the network Provider performing a PHA becomes aware that a child Member who is 24 to 72 months of age has no documented evidence of a blood lead screening test performed.
    d. At any time, a change in circumstances has, in the professional judgement of the network Provider, put the child Member at risk.
    e. If requested by the parent or caregiver.
    f. Laboratories and Providers that perform a blood lead analysis drawn in California must electronically report all blood lead levels, along with the information specified in California Health and Safety Code, Section 124130, to the EBLR System.
3. Follow up must be performed for all positive screening results. While the minimum requirements for appropriate follow-up activities, including referral, case management and reporting, are set forth in the CLPPB guidelines, a Provider may determine additional services that fall within the EPSDT benefit are medically necessary. Health Plan will ensure that Members under the age of 21 receive all medically necessary care as required under EPSDT.
4. Reporting timeframe for all blood lead results:
    a. Greater than or equal to 10 ug/dl must be reported within 3 working days of analysis.
    b. Less than 10 ug/dl must be reported within 30 calendar days of analysis.

Reporting of the blood lead test results to the State go into a system called The Response and Surveillance System for Childhood Lead Exposures (RASSCLE).

Providers may also report directly to San Joaquin County Public Health Services Childhood Lead Poising Prevention Program (CLPPP), by faxing the results to 1-209-953-3632. Once received via fax and reviewed they will be entered into RASSCLE if they are not, they will send them to the State to be uploaded into RASSCLE.

To reach your local CLPPP resources:
For San Joaquin:
Email: phs-clppp@sjcphs.org
Main line: 1-209-468-2593
Fax: 1-209-953-3632
Website: Childhood Lead Poisoning Prevention Program (CLPPP)

For Stanislaus County:
Phone: 1-209-558-8860
Fax: 1-209-558-8859
Email: CLPPP@schsa.org

For El Dorado County:
Phone: 1-530-573-3165

For Alpine County:
Contact the State Childhood Lead Poisoning Prevention Branch at 1-510-620-5600.
For case management inquiries: CLPPBPHN@cdph.ca.gov
For all other inquiries: CLPPBOutreach @cdph.ca.gov

For more information
Blood Lead Reporting Requirements Website:
www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx

Blood Lead reporting inquiries: EBLRSupport@cdph.ca.gov or complete the EBLR Contact Form

1. Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.
2. Network Providers are not required to perform a blood lead screening test but should clearly document in patient medical record if either of the following applies:
    a. In the professional judgment of the network Provider, the risk of screening poses a greater risk to the child Member's health than the risk of lead poisoning.
    b. If a parent, caregiver, or other person with legal authority chooses to withhold testing, the Provider must obtain and retain a signed statement of voluntary refusal along with the reason for the refusal to consent to the screening. This evidence shall be retained to ensure compliance with Blood Lead Screening requirements.
    c. Follow the current CLPPB issued guidelines when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up care.

Including additional confirmatory venous testing, referrals, case management and reporting as set forth in the CLPPB guidelines. Additionally, network Providers may determine additional services that fall within the Early and Periodic Screening, Diagnostic and Testing (EPSDT) benefit are medically necessary.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) – CALIFORNIA HEALTH AND DISABILITY PROGRAM (CHDP)

Providers who see children less than twenty-one (21) years of age must participate in CHDP. CHDP is Medi-Cal's comprehensive and preventive child health program for individuals. Recipients receive periodic health screening exams required by the federal Medicaid "*Early and Periodic Screening, Diagnostic and Treatment"* mandates in California. Corrective treatment resulting from child health screenings must be arranged even if the service is not available to the rest of populace.

The Health Plan's Utilization Management team will assist Providers in such arrangements. The following minimum elements are included in the periodic health screening assessment:

- Comprehensive health and development history (including assessment of both physical and mental development
- Comprehensive unclothed physical examination
- Immunizations appropriate to age and health history
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
- Dental screening and services
- Hearing screening and services, including at a minimum diagnosis and treatment for defects in hearing, including hearing aids
- Appropriate behavioral health and substance abuse screening
- Health education, counseling, and anticipatory guidance as the child develops
- Appropriate laboratory tests (including lead toxicity screening)

VACCINES FOR CHILDREN (VFC)

The Vaccines for Children Program (VFC) Program is administered through the Centers for Disease and Prevention (CDC) and the National Center for Immunization and Respiratory Diseases. VFC provides vaccines at no cost to children who might not otherwise be vaccinated because of their inability to pay. CDC buys vaccines at a discounted rate and distributes them at no charge to those private physicians' offices, public health clinics, and pharmacies registered as VFC Providers. Children enrolled in Health Plan are eligible for free vaccines. Providers are paid for administering the vaccines. Please see the section in this Manual on "Claims and Billing" for billing instructions. Health Plan's Network Providers must document each member's need for ACIP-recommended immunizations as part of all regular health visits, including, but not limited to the following types of encounters:

- Illness, care management, or follow-up appointments
- Initial Health Appointments (IHAs)
- Pharmacy Services

- Prenatal and postpartum care
- Pre-travel visits
- Sports, school, or work physicals
- Visits to an LHD
- Well patient checkups

Effective January 1, 2023, all California healthcare providers who administer vaccines are to enter immunization information for each patient in the immunization registry(ies) established in Health Plan's service areas as part of the Statewide Immunization Information System within fourteen (14) calendar days, and in accordance with state and federal laws.

Please see the VFC program details at the following link. https://eziz.org/vfc/overview/

- Benefits to Providers
- How to enroll Online https://eziz.org/vfc/enrollment/
- Covered Vaccines
- Who can be a VFC Provider
- Medi-Cal's relationship with VFC

Additional resources:

- VFC Provider Requirements https://eziz.org/vfc/Provider-requirements/
- Provider Enrollment https://eziz.org/vfc/enrollment/
- Immunization Quality Improvement for Providers https://eziz.org/vfc/Provider-requirements/iqip/

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Preventative Care

Health Plan and its contracted practitioners and Providers must comply with state and federal laws and regulations regarding the provision of Medi-Cal services including Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The EPSDT benefit is set forth in the Social Security Act (SSA) Section 1905(r) and Title 42 of the United States Code (USC) Section 1396d. 1, 2. The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program.
According to guidance from the Centers for Medicare and Medicaid Services (CMS), titled EPSDT — A Guide for States,

"The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting."

"California Welfare and Institutions Code, section 14059.5, subd. (b), defines medically necessary services for individuals under 21 years of age as those services that meet the standards set forth in Section 1396d(r)(5) of Title 42 of The United States Code. Accordingly, a service is considered "medically necessary" or a "medical necessity" if it corrects or ameliorates defects and physical and mental illnesses and conditions discovered by the screening services, whether such services are covered under the State Plan".

Health Plan adopts Preventative Screening Guidelines recommended by The American Academy of Pediatrics, Bright Futures Guidelines, Guidelines for the Pediatric Prevention Care and American Academy of Family Physicians Adult Preventative Guidelines.

Linked and carved out services must be coordinated for the following services when a need is identified:

Behavioral Health Care Services

Prior authorization is not required for referral to an in-network mental health practitioner. If out of network services are needed for continuity of care or other medically necessary reasons, please submit a prior authorization request (see Forms & Documents for HPSJ/MVHP Providers found at www.hpsj.com/forms-documents). Physician and other medical practitioner offices can refer Members directly to in-network mental health practitioners listed in Health Plan's Provider directory, Members can call for appointments directly (they can self-refer), or call Health Plan's Behavioral Health Customer Service Department at 1-888-581-PLAN (7526) for questions and assistance.

Behavioral Health Treatment or Applied Behavior Analysis for Members under 21 PCP Referral Options:

For Members under age 21 that need BHT services including but not limited to autism spectrum disorder:

- Send prior authorization request for Behavioral Health Treatment, complete and send the "Behavioral Health Treatment Prior Authorization Form" located on Forms & Documents for HPSJ/MVHP Providers (found at www.hpsj.com/forms-documents) along with the recommendation completed by a Licensed Physician or Licensed Psychologist.
    - An option for this is for the provider to complete the BHT/ABA Recommendation Form located on Forms & Documents for HPSJ/MVHP (www.hpsj.com/forms-documents)
- Should a member be in need of case management or care coordination, a provider can send referral using the "Behavioral Health Services Referral form" located on Forms & Documents for HPSJ/MVHP Providers (www.hpsj.com/forms-documents).

Call Behavioral Health Customer Service Center at 1-888-581-PLAN (7526) during normal business hours (M-F 8:00 a.m. - 5:00 p.m.) for any questions or guidance regarding the referral process. Also applies to Community Providers.

Behavioral Health Department's Next Steps:

- BHT Services Care Coordinator contacts Member to assist securing resources for services
- Health Plan representative will contact the PCP to confirm completion of referral process

Health Plan of San Joaquin

Health Plan of San Joaquin/Mountain Valley Health Plan
Behavioral Health Services Referral Form

Mountain Valley Health Plan

Referral Date:_____ Member Name:_____ Medi-Cal CIN ID#:_____

DOB: _____ Parent/Guardian Name:_____ Preferred Language: _____

Phone: _____ (home); _____ (parent/guardian's cell); _____ (member's cell)

Member address: _____

Does the minor 12 and older have capacity to give consent to services? ☐ Yes ☐ No If no, please explain _____

Best day/time to reach the member: _____ Best day/time to reach the parent/guardian: _____

PCP Clinic/Agency: _____ Name of PCP: _____ PCP Phone #: _____

To receive a confirmation of this referral's outcome, please check the box below noting preferred method and contact details:

☐ Email address: _____ ☐ Fax Number: _____

☐ **Please check** to confirm member eligibility was verified

---

Name of Requestor _____

Requestor (one request per referral form)

☐ PCP ☐ BH Provider ☐ Regional Center ☐ Other _____

☐**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Health Plan's network of providers when their needs are outside the PCP scope of practice. Health Plan can coordinate member care with county mental health. *Fax:* ***1-209-762-4761*** *OR secure email: BHCM@hpsj.com*

☐**Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old with a Licensed Psychologist or Physician order requesting ABA services. *Fax:* ***1-209-762-4760*** *OR secure email: BHTReferral@hpsj.com*

☐**Referral for Psychological or Neuropsychological testing:** Refer members to psychological/neuropsychological testing via Health Plan's network of providers when their needs are outside the PCP scope of practice. Health Plan can coordinate member care with county mental health. *Fax:* ***1-209-762-4760*** *OR secure email: BHTReferral@hpsj.com*

Request Reason (check all that apply):

Symptoms:

☐ Depression
☐ Poor self-care due to mental health
☐ Psychosis (auditory/visual hallucinations, delusional)
☐ Adverse Childhood experiences (ACEs)
☐ Perinatal depression/anxiety
☐ Violence/Aggressive behavior
☐ Psychological testing
☐ Neuropsychological testing
☐ PTSD/Trauma
☐ Abuse/CPS
☐ Chronic Pain
☐ Anxiety
☐ Substance use type: _____
☐ Other BH symptoms: _____

Impairments:

☐Difficult/Unable to complete ADLs ☐Difficulties maintaining relationships ☐Legal/CPS
☐Difficult/Unable to go to work/school ☐Other:_____
Medications (list below or send medication list with this form):
_____

Motivation for Services (check all that apply)

☐ Member (or guardian) has been informed for referral to Health Plan's Behavioral Health Services
☐ Member wants services for self (or dependent)
☐ Member is unsure or ambivalent about services for self (or dependent)
☐ If applicable, Patient has completed a PHQ-2/PHQ-9, Score _____

For members 12 and older, in certain situations under privacy law AB1184 a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.

DUALBHPCPRFRL09302024E

DEVELOPMENTAL DISABILITY SERVICES (DDS)

A developmental disability is a disability which originates before an individual reaches twenty-one (21) years old, continues or can be expected to continue indefinitely, and which constitutes a substantial disability for that individual. This term includes but is not limited to developmental delay, cerebral palsy, epilepsy, autism, and disabling conditions, but exclude other handicapping conditions that are solely physical in nature.

As part of the initial health assessment and routine health assessment (which will be done according to the American Academy of Pediatrics Periodicity Schedule), the PCP or Specialists must screen and identify individuals with significant developmental delay or those at risk for developmental disability and make the appropriate referral to the appropriate Regional Center and for cognitive delays and behavioral health concerns to our Behavioral Health Treatment team to request an evaluation and referral for services. The following information must be included:

- Reason for the referral
- Complete medical history and physical examination, including appropriate developmental screens
- Results of developmental assessment/psychological evaluation and other diagnostic tests as indicated.
- For Members that need care coordination and case management or social needs please refer them to Health Plan's Case Management team at 1-209-942-6352.

REGIONAL CENTERS

Regional Centers (RC) are nonprofit agencies that have a contract with Department of Developmental Services to provide or coordinate services and support for individuals with developmental disabilities who reside in our covered counties: Alpine, El Dorado, San Joaquin and Stanislaus Counties.

To be eligible for RC services the person must have a disability that begins before the individual's 18th birthday that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, epilepsy, autism, and other conditions as defined in Section 4512 of the California Welfare and Institutions Code.

Services offered by RCs include:

- Diagnosis and assessment of eligibility
- Access, coordinate and monitor services and supports
- Early Start Therapeutic services
- Adult day centers/program services
- Behavioral Management Services
- Client/Parent Support/Behavior Intervention Training
- Crisis Intervention Facility/Bed
- Crisis Team – Evaluation and Behavioral Intervention
- Day Care Services
- Durable Medical Equipment
- Employment Programs
- Family Home Agency
- Foster Grandparent/Senior Companion Programs
- Health Care Facilities
- Home Health Supports
- Housing Support Services
- Increase Community Access
- Independent Living Services
- Infant Development Services
- Medical Specialists and Professionals
- Mobility Training
- Out-of-home respite services
- Parent Coordinated Services
- Personal Emergency Response System
- Pharmaceutical Services
- Residential Care Homes
- Respite Services – In-home
- Social/Recreational Services and Non-Medical Therapies
- Self-Determination
- Specialized Transportation
- Speech Services
- Supplemental Program Supports
- Supported Living Services
- Therapies
- Translator/Interpreter Services

Resource: www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf

SECTION 8: UTILIZATION MANAGEMENT

Providers can refer Members to RCs by contacting their corresponding office:

Regional Center	Office Location(s)	Counties Served
Alta California Regional Center Website: www.altaregional.org	Main Office: 4151 E Commerce Way, Suite 100 Sacramento, CA 95834 Phone: 1-916- 978-6400 Placerville – Serving El Dorado County: 573 Main Street Placerville, CA 95667 Phone: 1-530-626-1353 Fax: 1-530-626-0162 South Lake Tahoe – Serving Alpine and Eastern El Dorado Counties: 2489 Lake Tahoe Boulevard, Suite 1 South Lake Tahoe, CA 96150 Phone: 1-530- 314-5970 Fax: 1-530-314-5971 Phone: 1-916-978-6400 TTY:1-916-489-4241 Early Start Intake (Under Age 3): 1-916-978-6249 Lanterman Act Intake Line (Over Age 3): 1-916-978-6317	Alpine and El Dorado
Valley Mountain Regional Center Website: www.vmrc.net	Main Office – San Joaquin : 702 N Aurora St. P.O. Box 692290, Stockton, CA 95269-2290 Phone: 1-209-473-095 South San Joaquin County: 4596 S Tracy Blvd Tracy, CA 95377 Phone: 1-209-498-5724 Phone: 1-209-473-0951 TTY: NA Early Start Intake (Under Age 3): 1-209-955-3281 Lanterman Act Services (Over Age 3): 1-209-955-3209	San Joaquin and Stanislaus

	Stanislaus: 1820 Blue Gum Ave. Modesto, CA 95358 Phone: 1-209-529-2626 Early Start Services (Under Age 3): 1-209-557-5619 Lanterman Act Services (Over Age 3): 1-209-557-2197	

CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS) is a State program for children with certain diseases or health problems. The CCS program provides health care services, including diagnostic, treatment, dental, administrative case management, physical therapy, and occupational therapy services, to children from birth up to twenty-one (21) years of age with CCS-eligible medical conditions. Applicants must meet age, residence, income and medical eligibility requirements to participate in the CCS program. Medically Necessary services to treat a child's CCS-eligible medical condition are "carved out" of HPSJ's financial responsibility. This means that HPSJ is not financially responsible for reimbursing Providers for CCS eligible services.

The CCS program requires authorization for health care services related to a child's CCS-eligible medical condition. Providers must request CCS services to CCS by submitting Service Authorization Requests (SARs) to a CCS county or State office, except in an Emergency. To render CCS-eligible services to a Medi-Cal patient and to receive reimbursement from CCS, any Provider must be CCS paneled, and the facility must be a CCS certified facility. During the interim, between the submission for the child to become enrolled in CCS, Providers must continue to provide care to the Member either under capitation or fee-for-service depending upon the Provider's Agreement. CCS is in place to help Providers care for Members with special health care needs. For more information about the CCS program, please visit the CCS website at www.dhcs.ca.gov.

Referrals to CCS are accepted from any source, health professionals, parents, legal guardians, school nurses, Health Plan, etc. Referral forms are available on Health Plan, Medi-Cal, or CCS websites. Health Plan remains responsible for all other required services including preventative services for everything except the CCS eligible services.

Members must be diagnosed with a CCS qualifying condition. CCS eligible conditions include but are not limited to:

- AIDS
- Cancer
- Cataracts
- Cerebral palsy
- Chronic kidney disease
- Cleft lip/palate
- Congenital heart disease
- Diabetes
- Endocrine, Nutritional, and Metabolic Diseases and Immune Disease
- Hearing loss
- Hemophilia
- Intestinal disease
- Infectious diseases
- Liver disease
- Medical Therapy Program
- Mental Disorders
- Muscular Dystrophy
- Neoplasms
- Prematurity
- Rheumatoid arthritis
- Severe burns
- Severe crooked teeth
- Severe head, brain or spinal cord injuries
- Sickle cell anemia
- Spina bifida
- Thyroid conditions
- Tumors

For a complete list of CCS eligible conditions refer to the CCS website. Providers can refer Members to CCS by contacting the CCS county office at:

San Joaquin County California Children's Services
16988 S Harlan Rd
Lathrop, CA 95330
1-209-468-3900

Stanislaus County California Children's Services
917 Oakdale Road
Modesto, CA 95355
1-209-558-7515

Alpine County California Children's Services
75 Diamond Valley Road #B
Markleeville, CA 96120
1-530-694-2146

El Dorado County California Children's Services
941 Spring Street, Ste. 3
Placerville, CA 95667
1-530-621-6128

CHILDREN WITH SPECIAL HELATH CARE NEEDS (CSHCN)

Children with Special Health Care Needs (CSHCN) are defined by the Department of Health Care Services (DHCS) as: "those who have or are at increased risk for a chronic, physical, behavioral, developmental, or emotional condition and who also require health or related services of a type or amount beyond that required by children generally."

Health Plan is committed to assuring that all Medically Necessary screening, preventative, and therapeutic services are provided to Members with developmental disabilities. PCPs and/or Specialists are responsible for identifying Members with potentially eligible conditions and subsequently referring those Members to appropriate programs for genetically handicapped persons. Members that require evaluation and services for developmental delay should be referred to the appropriate Regional Center (RC) which is the primary referral source for Health Plan's Service Area.

FAMILY PLANNING SERVICES

Members may obtain family planning services from their PCP or a Specialist on Health Plan's panel of Providers without prior Authorization or a referral. Members can also obtain these services by going outside of Health Plan's network to any family planning Provider or Provider of Sensitive Services without a referral or Authorization. This out-of-network provision is without any restrictions.

CONFIDENTIAL SERVICES FOR ADOLESCENTS AND ADULTS

These are services that require some form of confidentiality in the way services are provided and the way medical records are disclosed for all Medi-Cal Members. These services must be administered with the following guidelines in mind:

- Confidential Services are provided in confidence to adolescents and adults without barriers (e.g., can't require parental consent)
- Authorization for Confidential Services is not required
- Adult Members may self-refer without prior Authorization for Confidential Services except in cases where those services require hospitalization
- Parental consent for children twelve (12) years and older is not required to obtain Confidential Services
- Providers will not at any time inform parents or legal guardians of a minor's Confidential Services care and information without minor's permission, except as allowed by law

Health Plan provides access without prior Authorization or referral to any in-network Provider or out- of-network Provider that a Member may select to provide Confidential Services.

Confidential Services include but are not limited to consultations, provision of supplies or medical devices, examinations, education, and treatment related to:

- Family Planning
- Pregnancy Testing
- Preventive Services

- Basic Prenatal Care
- Sexually transmitted disease services
- HIV Testing
- Mental health and substance abuse assessments

AIDS Medi-Cal Waiver Program

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home- and community-based services as an alternative to nursing facility care or hospitalization.

The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. Case management is participant centered and provided using a team-based approach by a registered nurse and social work case manager. Case managers work with the participant, their primary care Provider, family, caregivers, and other service Providers to determine and deliver needed services to participants who choose to live in a home setting rather than an institution.

The goals of the MCWP are to:

- Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care.
- Increase coordination among service Providers and eliminate duplication of services.
- Transition participants to more appropriate programs as their medical and psychosocial status improves, thus freeing MCWP resources for those in most need; and • Enhance utilization of the program by underserved populations.

Clients eligible for the program must be Medi-Cal recipients: whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disabilities related to HIV disease or treatment; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service Providers.

For further information refer to the Office of AIDS.

FACILITY/ANCILLARY REFERRALS AND AUTHORIZATIONS

Hospital Authorizations

Facility referrals for elective Inpatient Service must be prior Authorized by Health Plan. After the Member is admitted to the facility, the admitting Provider, including any hospitalists, will manage the Member's treatment and care. Admissions to out-of-network facilities require prior authorization approval by Health Plan's UM Department.

SECTION 8: UTILIZATION MANAGEMENT

Health Plan uses *Milliman Care Guidelines* to determine the medical necessity for the admission, length of stay and treatment options. It is imperative that the Facility team and Health Plan work together for the clinical benefit of the Member, but also for clarity in determining claims payment.

Hospital Emergency Admissions

The Emergency admission of a Member to any facility must be reported to Health Plan within twenty-four (24) hours for post hospitalization admission. This reporting must be followed with a detailed summary of the Member's clinical condition, options, and prognosis for treatment. This report must clinically demonstrate the need for inpatient treatment. Without this clinical information, Health Plan may deny the admission as not Medically Necessary. Once the clinical information is received and reviewed by Health Plan, the admission may be authorized, denied, or pended for additional information after the first 24 hours of admission. Post stabilization admissions for out of network hospitals will be paid at a DRG rate. Call the UM line for authorization of services 1-209-461-2205 prior to admitting to an inpatient stay.

Outpatient and Ancillary Referrals

Providers should consult the Provider Portal for guidance on referrals for outpatient and ancillary services. For Covered Services requiring Authorization, the requesting Provider will be notified of Health Plan's decision to Authorize or deny. Upon Authorization, Health Plan will coordinate with contracted outpatient and/or ancillary Providers. Ancillary services are routinely limited to the Medi-Cal guidelines for ancillary benefits.

Prior Authorization

Health Plan requires all covered services for physical and behavioral health conditions that require authorization, be submitted to Health Plan's Utilization Management (UM) department for review for medical necessity.

Health Plan's physicians and other licensed clinical staff apply national standards of care MCG to determine the medical necessity for outpatient services. If the requested service is not addressed in the MCG guidelines the Medi-Cal criteria in the Medi-Cal Provider Manual is utilized, if there are no applicable guidelines in both resources, the reviewer will consult Health Plan's internal policies, followed by peer reviewed, published literature to determine the medical necessity for the requested service. If medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the requested outpatient service, it will be denied by the Medical Director.

Rape and Sexual Assault Treatment

Health Plan covers emergency room and follow-up health care treatment for members who are treated following a rape or sexual assault without cost-sharing. (Please refer to the Provider Payment section in this manual for more information on Cost-Sharing.) "Follow-up health care treatment" includes medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault.

Rape and sexual assault includes all forms of nonconsensual sexual activity achieved through acts including, but not limited to, force, threats, fraud, coercion, exploitation and/or when the victim is unable to consent due to some sort of incapacitation. Please see California Penal Code sections 261, 261.6, 263, 263.1, 286, 287, and 288.7 for more information.

SECTION 9: CARE COORDINATION

PROVIDER RESPONSIBILITIES FOR CARE COORDINATION

All primary care Providers including FQHCs are responsible for basic care management, care coordination, and health education functions for their Members. PCPs are responsible for outreaching to their assigned members to establish and provide any needed care coordination.

INTEGRATED CARE COORDINATION

Health Plan provides a comprehensive suite of care coordination services that offers a continuum of care. These services include:

- Complex Case Management
- Standard Case Management
- Disease Management
- Behavioral Health Prenatal Case Management
- Behavioral Health Treatment Case Management
- Social Services Case Management

Health Plan views care coordination as a collaboration between the Member, Providers, and Health Plan. Our common goal is to ensure high-quality, cost-effective care.

The specific goals of care coordination programs are (1) to achieve efficient and effective communication between Members and Providers, and (2) to utilize appropriate resources which enable Members to improve their health status and self-management skills.

Health Plan's care coordination programs provide a consistent method to identify, address, and document the health care and social needs of Members along the continuum of care. Once a Member has been identified for case management or disease management, a nurse will work with the Member to:

- Complete an initial assessment
- Determine benefits and resources available to the Member
- Develop and implement an individualized care plan in partnership with the Member, Providers, and family or caregiver, as appropriate to the Member's needs
- Identify barriers to care
- Monitor and follow up on progress toward collaborative care management goals

COMPLEX CASE MANAGEMENT (CCM)

Complex Case Management (CCM) consists of coordinated care services provided to Members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the health care system to facilitate appropriate delivery of care and services. CCM promotes behavior change through self-management education in order to reduce the exacerbation of chronic illness and the related costs.

CCM addresses the Member's social, physical, and behavioral health needs in order to maximize disease prevention and promote Member wellness in a high-quality, cost-effective manner. This

may involve coordination of care, assisting Members in accessing community-based resources, providing education on self-management, improving adherence to medication and other treatment regimens, or any of a broad range of interventions designed to improve the quality of life and functionality of Members.

Health Plan's CCM program is designed to improve communication between Members and Providers and to make efficient use of the available health care and community-based resources.

Members are identified for the CCM program through analysis of assessment information including HIF/MET and HRA information, authorization data, claims and encounter data, and pharmacy reporting.

PCPs or specialists can refer Members with complex health care and coordination needs directly to the Case Management team by calling 1-209-942-6352 or 1-888-318-7526. Case Management team Members will take all available information and reach out to Members as quickly as possible. Members can also self-refer to this program by calling the Case Management number above.

DISEASE MANAGEMENT PROGRAMS

Health Plan actively works to improve the health status of Members and intervenes to help Members and Providers manage chronic conditions. Health Plan offers disease management programs for five (5) chronic conditions:

- Asthma
- Diabetes
- Congestive Heart Failure (CHF)
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)

Members are identified for these DM programs through detailed analysis of claims, encounter data, and pharmacy and utilization data. Members can also self-refer or be referred to the program by Providers.

Asthma Management Program

Members enrolled in the Asthma Disease Management Program receive educational materials regarding asthma triggers, appropriate use of asthma medications, condition monitoring and appropriate use of inhaler and nebulizer devices. High-risk Members receive individualized case management.

The case manager works with the Member and Provider to develop a care plan for the Member. The case manager also follows up with the Member to ensure progress with the care plan. To refer a Member to the Asthma Disease Management Program or for more information, contact Health Plan's Case Management Department at 1-888-318-7526.

Diabetes Management Program

The diabetes disease management program equips Members with the tools needed to better understand, monitor, and manage their diabetes to improve their quality of life. Educational materials empower Members with the knowledge of their condition, their medications, and the importance of screening tests such as HgA1c, kidney functions, blood lipids, and blood pressure.

High-risk Members receive individualized Case Management. The case manager works with the Provider and the Member to develop a care plan for the Member and follows the Member's progress with the care plan. To refer a Member to the Diabetes Disease Management Program or for more information, please call the Case Management Department at 1-888-318-7526.

Congestive Heart Failure (CHF) Management Program

Members enrolled in the Congestive Heart Failure Disease Management Program receive educational materials on monitoring weight, salt intake, reading nutrition facts labels, checking blood pressure, and medication regimen. High-risk Members receive individualized Case Management. To refer a Member to the Congestive Heart Failure Disease Management Program or for more information, please call the Case Management Department at 1-888-318-7526.

Chronic Kidney Disease (CKD) Management Program

Members enrolled in the Chronic Kidney Disease Management Program receive educational materials to empower them with the knowledge of the disease condition, their medications, and the importance of screening tests such as kidney functions (GFR) and monitoring their HbA1c and blood pressure. High-risk Members receive individualized case management. The case manager works with the PCP and the Member to develop a care plan for the Member and follows the Member's progress with the care plan. The PCP will receive a written plan of care from the case manager along with the invitation to provide feedback and inform the case manager on areas the PCP would like to emphasize during case management efforts. To refer a Member to the Chronic Kidney Disease Management Program or for more information, please call the Case Management Department at 1-888-318-7526.

Chronic Obstructive Pulmonary Disease Management Program

Members enrolled in the Chronic Obstructive Pulmonary Disease Management Program receive educational materials regarding managing triggers such as first and secondhand smoke, and pollution, appropriate use of medications, condition monitoring and appropriate use of inhaler and nebulizer devices. High-risk Members receive individualized Case Management. The Case Manager works with the Provider and the Member to develop a care plan for the Member and follows the Member's progress with the care plan. To refer a Member to the Chronic Obstructive Pulmonary Disease Management Program or for more information, please call the Case Management Department at 1-888-318-7526.

TRANSGENDER SERVICES

Transgender services are a covered benefit for Medi Cal Members. Health Plan continues to work with community partners to offer guidance, support and local resources to provide the best possible culturally sensitive care.

The basic elements available to support Providers caring for transgender Health Plan Members

are:

- Identification and criterion for transgender Members
- Specialists in the Service Area and surrounding areas for transgender care and support
- Hospitals specializing in the surgical needs of transgender Members
- Continuing dialogue with transgender advocates about support, programs, and initiatives

Providers and Members can access information and available resources through Health Plan's transgender program by calling the Case Management Department at 1-209-942-6352.

SOCIAL SERVICES

The primary mission of the social services team is to enhance human well-being and help meet basic and complex needs of all people with a particular focus on those who are vulnerable, oppressed and living in poverty.
Our team includes social services care coordinators, case managers and leadership to ensure the following:

- Timely Access
- Coordination of Care
- Quality of Care
- Support Linkages

Health Plan's Social Services team conducts Member needs assessments and based on assessment findings, can assist with:

- Community Services and Support Referrals
- Enhanced Case Management Referrals
- Food Resources (i.e., food banks)
- Clothing Resources
- Financial Resources
- Utility Resources
- Caregiver Resources
- Housing/Shelter Resources

For questions or printed information about Social Services or community resources, please call 1-888-936-7526.

CENTERS OF EXCELLENCE

Health Plan has contracted with several hospitals that provide specialty services with outstanding clinical results. These "Centers of Excellence" offer Health Plan Members and our network Providers options for special cases demanding clinical expertise. One such example is Health Plan's relationship with Shriner's Hospital in Sacramento for pediatric burn cases, as well as pediatric orthopedics. For more information about Centers of Excellence and services for special clinical cases, contact the UM Department at 1-888-936-7526.

SECTION 10: CLAIMS SUBMISSION

CLAIMS MANAGEMENT

A key component of quality health care is accurate, timely and efficient claims processing. Health Plan utilizes industry standard billing codes and guidelines in the processing of paper and electronic claims set forth by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).

REQUIREMENTS FOR A COMPLETE CLAIM

A **Complete Claim**, as defined in the *California Knox-Keene Act*, is a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information and "information necessary to determine payer liability" as defined.

Reasonably relevant information and/or Information necessary to determine payer liability: the minimum amount of itemized, accurate and material information generated by or in the possession of the Provider related to the billed services that enables a claims adjudicator to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with any governmental information requirements in a timely and accurate manner.

For Emergency Services and Care Provider Claim as Defined by Section 1371.35©

- The information specified in section 1371.35© of the Health and Safety Code; and
- Any state-designated data requirements included in statues or regulations

For Institutional Providers:

- The completed **UB04** data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC.
- Entries stated as mandatory by NUBC and required by federal statute and regulations; and
- Any state-designated data requirements included in statutes or regulations.

For Physicians and Other Professional Providers:

- The Centers for Medicare and Medicaid Services **(CMS) Form 1500** or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format.
- Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-10 or its successors) codes.
- Entries stated as mandatory by NUCC and required by federal statute and regulations; and
- Any state-designated data requirements included in statutes or regulations.

For Providers Not Otherwise Specified in These Regulations:

- A properly completed paper or electronic billing instrument submitted in accordance with the plan's reasonable specifications; and
- Any state-designated data requirements included in statutes or regulations

SECTION 10: CLAIMS SUBMISSION

COMPLETE CLAIM SUBMISSION OPTIONS

Claims can be submitted either paper form or electronically.

Note: *Before submitting a claim, verify the Member's eligibility (See Eligibility Verification, Enrollment, and Customer Service section).*

Paper claim submissions are mailed to address below:

Health Plan of San Joaquin/Mountain Valley Health Plan
Paper Processing Facility
P.O. Box 211395
Eagan, MN 55121

To submit claims electronically, Providers must establish an account with a clearing house of choice.

Examples of clearing houses are TriZetto/Cognizant (Payer ID HPSJ), Office Ally (Payer ID HPSJ1) and Waystar (Payer ID 68035). Please contact the clearinghouse vendor of choice to set up electronic claim submission. If Health Plan does not already have the clearing house set up as a trading partner, it will be set up once Health Plan is contacted by the clearing house. For any questions or assistance, contact the Provider Services Department at 1-888-936-7526.

Health Plan will acknowledge the receipt of electronic claims within two (2) working days of receipt and acknowledge receipt of paper claims within fifteen (15) working days.

Note: *Working Days are defined as Monday through Friday, excluding recognized federal holidays.*

Advantages of Electronic Claims Submission

- **Expedited claims processing:** Electronic submission allows Health Plan to begin adjudicating claims faster than if the claim is submitted by paper.
- **Cost effectiveness:** Electronic submission eliminates the cost of purchasing billing forms, envelopes and postage.
- **Claims Submission Confirmation:** Electronic submission provides fast electronic confirmation of a claim submission from the clearinghouse.

SECTION 10: CLAIMS SUBMISSION

CLAIM SUBMISSION TIMELINES

Health Plan's timely filing guideline for claims submission is three hundred and sixty-five (365) days from the date of service. If a claim is not received within the appropriate time frame, the claim will be denied unless disputed pursuant to C.C.R. Section 1300.71.38 and a good cause for delay as defined can be presented.

Note: *Date of Service is the date upon which the Provider delivered separately billable health care services to the Member.*

Note: *Date of Receipt is the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor.*

- ❖ *In the event where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.*

A "good cause", as defined in the California Knox-Keene Act, is as follows:

- A catastrophic event that substantially interferes with normal business operations of the Provider
- Administrative delays or errors by Health Plan or the California Department of Health Care Services (DHCS) and/or Department of Managed Health Care (DMHC)
- Other special circumstances reviewed and approved by Health Plan

**The submission of complete documentation to establish "good cause" is required for such consideration and approval.*

The requests for a claim adjustment, corrections, or reconsideration of an adjudicated claim must be received no later than three hundred sixty-five (365) days following the date of payment or denial of the original claim.

CLAIMS DETERMINATION NOTIFICATION

Upon submission of a **Complete Claim**, beginning January 1, 2026 payment or denial will be made within thirty (30) calendar days. Health Plan shall notify Providers in writing no later than thirty (30) calendar days after receipt of a claim by Health Plan. If a portion and/or whole claim has been contested (denied), the notice will identify the portion of the claim that is contested (denied) and the specific reason Health Plan is contesting the claim. If the claim is contested (denied) because Health Plan has not received the information necessary to determine Health Plan liability for the claim, then the Provider will have thirty (30) calendar days from the date of the notice to provide the information requested. Heath Plan will then complete its consideration of the claim within thirty (30) calendar days after receiving the requested information.

Note: *Date of contest, Date of denial or Date of notice: the date of postmark or electronic mark accurately setting forth the date when the contest, denial or notice was electronically transmitted*

or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage prepaid.

Claims Pend/Review

Claims that cannot be auto adjudicated, fail an edit, and/or audit check, may "pend" for review either by rule-based algorithms, claim editing system (CES), coding standards, or by a claims processor who has identified potential additional review is needed. All paper claim submissions are scanned, and images reviewed for completeness along with any attachments submitted with the claim.

Claims Denial and Rejections

Health Plan will contest (deny) or reject a claim when the claim has been billed with invalid and/or incomplete information and/or does not meet Health Plan guidelines. *Reference Important Billing Tips and Claim Form Requirements* to avoid denials and ensure prompt payment.

CLAIM REIMBURSEMENT

The reimbursement of a submitted complete claim is the payment for services rendered based upon either a contract term, letter of agreement (LOA) and/or in accordance with the Medi-Cal fee-for-service base rates in effect at the time services are rendered and in accordance with Medi-Cal guidelines. All Providers will receive a Remittance Advice (RA), indicating payment and/or the denied/contested reason *(see Claims Determination Notification)*.

Interest on Claims

Health Plan will pay interest on each uncontested claim not paid timely, frivolous contested claims, and claims where Health Plan supplies late notice, or no notice of the claim being contested or denied *(see Claims Determination Notification)*. Health Plan will also pay interest on payment adjustments made if a Provider Dispute Resolution (PDR) involves a claim and the dispute is determined in whole or in part in favor of the Provider. Interest payments will apply to both contracted and non- contracted Providers.

Claims received beginning January 1, 2026, the interest rate is fixed at a fifteen percent (15%) annual rate beginning on the first day after the thirtieth (30) calendar day period. For the purpose of calculating interest, the first day is the first calendar day after thirty (30) calendar days following receipt of the claim. Interest will be paid for each day beginning with the first day after the deadline through the date payment is mailed.

If Health Plan fails to pay the interest due on the late claim payment within five (5) business days, as penalty, Health Plan will pay an additional, greater of, fifteen dollars ($15) or ten percent (10%) of the accrued interest on the claim. The requirement for interest and penalty apply to all claims, including claims for emergency services and care. Health Plan will use the receipt date of the original claim, or the receipt date of the dispute, whichever is appropriate.

Capitated Providers are also subject to the payment of interest at the amounts outlined above for any fee-for-service claims that are not covered under the capitation agreement.

California Children's Services (CCS)

Health Plan is not financially responsible to reimburse Providers for unauthorized services to patients (Members) who qualify under California Children's Services (CCS). The Provider must submit a Service Authorization Request (SAR) to a CCS county or state office and bill CCS for eligible services, except in an emergency. The Provider and facility must be CCS paneled and/or certified to receive reimbursement for such services. For more information about the CCS program, please visit the CCS website at www.dhcs.ca.gov/services.

For information on the authorization process for CCS qualifying conditions, please refer to Section 8 – Utilization Management.

Emergency Department (ED)/Trauma Admissions

If an inpatient stay that was the result of an Emergency or Trauma is denied, Providers have the right to dispute the denial. If the Provider is requesting reimbursement for ED room charges only, please bill those services on a separate claim following the outpatient billing guidelines.

CLAIM OVERPAYMENT

If a Provider identifies an overpayment, the Provider is required to inform Health Plan and return the overpayment to Health Plan within thirty (30) working days from the date the Provider identifies the overpayment.

In accordance with California Knox-Keene Health Care Service Plan Act and Regulations 2019 edition §1300.71 and DHCS, All Plan Letter (APL) 17-003, if Health Plan determines that it has overpaid a claim(s) to a Provider, Health Plan will notify the Provider in writing within 365 days of claim paid date and pursue collections of overpayments. * *The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the Provider or deemed inappropriate by DHCS.* DHCS All Plan Letters (APLs) may be found here, www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Additionally, in accordance with DHCS, APL 20-010, all post-payment recoveries and identified overpayments related to Member(s) having Other Healthcare Coverage (OHC) at the time services are rendered will be reported no later than the 15th of each month to DHCS. All unrecovered monies after the 13th month of the date of payment will be reported and pursued by DHCS and/or assigned contractor. Any monies received by Health Plan after the 13th month of the date of payment from the Provider will be paid to DHCS.

Health Plan will notify the Provider in writing, to the Provider's address of record with Health Plan, which clearly identifies the claim, the name of the patient (Member), the date of service and explanation of the basis upon which Health Plan believes the amount paid on the claim was more than the amount due, including interest and penalties.

Non-Contested Overpayment

If the Provider does not contest the notice of reimbursement of overpayment, the Provider must reimburse Health Plan within 30 working days of receipt of Health Plan's notice of reimbursement of overpayment [Knox-Keen Act §1300.71(5)].

Offsetting Against Future Claims
Health Plan may offset an uncontested notice of reimbursement of overpayment against a Provider's current claim submissions plus interest at ten percent (10%) per annum [Knox-Keen Act §1300.71(6)] when:

- The Provider fails to reimburse Health Plan within 30 working days of the notice, and
- The Provider's contract specifically authorizes Health Plan to offset an uncontested notice of overpayment from the Provider's current claim submission.
- OR Provider submits Offset Request Form allowing Health Plan to offset overpayment and/or future identified overpayments.

If the overpayment is offset against the Provider's current claim submission, Health Plan will provide a detailed written explanation identifying the specific payments that have been offset against that specific current claim(s).

Contested Overpayment
If the Provider wishes to contest the notice of reimbursement of overpayment, the Provider must state in writing the basis upon which the Provider believes the claim was not overpaid within 30 working days of the date of notice [Knox-Keen Act §1300.71(4)].

Note: *The written notice is considered a Provider Dispute Resolution and is tracked and acknowledge as such (See Provider Dispute Resolution)*

PERSONAL CARE SERVICES (PCS) AND HOME HEALTH CARE SERVICES (HHCS)

All claims for personal care services (PCS) and home health care services (HHCS) for in-home visits by a Provider must be submitted with:

- Allowable current procedural terminology and healthcare common procedure codes as outlined in the DHCS Medi-Cal Provider Manual.
- Proper Place of Service Code or Revenue Code and Bill Type to indicate the rendering of PCS or HHCS in a Member's home

Refer to the following link for EVV Provider Type, Procedure, and Place of Service Code:
www.dhcs.ca.gov/provgovpart/Documents/EVV-Provider-Types-and-Codes.pdf

For more information on EVV, visit the DHCS website at www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx.

ANCILLARY CLAIMS

Billing for ancillary Covered Services should be in accordance with Medi-Cal guidelines. Specific information for all ancillary Covered Services can be found in the online Medi-Cal Provider Manual at www.medi-cal.ca.gov under "Publications."

Below are the forms that should be used for billing the following ancillary services:

PROVIDER TYPE	BILLING FORMS
Diagnostic Services	1500 Form
Skilled Nursing Facilities	UB Form
Ambulatory Surgery Center	UB Form, include correct place of service
Ambulance Services	1500 Form
Durable Medical Equipment	1500 Form
Home Health/Hospice	UB Form; use bill type 32X

Administrative Day Claims Submission and Payment Rules

Certain Health Plan contracted hospital service agreements contain a provision for the reimbursement of an administrative day. When a hospital identifies that a Member requires an administrative day, the hospital must obtain Authorization from Health Plan's Utilization Management (UM) Department. See Chapter 8-Utilization Management- Facility/Ancillary Referrals and Authorizations for authorization requirements for an administrative day.

When the Member is released from the hospital, the hospital must submit separate claims for the inpatient stay and administrative day. An administrative day must be billed with Rev Code 0169. The hospital will be reimbursed at the hospital's contracted reimbursement rates for the inpatient stay and administrative day.

Observation Stay Claims Submission and Payment Rules

Certain Health Plan contracted hospital service agreements contain a provision for reimbursement of an observation stay. No Authorization is required for an observation stay lasting 0-24 hours.

The following claims payment rules for an observation stay will apply if a Member is admitted to the hospital:

- When the inpatient admission and observation stay occur on the same day the observation stay will be included in the hospital's contracted inpatient reimbursement rate. The hospital will only submit a claim for the inpatient admission and be reimbursed for the inpatient admission. No separate reimbursement will be paid for the observation stay.
- When the inpatient admission occurs on the day following the observation stay the hospital will be reimbursed for the inpatient stay and the observation stay at the hospital's contracted reimbursement rates. Separate claims for the inpatient admission and the observation stay must be submitted. Rev code 0762 with the corresponding CPT/HCPCS code must be submitted on the claim for the observation stay. The unit(s) billed for the observation stay should be based on the hospital's contracted reimbursement rate:
    - For an observation stay per diem rate up to 24 hours, 1 day =1 unit
    - For an observation stay hourly rate up to 24 hours, 1 hour =1 unit
- When the Member is not admitted to the hospital after an observation stay a claim should be submitted for the observation stay with Rev code 0762 and the corresponding CPT/HCPCS. The unit(s) billed should be based on the hospital's contracted reimbursement rate:

- For an observation stay per diem rate up to 24 hours, 1 day = 1 unit
- For an observation stay hourly rate up to 24 hours, 1 hour = 1 unit

An observation stay prior to or post of an outpatient surgery will be included in the hospital's contracted outpatient surgery reimbursement rate. No separate payment will be made for the observation stay.

Trauma Care Claims Submission and Payment Rules

Certain Health Plan contracted hospital service agreements contain a provision for the reimbursement of trauma care. When a hospital identifies a Member as a trauma case the hospital must obtain Authorization from Health Plan's Utilization Management (UM) Department. See Chapter 8- Utilization Management -Facility/Ancillary Referrals and Authorizations for authorization requirements for trauma care. The hospital must be a designated trauma facility to receive trauma care reimbursement rates.

When the Member is discharged from the hospital, the hospital will submit a claim for payment of the trauma admission. If the hospital's service agreement contains a provision for the reimbursement of a trauma activation fee, the trauma activation fee must be billed with Rev code 681-684 and admit type 5 indicating a trauma admission. The trauma activation fee (if applicable) will only be paid once per trauma admission. The following payment rules apply to the reimbursement of trauma care:

1. The hospital's contracted trauma reimbursement rate will not be paid if the initial evaluation of the Member does not take place within 30 minutes of the Member arriving in the emergency department or within 8 hours of the traumatic event if the Member is transferred to another facility.
2. The activation of the trauma team must be in response to the notification of key hospital personnel by pre-hospital caregivers.
3. A Member who dies prior to arriving at the hospital cannot be charged the trauma team activation rate regardless of whether the pre-hospital caregiver notification was provided to the receiving hospital.
4. A Member who dies within 24 hours of arriving in the Emergency Department can be charged the outpatient trauma rate.
5. Authorized trauma admissions will be paid at the hospital's contracted rate for the applicable trauma level of care (Level 1-4). When the Member is downgraded to med/surg during the hospital stay the hospital will be paid the hospital's contracted rate for med/surg inpatient days.
6. Hospital admissions not authorized as trauma will be reimbursed at the hospital's contracted rate for inpatient med/surg admission.

Inpatient and Outpatient Implant and Prosthetic Device Claims Submission and Payment Rules

Certain Health Plan contracted Provider agreements contain a provision for the reimbursement of implants and prosthetic devices. Based on the terms of the Provider's agreement, Providers may receive reimbursement for high-cost implants and prosthetic devices provided to a Member or only receive reimbursement for high-cost implants and prosthetic devices when the unit cost exceeds a

defined dollar amount threshold. Health Plan follows the Medi-Cal covered benefit guidelines for implants and prosthetic devices and will only reimburse Providers for such covered services. When a Provider identifies an implant or prosthetic device has been provided to a Member and (if applicable) exceeds the unit cost dollar threshold as defined in their Provider agreement, the Provider may submit a claim for the implant or prosthetic device. The claim must be billed with revenue code 274, 275, 276 or 278.

If the Provider's agreement reimburses implants and prosthetic devices at the manufacture's invoice cost plus an additional %, the Provider must submit a manufacture's invoice with the claim. Claims for implants and prosthetic devices will be paid according to their Provider agreement.

Claims missing the required revenue code 274, 275, 276 or 278 and manufacturer's invoice (if applicable) will be denied for lack of information.

Health Plan may perform periodic audits of the Provider's implant and prosthetics billing practices to ensure compliance with their Provider agreement and these rules.

Inpatient and Outpatient High-Cost Drug Claim Submission and Payment Rules
Health Plan has established a list of drugs, medications and biologics that are defined as high-cost drugs. (See High-Cost Drug List Below) Periodic updates will be made to this list as new drugs, medications and biologics are approved by the FDA.

Certain Health Plan Provider agreements contain a provision for the reimbursement of high-cost drugs. Depending upon the terms of the Provider's agreement Providers may receive reimbursement for all high-cost drugs provided to a Member or will only receive reimbursement for high-cost drugs when the unit cost exceeds a defined threshold dollar amount.

When a Provider identifies a high- cost drug on Health Plan's approved list has been provided to a Member and (if applicable) exceeds the unit cost threshold as defined in their Provider agreement, the Provider may submit a claim for the high-cost drug.

The claim must be billed with revenue code 0636, HCPCS code and NDC code. If the Provider's agreement reimburses high-cost drugs at manufacturer's invoice cost or manufacture's invoice cost plus an additional %, the Provider must submit a manufacture's invoice with the claim.

Revenue code 0636 should only be used when the high-cost drug qualifies as separately payable as defined by their Provider agreement.

Claims for high-cost drugs will be paid according to their Provider's agreement.

Claims missing the required revenue code 0636, HCPCS, NDC code and manufacturer's invoice (if applicable) will be denied for lack of information.

Health Plan may perform periodic audits of the Provider's high- cost drug billing practices to ensure compliance with their Provider agreement and these rules.

REQUIRED FIELDS FOR CMS-1500 FORM (PROFESSIONAL)

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y,
1	MEDICAID/ MEDICARE/ OTHER ID	For Medi-Cal, enter an "X" in the Medicaid box. Billing Tip: If billing Medicare crossover, there is no need to submit a paper/electronic claim. Health Plan receives crossover claims from CMS.	Y
1a	INSURED'S ID NUMBER	Enter the recipient's ID number from Health Plan's Identification Card. **NOTE:** When submitting a claim for a newborn infant under the mother's eligibility, use the newborn infants Health Plan ID number. This number is available 24-48 hours after receipt of the newborn face sheet. **Billing Tip:** Use Health Plan's Portal to verify that the recipient is eligible for the services rendered.	Y
2	PATIENT'SNAME	Enter the recipient's last name, first name and middle initial (if known). A comma is required between recipient's last name, first name and middle initial (if known). **Billing Tip: Newborn Infant:** When submitting a claim for a newborn infant under the mother's eligibility, use the mother's last name followed by BABY BOY or BABY GIRL. Avoid nicknames or aliases.	Y
3	PATIENT'S BIRTH DATE (MM/DD/CCYY) and SEX	Enter the recipient's date of birth in six-digit MMDDYY format (month, day, year). If the recipient is 100 years or older, enter the recipient's age and the full four-digit year of birth in Box 19. Enter an "X" in the M or F box. **Billing Tip**: **Newborn Infant:** Enter the infant's sex and date of birth in Box 3.	Y
4	INSURED'S NAME	Not Required.	N
5	PATIENT'S ADDRESS	Enter the recipient's complete address and telephone number.	Y
6	PATIENT'S RELATIONSHIP TO INSURED	Not Required.	N
9	OTHER INSURED'S NAME	This field should only be used when the primary insurance is Medicare or Other Healthcare Coverage (OHC), and the policy holder's name differs from the patient's name.	Y
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	This field should only be used when the primary insurance is Medicare or Other Healthcare Coverage (OHC).	Y
9d	INSURED PLAN NAME OR PROGRAM NAME	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	Y
10a, b or c	PATIENT'S CONDITION	Complete this field if services were related to an accident or injury. Enter an "X" in the Yes box if accident/injury is employment related. Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the Date of Current Illness, Injury or Pregnancy field (Box 14).	Y

SECTION 10: CLAIMS SUBMISSION

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
11	INSURED'S POLICY GROUP OR FECA NUMBER	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	Y
11a	INSURED'S DATE OF BIRTH	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	Y
11c	INSURANCE PLAN NAME OR PROGRAM NAME	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	N
11d	ANOTHER HEALTH PLAN BENEFIT	Enter an "X" in the Yes box if the recipient has Other Health Coverage (OHC). Enter the amount paid (without the dollar or decimal point) by the other health insurance in the right side of Box 11d. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal. Eligibility under Medicare is not considered OHC.	N
14	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP)	Enter the date of the onset of the recipient's illness, the date of accident/injury or the date of the Last Menstrual Period (LMP).	Y
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name of the referring Provider in this box. When the referring Provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the NMP must be entered. However, the NPI of the supervising physician needs to be entered in box 17b, below.	Y
17b	NPI (OF REFERRING PHYSICIAN)	Enter the 10-digit NPI. The following Providers must complete Box 17 and Box 17b: Audiologist, Clinical laboratory (services billed by laboratory), Durable Medical Equipment (DME) and medical supply, Hearing aid dispenser, Nurse anesthetist, Occupational therapist, Orthotist, Pharmacy, Physical therapist, Podiatrist (services are rendered in a Skilled Nursing Facility [NF] Level A or B, Portable imaging services, Prosthetist, Radiologist, Speech pathologist.	Y
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.	Y
19	ADDITIONAL CLAIM INFORMATION	Use this area for procedures that require additional information, justification, or an Emergency Certification Statement. **Billing Tip:** "By Report" codes, complicated procedures, modifier breakdown, unlisted services and anesthesia time require attachments. If the rendering Provider is an NP/PA or locum, there last name, first name and NPI should be documented in this field (for informational purposes only). Box 19 may be used if space permits. Please do not staple attachments.	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
20	OUTSIDE LAB	If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X." Outside laboratory refers to a lab not affiliated with the billing Provider. Indicate in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank, if not applicable.	Y
21a-l	DIAGNOSIS OR NATUREOF ILLNESS OR INJURY	Enter all letters and/or numbers of the ICD-10-CM (or latest version) diagnosis code, diagnosis code(s) should be in order of severity/illness presented, include fourth through seventh characters, if present. (Do not enter decimal point.) Relate A-L to service line(s) below (24e).	Y
22	RESUBMISSION CODE	Use to identify a corrected claim with appropriate frequency code 7 and add the original claim number when possible.	Y
23	PRIOR AUTHORIZATION NUMBER	Use for Health Plan authorization number. **Billing tip:** Only one authorization number can cover services billed on any one claim.	Y
24a	DATE(S) OF SERVICE	Enter the date the service was rendered in the From and To boxes in the six-digit, MMDDYY (month, day, year) format in the unshaded area. When billing for a single date of service, enter the date in From box in Field 24A.	Y
24b	PLACE OF SERVICE	Enter the two-digit national Place of Service code in the unshaded area, indicating where the service was rendered. **Billing Tip:** The national Place of Service codes are listed in the CMS-1500 Completion section (CMS COMP) of the Medi-Cal Provider Manual, Part 2.	Y
24c	EMG	Emergency Code: Only one emergency indicator is allowed per claim and must be placed in the bottom-unshaded portion of Box 24C. Leave this box blank unless billing for emergency services.	Y
24d	PROCEDURES, SERVICESOR SUPPLIES/MODIFIER(S)	Enter the appropriate procedure code (CPT-4 or HCPCS) and modifier(s). For additional information on how to bill modifiers, please refer to the Medi-Cal Provider Manual. **Billing Tip:** The descriptor for the procedure code must match the procedure performed, and the modifier(s) must be billed appropriately. Do not submit multiple National Correct Coding Initiative (NCCI)- associated modifiers on the same claim line. If necessary, the procedure description can be entered in the Additional Claim Information field (Box 19). **Billing Tip:** Do not submit a National Correct Coding Initiative (NCCI)-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted.	Y
24e	DIAGNOSIS POINTER	Use the diagnosis designations (A-L) listed in field 21, as the reference pointers in this field. The primary reason (primary diagnosis) for the service must be the first diagnosis pointer listed in the field. Use multiple pointers for secondary diagnoses related to the service line, if appropriate.	Y
24f	$CHARGES	In the unshaded area of the form, enter the usual and customary fee for service(s) in full dollar amount. Do not enter a decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000."	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
24g	DAYS OR UNITS	Enter the number of medical "visits" (days) or procedures, surgical "lesions," units of anesthesia time, items, or units of service, etc. The field permits entries up to 999 in the unshaded area. **Billing Tip:** Providers billing for units of time should enter the time in 15-min increments. For example, one hour should be entered as "4."	Y
24h	EDSDT FAMILY PLANNING	Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.	Y
24j	RENDERING PROVIDER ID#	Enter the NPI for a rendering Provider (unshaded area) if the Provider is billing under a group NPI. **Billing Tip:** If the rendering Provider is an NP/PA or locum, enter the supervising physicians NPI in this field.	Y
25	FEDERAL TAX ID#	Enter the Rendering/Supervising physicians Federal Tax ID in this field.	Y
26	PATIENT'S ACCOUNT NUMBER	Field use for Provider's unique patient account number.	N
27	ACCEPT ASSIGNMENT	"Yes" or "No" entry is required.	Y
28	TOTAL CHARGE	Enter the full dollar amount for all services without the decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000." **Billing Tip:** If billing more than 1 claim form (or more than 6 lines) only enter total charge on the last claim form.	Y
29	DOLLAR AMOUNT	Enter the full dollar amount of payments(s) received from the Other Health Coverage (Box 11D) and/or patient's Share of Cost (Box 10D), without the decimal point (.) or dollar sign ($). **Billing Tip:** Do not enter Medicare payments in this box. The Medicare payment amount will be calculated from the Medicare EOMB/MRN/RA when submitted with the claim.	Y
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	The claim must be signed and dated by the Provider, or a representative assigned by the Provider, in black ballpoint pen only. **Billing Tip:** If the rendering physician/Provider is PA/NP or locum, enter the supervising physicians name in this field. Signatures must be written, not printed and should not extend outside the box. Stamps, initials, or facsimiles are not accepted.	Y
32	SERVICE FACILITY LOCATION INFORMATION	Enter the Provider's name. Enter the Provider's address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. **Billing Tip:** Use the name and address of the facility where the services were rendered if other than a home or office.	Y
32a	SERVICE FACILITY NPI	Enter the NPI of the facility where the services were rendered.	Y
33	BILLING PROVIDER INFORMATION AND PHONE NUMBER	Enter the Provider's name. Enter the Provider address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. Enter the telephone number.	Y
33a	BILLING PROVIDER NPI	Enter the billing Provider's NPI.	Y

REQUIRED FIELDS FOR UB-04 FORM (INSTITUTIONAL)

The following form outlines only the REQUIRED Field Information:

UBREQUIREDFIELDINFORMATON			
BOX #	**FIELDNAME**	**INSTRUCTIONS**	**REQUIRED (Y, N)**
1	ADDRESS, ZIP CODE	Enter the Provider's name, hospital and clinic address, without a comma between the city and the state, and the nine-digit ZIP code without a hyphen. A telephone number is optional in this field. **NOTE:** The nine-digit ZIP code entered in this box must match the billing Provider's ZIP code on field for claims to be reimbursed correctly.	Y
3a	PATIENT CONTROL NUMBER	Enter the patient's financial record number or account number in this field.	N
3b	MEDICAL RECORD NUMBER	Use Box 3a to enter a patient control number.	N
4	INSURED'S NAME	Not Required.	Y
6	STATEMENT COVERS PERIOD (FROM-THROUGH)	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the dates of service for this claim in six-digit MMDDYY (month, day, year) format. The date of discharge should be entered in the THROUGH box, even though this date is not reimbursable (unless the day of discharge is the date of admission). **NOTE:** For "From- Through" billing instructions, refer to the UB-04 Special Billing Instructions for Inpatient Services section (U B SPEC IP) in the Part 2 portion of the Medi-Cal Provider manual.	Y
8b	PATIENT NAME	Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases. **Newborn infant:** When submitting a claim for a newborn infant using the mother's eligibility, enter the infant's name in Box 8b. if the infant has not yet been named, use the mother's last name followed by "Baby Boy" or "Baby Girl" (for example, JONES, BABY GIRL). **Billing Tip:** If billing for newborn infants from a multiple birth, each newborn must also be designated by a number or a letter (for example, JONES, BABY GIRL TWIN A) on separate claims. Enter infant's date of birth/sex in boxes 10 and 11. **Organ Donors:** When submitting a claim for a patient donating an organ to an HPSJ/MVHP recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Heath Plan recipient's name in the Insured's Name field (Box 58) and enter "11" (Donor) in the Patient's Relationship to Insured field.	Y
10	BIRTH DATE	Enter the patient's date of birth, using an eight-digit MMDDYYY (month, day, year) format (for example, September 16, 1967 = 09161967). **NOTE:** If the recipient's full date of birth is not available, enter the year preceded on 0101. For newborns and organ donors, see item 8b).	Y
11	SEX	Enter the capital letter "M" for male or "F" for female	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
12 and 13	ADMISSION DATE AND HOUR	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the date of hospital admission, in a six- digit format. Convert the hour of admission to the 24- hour (00-23) format. Do not include the minutes. **Billing Tip:** The admit time of 1:45p.m. will be entered on the claims as 13.	Y
14	ADMISSION TYPE	**Outpatient Claims:** Enter an admit type code of "1" when billing for emergency room-related services (in conjunction with the facility type "14" in Box 4). This field is not required by Health Plan for any other use. **Inpatient Claims:** Enter the numeric code indicating the necessity for admission to the hospital. **NOTE:** If the delivery was outside the hospital, use admit type code "1" (emergency) in the Type of Admission and admission source code "4" (extramural birth) in the Source of Admission field (Box 15).	Y
15	ADMISSION SOURCE	**Outpatient Claims:** Not required. **Inpatient Claims:** If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. Enter code "1" or "3" in Box 14 to indicate whether the transfer was an emergency or elective. When the type of admission code in Box 14 is "4" (newborn; baby born outside of hospital), submit claim with source of admission code "4" in Box 15 and appropriate revenue code in Box 42.	Y
31 through 34a and b	OCCURRENCE CODES AND DATES	Occurrence codes and dates are used to identify significant events related to a claim that may affect payer processing. Occurrence codes and dates should be entered from the left to right, top to bottom in numeric-alpha order starting with the lowest value. Example: If billing for two occurrence codes "24" (accepted by another payer) and "05" (accident/no medical or liability coverage), enter "05" in Box 31a and "24" in Box 32a. Enter the accident/injury date in corresponding box (6-digit format MMDDYY). **NOTE:** Enter code "04" (accident/employment- related) in Boxes 31 through 34 if the accident or injury was employment related**. Outpatient Claims:** Discharge date in not applicable. **Inpatient Claims**: Discharge Date: Enter occurrence code "42" and the date of hospital discharge (in six-digit format) when the date of discharge is different from the "THROUGH" date in Box 6.	Y
37a	UNLABELED (USE FOR DELAY REASONCODES)	If there is an exception to the billing limit, enter on the delay reason codes in Box 37a and include the required documentation. **NOTE:** Documentation justifying the delay reason must be attached to the claim for review. **For hospitals that are not reimbursed according to the diagnosis related groups (DRG) model:** Providers must use claim frequency code "5" in the Type of Bill field (Box 4) of the claim when adding a new ancillary code to a previous stay, if the original stay was already billed.	N

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
42	REVENUE CODE	**Outpatient Claims:** Revenue codes are required (for instance, for organ procurement). **Inpatient Claims:** Enter the appropriate revenue or ancillary code. Refer to the Revenue Codes for Inpatient Services section (REV CD IP) in the appropriate Part 2 of the Medi-Cal Provider manual. Ancillary codes are listed in the Ancillary Codes section (ANCIL COD) of the Part 2 Medi-Cal Provider manual. **Billing Tip:** For both outpatient and inpatient claims (single-page claims), enter code "001" in Box 42, line 23 to designate the total charge line. Enter the total amount in Box 47, line 23.	Y
43	DESCRIPTION	**Outpatient Claims:** Information entered this field will help separate and identify the descriptions of each service. The description must identify the service code indicated in the HCPCS/Rate/HIPPS Code field (Box 44). This field is optional, except when billing for physician-administered drugs. Refer to the Physician-Administered Drugs-NDC UB-04 Billing Instructions section (physician MDC UB) of the Part 2 Medi-Cal Provider manual for more information. **Inpatient Claims:** Enter the description of the revenue or ancillary code listed in the Revenue Code field (Box 42). **NOTE:** If there are multiple pages of the claims, enter the page numbers on line 23 in this field.	Y
44	HCPCS/RATE	**Outpatient Claims:** Enter the applicable procedure code and modifier. Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Attach reports to the claims for "By Report" codes, complicated procedures (modifier 22) and unlisted services. Reports are not required for routine procedures. Non-payable CPT codes are listed in the TAR & Non-Benefit List: Codes (10000- 99999) sections in the appropriate Part 2 Medi-Cal Provider manual. All modifiers must be billed immediately following the HCPCS code in the HCPCS/Rate field (Box 44) with no spaces. Up to four modifiers may be entered on the outpatient UB-04 claim form. **Inpatient Claims**: Not required.	Y
45	SERVICE DATES	Outpatient Claims: Enter the date the service was rendered in six- digit format. Inpatient Claims: Not required. Billing Tip: For "From- Through" billing instructions, see the UB-04 Special Billing Instructions for Outpatient Services section (UB SPEC OP).	Y
46	SERVICE UNITS	**Outpatient Claims:** Enter the actual number of times a single procedure or item was provided for the date of service. If billing for more than 99, divide the units on two or more lines**. Inpatient Claims:** Enter the number of days of care by revenue code. Units of service are not required for ancillary services. If billing for more than 99 units, divide the units between two or more lines. **Billing Tip:** Although Service Units is a seven-digit field, only two digits are allowed.	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
47	TOTAL CHARGES	In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents, even if the amount is even (e.g., if billing for $100, enter "10000" not "100"). Enter the total charge for all services on the last line or on line 23. Enter "001" in Revenue Code field (Box 42, line 23) to indicate this is the total charge line. **Outpatient Claims:** If an item is a taxable medical supply, include the applicable state and county sales tax. To delete a line, mark with a thin line through the entire detail line (Box 42-49), using a black ballpoint pen. **NOTE:** Up to 22 lines of data (fields 42-49) can be entered. It is acceptable to skip lines.	Y
50a through 50c	PAYER NAME	**Outpatient Claims:** Enter insurance plan name to indicate claim payer. **NOTE:** If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Health Plan. **Billing Tip:** When completing Boxes 50-65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: HPSJ/MVHP). Do not enter information on Lines A and B for other insurance (or Medicare) if payment was denied by these carriers. If Health Plan is the only payer billed, all information in Boxes 50-65 (excluding Box 56) should be entered online A.	Y
51	HEALTH PLAN ID	Enter the 9-digit Health Plan ID number. **NOTE:** If recipient is a newborn infant covered under the mother's eligibility, enter the newborn infant Health Plan ID number. This ID is available 24-48 hours after receipt of the newborn infant face sheet.	Y
54a through 54c	PRIOR PAYMENTS (OTHER COVERAGE)	Leave blank if not applicable. Enter the full dollar amount of the payment received from the OHC, online A or B that corresponds with OHC in the Payer field (Box 50). Do not enter a decimal point (.), dollar sign ($), plus (+) or minus (-) sign. **NOTE:** For instruction about completing this field for Medicare/Medi-Cal recipients, refer to the Medicare/Medi-Cal Crossover Claims: UB-04 section (MEDCR UB) in the Medi-Cal Provider manual.	N
55a through 55c	ESTIMATED AMOUNT DUE (NETAMOUNT BILLED)	In full dollar amount, enter the difference between "Total Charges" (Box 47, line23) and any deductions. Do not enter a decimal point (.) or dollar sign ($). **Example:** Patient's SOC Value Codes Amount and/or OHC Prior Payments.	N
56	NPI	Enter the appropriate 10-digit National Provider Identifier (NPI) number.	Y
57a through 57c	OTHER PROVIDER ID	Not Required	N

SECTION 10: CLAIMS SUBMISSION

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
58a through 58c	INSURED'S NAME	Enter the last name and first name of the policyholder, using a comma or space to separate the two. Do not leave a space between a prefix (e.g., MacBeth). Submit a space between hyphenated names rather than a hyphen (e.g., Smith Simmons). If the name has a suffix (e.g., Jr., III) enter the last name followed by a space and then the suffix (e.g., Miller Jr. Roger). **NOTE:** If billing for an organ donor, enter the recipient's name and the patient's relationship to the recipient in the Patient's relationship to Insured field.	N
60a through 60c	INSURED's UNIQUE ID	Enter the recipient's Health Plan 9-digit ID number as it appears on Health Plan's Identification Card. **NOTE:** Health Plan does not accept the 14-digit ID number on the Benefits Identification Card (BIC). **Billing Tips:** When submitting a claim for a newborn infant for the month of birth or the following month, under the mother's eligibility, use the newborn infant Health Plan9-digit ID number. (This ID number is available 24- 48 hours after receipt of the newborn infant face sheet.)	Y
63a through 63c	PRIOR AUTHORIZATION	For services requiring a Prior Authorization, enter the alpha-numeric number in this field. It is not necessary to attach a copy of the Prior Authorization. Recipient information on the claim must match the Authorization. Multiple claims must be submitted for services that have more than one Authorization. Only one Authorization can cover services billed on any one claim. **Inpatient Claims:** Inpatient claims must be submitted with an Authorization.	Y
66	DIAGNOSIS CODE HEADER	Claims with a diagnosis code in Box 67 must include the ICD indicator "0" for ICD-10-CM diagnosis codes, effective October 1, 2015.	Y
67	UNLABELED (PRIMARY DIAGNOSISCODE)	Include all letters and numbers of the ICD-10-CM diagnosis code to the highest level of specificity (when possible) including fourth through seventh digits if present for the primary diagnosis code. Do not include decimal point. Present on Admission (POA) indicator. Each diagnosis code may require a POA indicator. Hospitals must enter a POA indicator (unless exempt) in the shaded portion of boxes 67 and 67a, to the right of the diagnosis field, to indicate when the condition occurred, if known. When the condition is present, use "Y" for yes. When the indicator is "N" for no, it means that the condition was acquired while the patient was in the hospital.	Y
67a	UNLABELED (SECONDARY DIAGNOSIS CODE)	If applicable, enter all letters and/or numbers of the secondary ICD- 10-CM diagnosis code to the highest level of specificity (when possible). Do not include a decimal point. **NOTE:** Paper claims accommodate up to 18 diagnosis codes.	N

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
74	OTHER PROCEDURE CODES AND DATES	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. In six-digit format, enter the date the surgery or delivery was performed. **Billing Tip:** Inpatient Providers must enter ICD- 10-PCS code in this field (not CPT-4/HCPCS surgical procedure code).	Y
74a through 74e	OTHER PROCEDURE CODES AND DATES	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. **NOTE:** For OB vaginal or cesarean delivery and transplants, enter a suitable ICD-10-PCS code in Box 74 or 74a-e.	Y
76	ATTENDING	**Outpatient Claims:** Enter the referring or prescribing physician's NPI in the first box. This field is mandatory for radiologists. If the physician is not a Medi-Cal Provider, enter the state license number. Do not use a group Provider number. Referring or prescribing physician's first and last names are not required. **Billing Tip:** For atypical referring or prescribing physicians, enter the Medicaid Identifier "1D" in the Qual ID box and enter the Medi-Cal Provider number next to it. **Inpatient Claims:** Enter the attending physician's NPI in the first box. Do not enter a group number. The attending physician's first and last name is not required.	Y
77	OPERATING	**Outpatient Claims:** Enter the NPI of the facility in which the recipient resides or the physician providing services. Only one rendering Provider number may be entered on claim. Do not use a group number or state license number. **Billing Tip:** For atypical rendering physicians, enter the Medicaid Identifier "1D" in the Qual ID box and enter the Medi-Cal Provider number next to it. **Inpatient Claims:** Enter the operating physician's NPI in the first box. Do not enter a group number. The operating physician's first and last name is not required.	N
78	OTHER	Outpatient Claims: Not required. Inpatient Claims: Enter the admitting physician's NPI in the first box. Do not enter a group Provider number. The admitting physician's first and last name is not required by Medi-Cal.	N
80	REMARKS	Use this area for procedures that require additional information, justification, or an Emergency Certification Statement. This statement must be signed and dated by the Provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in this area, attach the statement to the claim. Billing Tip: If additional information cannot be completely entered in this field, attach the additional information to the claim on single- sided 81/2 by 11-inch white paper. "By Report" claim submissions do not always require an attachment. For some procedures, entering information in the Remarks field (Box 80)	N

SECTION 10: CLAIMS SUBMISSION

IMPORTANT BILLING TIPS

- Obtain prior authorization for any covered services that require authorizations.
- The Provider Portal has a list of codes that require authorization.
- File complete claims within the required timely filing requirements.
- File complete claims electronically as recommended.
- Use the standard and most updated Current Procedural Terminology (CPT) codes, International Classification of Diseases (ICD) codes, Health care Procedure Coding System (HCPCS) codes, or Revenue Codes. Please refer to the Medi-Cal manual and website at www.medi-cal.ca.gov for billing guidelines.
- Identify frequency limits for certain procedure codes www.medi-cal.ca.gov
- Use the National Provider Identifier Standard (NPI) correctly and appropriately.
- A valid 10-digit NPI must be entered in the billing Provider field on the paper claim form or electronic claim submission.
- The NPI must belong to the correct Provider. (A Provider rendering medical care cannot use the Group's NPI and vice versa. Providers who render medical care in a Facility cannot use the Facility's NPI, and vice versa. An individual Provider cannot use another individual Provider's NPI).
- A valid NPI is entered in the attending, admitting, or operating Provider ID field.
- A valid NPI is entered in the referring Provider field.
- The complete 9-digit ZIP code must be entered in the billing Provider address field.
- A valid NPI of the inpatient Facility where medical care is rendered is entered in the service facility NPI field.
- National Drug Code (NDC) numbers are required for physician administered drugs (PAD).
- For a list of High-Cost Pharmacy (drugs), see Section 11 – Provider Payment
- Invoices are also required for certain HCPCS codes.
- Review National Correct Coding Initiative (NCCI) and bill appropriate modifiers
- Submit claims with all required documentation
- Preventative exams for Medi-Cal Members under nineteen (19) years of age must be billed on 1500 claim forms.
- When submitting paper claims:
    - Send the original claim form and retain a copy for your records.
    - Do not submit multiple claims stapled together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.
    - Carbon copies, photocopies, facsimiles, or forms created on laser printers are not acceptable for claims submission and processing.

Newborns

Please note that Hospitals must notify Health Plan of Member newborns within twenty-four (24) hours of birth. Under Health Plan rules, newborns are covered under the mother's coverage one (1) month after birth or until the newborn has been their own approved eligibility.

- Newborn will be issued own Health Plan ID number under the mother's coverage.
- Claims should be submitted using newborn baby's Health Plan ID number
- Do not submit charges for the newborn on the same claim form as the mother
- Do not submit charges for the newborn with the mother's Health Plan ID number
- Submit the newborn claim after the mother's claim has been submitted.
- A healthy newborn is submitted with the newborn baby's id number, newborn information
- If the newborn requires a longer stay, an authorization is required under the newborn ID number
- In the case of multiple births, each child's information should be submitted on a separate claim.
- If the newborns require further hospitalization, each child will have a separate authorization number which must be submitted on each claim.

CLAIMS STATUS AND QUESTIONS

Claims status is available through the Provider Portal. The Provider Portal is available through Health Plan website, www.hpsj-mvhp.org. If you are unable to obtain satisfactory answers regarding claims status or other claim questions, please contact our Customer Service Department at 1-209-942-6320 or 1-888-936-7526.

MEMBER BILLING

As a Managed Care (Medi-Cal) Plan (MCP), many of the same rules that apply to Medi-Cal fee-for- service apply to Health Plan. Balance billing Medi-Cal Members is prohibited by federal and state laws. Medi-Cal Members should not pay for physician visits and other medical care when they receive covered services from any Health Plan Provider. This means Health Plan Members cannot be charged for co-pays, co-insurance, or deductibles. Health Plan Providers cannot bill a Member.

If the services provided are covered services in accordance with Health Plan benefits, then Health Plan's reimbursement to the Provider constitutes full payment and the Member cannot be balance billed for these services. If a Member was invoiced or charged in error, all billing efforts must cease as soon as the error is identified. If the Member paid for covered services, the Provider must refund the Member within fifteen (15) days.

Billing Medi-Cal Members violates Federal and State laws. as outlined in section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997; California Welfare and Institutions Code, section 14019.4; W&I Code section 14019.3; W&I Code section 14019.4; Title 28 CCR 1300.71; Title 22, §51002; Title 42 CFR, section 447.15.

If a Member is willing to compensate a Provider for a non-covered service and the Provider is willing to accept a negotiated payment between the parties, that agreement is considered outside of Medi-Cal and thus outside the supervision of Health Plan. However, the service must clearly be identified as not a covered benefit (NCB) in accordance with Health Plan and/or Medi-Cal. The violation of the Medi-Cal or Health Plan payment rules could result in the immediate termination of the *Provider's Agreement*.

SECTION 11: PROVIDER PAYMENT

PROVIDER PAYMENT

To ensure timely and accurate reimbursement please note the following:

FORMS

W-9 Forms

To ensure the correct reporting of Provider income to the Internal Revenue Service and the California Franchise Tax Board, Health Plan must have an accurate and current W-9 form on file. The information on the W-9 provides Health Plan with the following:

- The **entity** being paid
- The full and complete **mailing address** where payments are to be directed
- The **tax ID number** used to report income received from Health Plan.

The sections of the W-9 that are of key importance are:

- **Legal Name**: The name of the individual and/or corporation that will appear on the Provider's tax return.
- **Business Name**: The name under which the Provider does business, i.e., Doing Business As (DBA) name.

Federal 1099 Forms

A 1099 form will be sent by January 31st of each year to Providers with payments of six hundred dollars ($600) or more in the previous calendar year. Please contact the Provider Services Department at 1-209-942-6340 or via email to Providerservices@hpsj.com if you believe there is an error in the information reported on a 1099 form received from Health Plan.

CAPITATION PAYMENTS

Capitation is the "Per-Member-Per-Month" (PMPM) payment paid based on an individual Provider (or group) agreement and/or contract. The fixed monthly reimbursement is paid primarily to PCPs as full reimbursement for specified covered services provided to each assigned Member. Capitation payments are processed monthly and can be made by check or Electronic Funds Transfer (EFT). See information below on how to set up EFT. Capitation payments are post-marked or remitted electronically on or before the tenth (10th) of each month and are accompanied by a remittance advice (RA) identifying the assigned Members for which capitation payment is being made.

Note: *Due to Member enrollment fluctuation during the month, adjustments may be made to the following month's payment.*

SECTION 11: PROVIDER PAYMENT

FEE-FOR-SERVICE PAYMENT (FFS)

Under DHCS guidelines, Providers interested in contracting with Health Plan, are required to be enrolled in the Medi-Cal fee-for-service (FFS) program. Providers enrolled in the Medi-Cal FFS program must also be credentialed by Health Plan, meet all applicable screening and enrollment requirements, and adhere to criteria outlined in regulatory Provider bulletins. For more information or to apply, please visit www.dhcs.ca.gov/provgovpart/Pages/PED.aspx. For inquiries about the Medi-Cal FFS program, contact the Provider Enrollment Division (PED) at 1-916-323-1945 or submit an e-mail to PEDCorr@dhcs.ca.gov.

FFS payments apply to any covered services provided by non-capitated Providers or for non-capitated covered services provided by capitated Providers. FFS payments are made when a complete claim is submitted and processed for payment in accordance with the Provider contract and/or Medi-Cal guidelines for non-contracted Providers (See Section 10: Claim Submission).

FFS payments are accompanied by a remittance advice (RA) identifying claims being paid and/or denied/contested with an explanation reason.

Note: *Not all services are reimbursable. If services are rendered that require prior authorization and authorization is not obtained and/or are considered a Non-Covered Benefit (NCB) under Medi-Cal or DHCS guidelines, no payment will be issued.*

Electronic Remittance Advice (835)

Health Plan leverages Smart Data Solutions (SDS) for its 835 file delivery. This process will ensure that you receive your 835 files faster and more efficiently.

The process operates as follows:

Regular Check Run

After each check run, your 835 files are automatically generated and distributed to our clearinghouse partner, SDS.

To receive your 835 files, instructions are below:

- If you want to use SDS: Reach out to your existing clearinghouse vendor and ask them to add connection to SDS for Health Plan under Payer Enrollment using Payer ID: 68035 or visit https://sdata.us/ and select the Provider Portal link at the top of the webpage. Once there, you can log in if you have an account or you can register for a new account.
- For the SDS Provider Portal Companion Guide, you can access it here https://sdata.us/what-we-do/clearinghouse/smart-data-stream-provider-portal/.

We have also partnered with another clearinghouse, TriZetto/Cognizant, who can deliver 835 files to those who are already signed up or choose to sign up with them as their clearinghouse.

- If you want to use TriZetto: You must be signed up with TriZetto before Health Plan can deliver your 835 files. For new users and to sign up, visit: www.trizettoprovider.com/health-plan-of-san-joaquin-new-user-form.
- For existing users, please contact TriZetto to arrange delivery of 835 files from Health Plan.

SECTION 11: PROVIDER PAYMENT

COST-SHARING

Providers may not balance bill Health Plan's Medi-Cal members for any covered/authorized services, pursuant to 22 CCR section 51002.

Additionally, HSC section 1367.37 requires that Health Plan provide emergency room and follow-up health care treatment for members who are treated following a rape or sexual assault without cost-sharing. This waiver of cost-sharing only applies for those claims that include accurate diagnosis codes specific to rape or sexual assault.

STREET MEDICINE PAYMENTS

If the street medicine Provider is an FQHC, they shall be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located. The FQHC shall be paid their applicable PPS rate when the street medicine Provider is a billable clinic.

ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT) is a great way to receive your payments from Health Plan faster. You may also contact the Provider Services Department at 1-888-936-7526 or via email to providerservices@hpsj.com for more information.

CHECK TRACERS

If payment has not been received within thirty (30) days of the check issuance date, please contact the Provider Services Department at 1-209-942-6340 or via email to Providerservices@hpsj.com to initiate a check tracer. Provider Services staff will coordinate with Health Plan's Finance Department to investigate further and verify the check payment status.

If the check has been cashed or deposited, a copy of the canceled check will be provided. If the check has not been cashed or deposited, an affidavit form must be completed and returned to the Provider Services Department via email to Providerservices@hpsj.com or fax to 1-209-461-2565 to request payment to be reissued. Affidavits must be notarized for payments greater than $1,000.

Upon receipt of the completed affidavit, a stop payment order will be placed on the original check and Health Plan's Finance Department will process the reissued payment on the next scheduled payment date.

PAYMENT DELAYS RELATED TO PROVIDER DIRECTORY

Under Section 1367.27 of the Health and Safety Code, Health Plan may delay payments if a Provider does not respond to attempts to verify information about the Provider published in the Provider Directory. Health Plan will not delay payment unless it has attempted to first verify the Provider's information by contacting the Provider in writing, electronically, or by telephone to confirm whether the current information is correct or requires updates.
For Providers paid on a capitated basis, Health Plan may delay up to fifty percent (50%) of the next scheduled capitation payment for up to one (1) calendar month. FFS claim payments may also be delayed for up to one (1) calendar month beginning on the first (1st) day of the following

month. Health Plan will provide ten (10) business days' notice before delaying payment. If payment is delayed, Health Plan will reimburse the full amount within three (3) business days following the date the Provider Directory information is received, or at the end of the one (1) month delay period.

ENCOUNTER DATA SUBMISSION

PCP's receiving capitation payments are required under the terms of their agreement/contracts to submit encounter data to Health Plan monthly. The monthly encounter data is essential information used by Health Plan, CMS, and DMHC/DHCS to accurately report and assess patient care and potential additional needs. The data can be submitted easily by using a CMS1500 claim form and may be submitted electronically. The encounter data must be received by Health Plan no later than the fifteenth (15th) of the month following the date services are rendered.

COORDINATION OF BENEFITS (COB)

When Health Plan is the secondary payer, all claims must be submitted within three hundred and sixty-five (365) days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB must be attached to the claim if submitted via paper. COB data can also be submitted electronically if the claim is filed electronically. Medicare Part A and B claims are submitted directly to Health Plan from CMS electronically monthly. If the Member's primary plan denies services and requests additional information, the information must be submitted to the primary insurance carrier before submitting to Health Plan.

PAYMENTS TO OUT OF NETWORK PROVIDERS

Out-of-network Providers who treat and bill for Medi-Cal Managed Care Plans (MCP) and MCP beneficiaries who have other health coverage (OHC) (Commercial health insurance, Medicare, Tricare, etc.). Due to mandatory managed care enrollment, Medi-Cal beneficiaries can keep their OHC when they become mandatorily enrolled in managed care (MMCE). As you are aware, Medi-Cal is the payer of last resort, which means in most cases, Medi-Cal will be secondary to the OHC, covering allowable costs not paid by the primary insurance (typically wrap payments or co-pays) up to the Medi-Cal rate.

A Provider enrolled for Medi-Cal FFS or as a Medicare Provider does not need to be contracted with a Medi-Cal MCP to see and bill the Medi-Cal MCP for routine services for a patient who is dual-eligible or has OHC and is enrolled in the MCP. For Providers who are enrolled in Medi-Cal FFS but do not contract with an MCP, they may still see an MCP Member for a limited duration under "continuity of care" requirements by leveraging a letter of agreement (LOA) or similar mechanism when the service would typically require a prior authorization.

To bill Medi-Cal after billing the OHC, the Provider must present acceptable forms of proof to the MCP that all sources of payment have been exhausted, which may include a denial letter from the OHC for the service or an explanation of benefits indicating that the service is not covered by the OHC.

THIRD PARTY LIABILITY

Health Plan is responsible for notifying the Department of Health Care Services (DHCS) within ten days of identifying cases in which a Member might receive funds from a third party to which

DHCS has lien rights.

Health Plan must be notified in writing of all potential and confirmed third party liability cases that involve a Health Plan Member. Notification must include:

- Member name
- Member identification number and Medi-Cal number
- Date of birth
- Provider name and address
- Date(s) of service
- CMS approved diagnostic and procedural coding
- Billed charges for service(s)
- Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for denial
- Any requests received by subpoena from attorneys, insurers, or Members for bill copies must be reported to Health Plan. The request for copies and responses must be forwarded to:

  Health Plan of San Joaquin/Mountain Valley Health Plan
  Attn: Compliance/Third Party Liability Coordinator
  7751 S Manthey Road, French Camp, CA 95231-9802
- Upon receipt of a request for information from DHCS, Health Plan must respond within thirty (30) days. Providers will be contacted if their assistance is needed. The information requested from Providers must be returned within ten (10) days.

FACILITY PAYMENTS

Health Plan contracts with facilities within the service area and provides access to specialty facility services when needed outside of the service area. Each facility agreement/contract contains specific reimbursement information indicating payment methodologies.

As a Medi-Cal plan, Health Plan will reimburse any Providers on staff within the facilities using the Medi-Cal fee schedule and/or contracted agreement.

Note: *Members cannot be balance billed for services (see Section 10: Claims Submission for further details)*

All facilities are expected to coordinate with Health Plan's Medical Management team for services that require prior authorization by providing the Member information and medical documentation necessary to support high quality, timely, and cost-effective health care.

Immediate Postpartum Contraception

Providers may separately bill for devices, implants, professional services, or a combination thereof, associated with immediate postpartum contraception, if the birth takes place in a general acute care hospital or licensed birth center. These devices, implants, and services are not considered to be part of a payment for a general obstetric procedure in these instances.

No Payment for Never Events, Hospital Acquired Conditions (HAC), and Provider Preventable Conditions (PPC)

The Centers for Medicare & Medicaid Services (CMS) defines Never Events as "serious and costly errors in the provision of health care services that should never happen." Never Events, HACs, and PPCs can be avoided through the application of evidence based clinical guidelines.

Institutional Providers are encouraged to take appropriate actions to reduce the likelihood of Never Events, HACs, and PPCs.

Facility Providers will not be reimbursed for covered services related to or resulting from Never Events, HAC, or PPC including reimbursement for additional Inpatient Days that would not have been incurred in the absence of such Never Event, HAC, or PPC. These events shall not be included in either APR-DRG calculations, Per Diems, or included in any stop loss calculations.

If an HAC or PPC event occurs, institutional Providers must submit a copy of the Member's record with the claim and file the PPC with DHCS. PPC filing instructions are located at www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx

PRIVATE HOSPITAL DIRECTED PAYMENT PROGRAM, DIRECTED PAYMENTS DESIGNATED PUBLIC HOSPITAL ENHANCED PAYMENT PROGRAM, DISTRICT AND MUNICIPAL PUBLIC HOSPITAL DIRECTED PAYMENT ("PHDP") PROGRAMS

Hospital partners may be eligible to participate in a Hospital Directed Payment Program, subject to eligibility requirements and hospital designations set forth by DHCS.

Per the DHCS PHDP Program guidelines, qualifying hospital partners (private, public, or district) participating in PHDP Program must submit clean, accurate, and timely claims for contracted services. Hospital Partners must ensure claims meet regulatory requirements and billing standards so that encounters are accepted by DHCS. Health Plan will not make corrections to claims or encounters on Hospital Partners' behalf.

Hospital Partners must review rejection reasons in reconciliation reports provided by Health Plan timely. If Hospital Partners opt to resubmit previously denied claims and/or rejected encounters, Hospital Partners must resubmit in a timely pursuant to Health Plan's schedule, as outlined below. If Hospital Partners do not resubmit timely, DHCS will not count such denied claims and rejected encounters toward PHDP.

Key Dates and Deadlines:

- Calendar Year (CY) Phases:
    - CY 20XX Phase 1: Claims and encounters with Dates of Service (DOS) January 1, 20XX through June 30, 20XX
    - CY 20XX Phase 2: Claims and encounters with DOS July 1, 20XX through December 31, 20XX.
- Encounter Data Submission Deadline to DHCS: Twelve (12) months following last DOS

for the applicable calendar year phase.

  - For example, claims and encounters with DOS January 1, 2025, through June 30, 2025 (CY 2025 Phase 1) are due to DHCS on or before June 30, 2026.
  - While Health Plan accepts claims up to 365 days from the DOS, Health Plan strongly recommends Hospital Partners submit claims as soon as practicable and well before the DHCS Encounter Data Submission Deadline to allow time for reconciliation with Health Plan and to ensure the encounters are accepted by DHCS and counted toward PHDP.

- Monthly DHCS PHDP Volume Charts File Delivery and Health Plan Reconciliation Reports:
  - DHCS will release Monthly Volume Charts on or around the last Friday of each month.
  - Approximately one month following the release of each DHCS Volume Chart, Health Plan will provide reports to Hospital Partners via DRE to inform Hospital Partners of paid/denied claims and accepted/rejected encounters.
  - Hospital Partners must review these monthly files and reports to identify discrepancies between claims submitted to Health Plan and the encounters accepted by DHCS for PHDP.
- Encounter Reconciliation Request Deadline: If Hospital Partner believes there are discrepancies, Hospital Partner may request to reconcile claims and encounters with Health Plan.
  - Hospital Partner must submit reconciliation requests to Health Plan by sending an email to PHDP@hpsj.com at least sixty (60) calendar days before the DHCS Encounter Deadline.
  - Health Plan will not accept reconciliation requests received less than sixty (60) calendar days before the DHCS Encounter Deadline.
- Contract Status Confirmation Deadlines: DHCS will notify Health Plan and Hospital Partners of the release of the First and Final Pass Encounter Detail Files via DHCS SFTP site. Hospital Partners must report contract status for each line of the Encounter Detail Files.
  - Contract Flagging Status File First Pass: Hospital Partners must submit file to Health Plan no later than ten (10) business days before the DHCS deadline.
  - Contract Flagging Status File Final Pass: Hospital Partners must submit file to Health Plan no later than ten (10) business days before the DHCS deadline.
- DHCS PHDP Funds Release to Health Plan: Six (6) months post contract flagging final pass.
- Health Plan Releases Funds to Providers: No later than thirty (30) days of receipt of DHCS funds.
- Estimated Funds: To be determined by DHCS.

For questions or additional support with file preparation for PHDP programs, please email PHDP@hpsj.com. Contract status file delivery methods include DRE File Exchange, SFTP, or secure email.

SECTION 11: PROVIDER PAYMENT

For more information on the PHDP Program for qualifying contracted hospitals, refer to the DHCS website at the links below.

Private Hospital Directed Payment Program
www.dhcs.ca.gov/services/Pages/DP-PHDP.aspx

District and Municipal Public Hospital Directed Payment
www.dhcs.ca.gov/services/Pages/District-and-Municipal-Public-Hospital-Directed-Payment.aspx

Directed Payments Designated Public Hospital Enhanced Payment Program
www.dhcs.ca.gov/services/Pages/DP-DPH-EPP.aspx

HIGH-COST PHARMACY (DRUGS)

Health Plan has established a list of drugs, medications and biologics that are defined as high-cost pharmaceuticals (drugs). When a Provider has administered a pharmaceutical (drug) identified on the list, the Provider must bill in accordance with claim billing requirements to receive payment. Health Plan will reimburse the Provider and/or facility according to Provider's agreement/contract.

Health Plan may perform bi-annual audits of Provider billing of high-cost pharmaceuticals (drugs) as defined in the Provider contract (if applicable) to ensure Providers billing are in accordance with established guidelines.

High-Cost Pharmacy (drugs) List
Effective 08/01/2024

Generic Name	Trade Name	HCPCS	HCPCS Description
Amphotericin b lipid complex	N/A	J0287	Injection, amphotericin b lipid complex, 10 mg
C-1 esterase, berinert	N/A	J0597	Injection, c-1esterase Inhibitor (human), berinert, 10 units
Miacalcin 200 IU/mL 2mL MDV 1pk	Miacalcin 200 IU/mL 2mL MDV 1pk	J0630	Injection, calcitonin salmon, up to 400 units
Ceftazidime and avibactam	N/A	J0714	Injection, ceftazidime and avibactam, O.Sg/0.125g
Cidofovir injection	N/A	J0740	Injection, cidofovir, 375 mg
Crotalidae poly immune fab	N/A	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1g
Dalvance 500 mg	Dalvance 500 mg	J0875	Injection, dalbavancin, 5 mg
DAPTOMYCIN LYO INJECTION 500 mg/10ML 1	DAPTOMYCIN LYO INJECTION 500 mg/10ML 1	J0878	Injection, daptomycin, 1 mg
ARANESP (darbepoetin alfa)	ARANESP (darbepoetin alfa)	J0881	Injection, darbepoetin alfa, 1 microgram (non-esrd use)
Argatroban Inj, 100 mg/mL, 2.5 mL Vial	Argatroban Inj, 100 mg/mL, 2.5 mL Vial	J0883	Injection, argatroban, 1 mg (for non-ESRD use)
EPOGEN (Epoetin alfa)	EPOGEN (Epoetin alfa)	J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units
DECITABINE FOR INJECTION 50 mg 1 SD VIAL	DECITABINE FOR INJECTION 50 mg 1 SD VIAL	J0894	Injection, decitabine, 1 mg
Prolia (denosumab)	Prolia (denosumab)	J0897	Injection, denosumab, 1 mg
Soliris	Soliris	J1300	Injection, ecullzumab, 10 mg
NEUPOGEN (Filgrastim)	NEUPOGEN (Filgrastim)	J1442	Injection, filgrastim (G- CSF), excludes biosimilars, 1 mcg
Galsulfase injection	N/A	J1458	Injection, galsulfase, I mg
PRIVIGEN	PRIVIGEN	J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g. liquid},500 me
Inj, imm glob bivigam, 500 mg	N/A	J1556	Injection, immune globulin (Bivigam}, 500 mg

Gammaplex injection	N/A	J1557	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g. liquid}, 500 mg
Gamunex-C 5GM 50ML Vial	Gamunex-C 5GM 50ML Vial	J1561	Injection, immune globulin, (gamunex-c/gammaked}, non-lyophilized (e.g. liquid), 500 mg
Immune globulin, powder	N/A	J1566	Injection, immune globulin, intravenous, lyophilized (e.g. powder}, not otherwise specified, 500 mg
Octagam 10%	Octagam 10%	J1568	Injection, immune globulin, (octagam}, intravenous, non-lyophiiized (e.g. liquid}, 500 mg
GAMMAGARD LIQUID IMMUNE GLOBULIN INTRAVENOUS	GAMMAGARD LIQUID IMMUNE GLOBULIN INTRAVENOUS	J1569	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg
Flebogamma 5% DIF	Flebogamma 5% DIF	J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif}, intravenous, nonlyophilized (e.g., liquid), 500 mg
IMMUNE GLOBULIN INTRAVENOUS	PANZYGA	J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid}, not otherwise specified, 500 mg
Idursulfase injection	N/A	J1743	Injection, idursulfase, I mg
TRELSTAR 3.75 mg	TRELSTAR 3.75 mg	J3315	Injection, triptorelin pamoate, 3.75 mg
DOXORUBICIN HYDROCHLORIDE	DOXORUBICIN HYDROCHLORIDE	J9000	Injection, d_oxorubicin hydrochloride, 10 mg
Inj., treanda 1 mg	N/A	J9033	Injection, bendamustine hcl,1 mg
Bevacizumab Syringe 1.25 ML	Bevacizumab Syringe 1.25 ML	J9035	Injection, bevacizumab, 10 mg
BORTEZOMIB	VELCADE	J9041	Injection, bortezomib, 0.1 mg
ADCETRIS (brentuximab vedotin)	ADCETRIS (brentuximab vedotin)	J9042	Injection, brentuximad vedotin, 1 mg
XGEVA (denosumab)	XGEVA (denosumab)	J9047	Injection, carfilzomib, 1 mg
CETUXIMAB	ERBITUX	J9055	Injection, cetuximab,10 mg
CYCLOPHOSPHAMIDE FOR INJECTION, USP 500 mg/VIAL SDV PF	CYCLOPHOSPHAMIDE FOR INJECTION, USP 500 mg/VIAL SDV	J9070	Cyclophosphamide,100 mg
Dactinomycin injection	N/A	J9120	Injection, dactinomycin, 0.5 mg
DARZALEX (DARATUMUMAB) 5ML	DARZALEX (DARATUMUMAB) 5ML	J9145	Injection, daratumumab, I0 mg
DOCETAXEL (DOCETAXEL) 10 mg/ML INJ	DOCETAXEL (DOCETAXEL) 10 mg/ML INJ	J9171	Injection, docetaxel,1 mg
Ceftriaxone for Injection, USP - 1g / 15mL (25 pack)	Ceftriaxone for Injection, USP 1g /15mL (25 pack)	J9179	Injection, eribulin mesylate,0.1 mg
Zoladex Safesystem Syringe 3.6 mg 1x1 EA DEPOT	Zoladex Safesystem Syringe 3.6 mg 1x1 EA DEPOT	J9202	Goserelin acetate implant, per 3.6 mg
KEYTRUDA 100 mg INJ LIQUID INNER PACK	KEYTRUDA 100 mg INJ LIQUID INNER PACK	J9271	Injection, pembrolizumab, 1 mg
FULVESTRANT	FASLODEX	J9395	Injection, fulvestrant,25 mg
EPOGEN (Epoetin alfa)	EPOGEN (Epoetin alfa)	Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)
Opdivo	Opdivo	J9299	NIVOLUMAB 1 mg INJ

Herceptin 150 mg (10mL) Vial	Herceptin 150 mg (10mL) Vial	J9355	TRASTUZUMAB 10 mg INJ
PEMETREXED DISODIUM	ALIMTA	J9305	PEMTREXED 10 mg INJ PN
PANITUMUMAB	VECTIBIX	J9303	PANITUMUMAB 10 mg INJJG
SODIUM CHLORIDE	SODIUM CHLORIDE	J9312	RITUXIMAB 10 mg INJJG
Herceptin 150 mg (10mL) Vial	Herceptin 150 mg (10mL) Vial	J9306	PERTUZUMAB 1 mg INJ
INJECTAFER 750 mg IRON, 15ML SDV (FERRIC CARBOXYMALTOSE INJ.)	INJECTAFER 750 mg IRON, 15ML SDV (FERRIC CARBOXYMAL	J1439	FERRIC CARBOXYMAL 1 mg INJ
REMICADE	REMICADE	J1745	INFLIXIMAB 100 mg INJ
NPLATE (romiplostim)	NPLATE (romiplostim)	J2796	ROMIPLOSTIM PER 10MCG INJJG
NEULASTA (pegfilgrastim)	NEULASTA (pegfilgrastim)	J2505	PEGFILGRASTI M 6 mg INJ
PALONOSETRON HCL INJ 0.25 mg/5ML SSOL GVL	PALONOSETRON HCL INJ 0.25 mg/5ML SSOL GVL	J2469	PALONOSETRON 2SMCG INJ PN
UDENYCA (PEGFILGRASTIM-CBQV)	UDENYCA (PEGFILGRASTIM-CBQV)	Q5111	PEGFILGRAS-CBQV 0.5 mg INJ
OXALIPLATIN	ELOXATIN	J9263	OXALIPLATI N 0.5 mg INJ PN
ZARXIO 480 MCG/0.8ML INJECTION PREFILLED SYRINGE	ZARXIO 480 MCG/0.8ML INJECTION PREFILLED SYRINGE	Q5101	FILGRASTIM G-CSF BIO 1MCGPN
GEMCITABINE HCL	GEMZAR	J9201	GEMCITABINE HCL 200 mg PN
EMEND 150 mg POWDER IV	EMEND 150 mg POWDER IV	J1453	FOSAPREPITANT 1 mg INJ PN
Degarelix injection	N/A	J9155	DEGARELIX 1 mg INJ PN
CISPLATIN	CISPLATIN	J9060	CISPLATIN PER 10 mg INJ
IRINOTECAN HCL	CAMPTOSAR	J9206	IRINOTECAN 20 mg/1ML SDV
Etoposide Inj (100 mg/5mL)	Etoposide Inj (100 mg/5mL)	J9181	ETOPOSIDE 10 mg (500 mg) MDV
LUPRON DEPOT 11.25 mg PED	LUPRON DEPOT 11.25 mg PED	J9217	LEUPROLIDE 7.5 mg DEPO KIT
EPOETIN ALFA-EPBX	RETACRIT	Q5106	EPOETIN A NONESRD 1KU INJ
EMEND 150 mg POWDER IV	EMEND 150 mg POWDER IV	J9045	CARBOPLATIN /50 mg 50 mg MDV
ZOMETA VIAL 4 mg/5ML	ZOMETA VIAL 4 mg/5ML	J3489	ZOLEDRONIC ACID PER 1 mg
BOTOX BOTULINUM TOXIN TYPE A	BOTOX BOTULINUM TOXIN TYPE A	J0585	ONABOTULINUMTOXI NA 100UVL
Vimpat Injection 200 mg/20mL	Vimpat Injection 200 mg/20mL	C9254	INJECTION LACOSAMIDE 1 mg
BOTOX BOTULINUM TOXIN TYPE A	BOTOX BOTULINUM TOXIN TYPE A	J0585	BOTULINUM TOXIN TYPE A PER UNIT
MYOBLOC	MYOBLOC	J0587	INJ RIMABOTULINUMTOXINB 100 UNITS
Cimzia	Cimzia	J0717	INJECTION CERTOLIZUMAB PEGOL 1 mg
XIAFLEX (collagenase clostridium histolyticum)	XIAFLEX (collagenase clostridium histolyticum)	J0775	INJ COLLAGENASE CLOSTRIDIUM HISTOLYTICUM 0.01 mg
Dalvance 500 mg	Dalvance 500 mg	J0875	INJECTION DALBAVANCIN 5 mg
EPOGEN (Epoetin alfa)	EPOGEN (Epoetin alfa)	J0885	INJ EPOETIN ALFA NON-ESRD 1000 UNIT
DECITABINE FOR INJECTION 50 mg 1 SD VIAL	DECITABINE FOR INJECTION 50 mg 1 SD VIAL	J0894	INJECTION DECITABINE 1 mg
Prolia (denosumab)	Prolia (denosumab)	J0897	INJECTION DENOSUMAB 1 mg
Soliris	Soliris	J1300	INJECTION ECULIZUMAB 10 mg
Radicava (edaravone injection)	Radicava (edaravone injection)	J1301	INJECTION EDARAVONE 1 mg

INJECTAFER 750 mg IRON, 15ML SDV (FERRIC CARBOXYMALTOSE INJ.)	INJECTAFER 750 mg IRON, 15ML SDV (FERRIC CARBOXYMAL	J1439	INJECTION FERRIC CARBOXYMALTOSE 1G
GRANIX INJ 0.5 ML	GRANIX INJ 0.5 ML	J1447	INJECTION TBO-FILGRASTIM 1MICROGRAM
PRIVIGEN	PRIVIGEN	J1459	INJ IG IV NONLYOPHILIZED 500 mg
Gamunex-C 5GM 50ML Vial	Gamunex-C 5GM 50ML Vial	J1561	INJECTION IMMUNE GLOBULIN NONLYOPHILIZED 500 mg
Injection, lacosamide	N/A	C9254	INJ IG IV LYPHILIZED NOS 500 mg
GAMMAGARD LIQUID IMMUNE GLOBULIN INTRAVENOUS	GAMMAGARD LIQUID IMMUNE GLOBULIN INTRAVENOUS	J1569	INJ IG GAMMAGARD LIQ IV NONLYOPHILIZED 500 mg
Flebogamma 5% DIF	Flebogamma 5% DIF	J1572	INJ IG IV NONLYOPHILIZED 500 mg
IMMUNE GLOBULIN INTRAVENOUS	PANZYGA	J1599	INJ IG IV NONLYOPHILIZED E.G. LIQUID NOS 500 mg
SIMPONI ARIA 50 mg/4mL Trade US	SIMPONI ARIA 50 mg/4mL Trade US	J1602	INJECTION GOLIMUMAB 1 mg FOR INTRAVENOUS USE
Hemin, 1 mg	N/A	J1640	INJECTION HEMIN 1 mg
REMICADE	REMICADE	J1745	INJECTION INFLIXIMAB EXCLUDES BIOSIMILAR 10 mg
Imuglucerase injection	N/A	J1786	INJECTION IMIGLUCERASE 10 UNITS
Somatuline Depot (lanreotide)	Somatuline Depot (lanreotide)	J1930	INJECTION LANREOTIDE 1 mg
NUCALA (MEPOLIZUMAB) INJ 100 mg1 VIAL/CARTON	NUCALA (MEPOLIZUMAB) INJ 100 mg1 VIAL/CARTON	J2182	INJECTION MEPOLIZUMAB 1 mg
MICAFUNGIN SODIUM	MYCAMINE	J2248	INJECTION MICAFUNGIN SODIUM 1 mg
SODIUM CHLORIDE	SODIUM CHLORIDE	J2323	INJECTION NATALIZUMAB 1 mg
Ocrevus 300 mg/10ml Vial	Ocrevus 300 mg/10ml Vial	J2350	INJECTION OCRELIZUMAB 1 mg
SANDOSTATIN LAR DEPOT 20 mg	SANDOSTATIN LAR DEPOT 20 mg	J2353	INJ OCTREOTIDE DEPOT FORM IM 1 mg
NEULASTA (pegfilgrastim)	NEULASTA (pegfilgrastim)	J2505	INJECTION PEGFILGRASTIM 6 mg
KRYSTEXXA	KRYSTEXXA	J2507	INJECTION PEGLOTICASE 1 mg
Lucentis 0.5 mg (0.05ml) PFS	Lucentis - 0.5 mg (0.05ml) PFS	J2778	INJECTION RANIBIZUMAB 0.1 mg
NPLATE (romiplostim)	NPLATE (romiplostim)	J2796	INJECTION ROMIPLOSTIM 10MCG
HUMAN SECRETIN	CHIRHOSTIM	J2850	INJ SECRETIN SYNTH HUMN 1 MCG
THYROTROPIN ALFA	THYROGEN	J3240	INJ THYROTROPIN .9 mg PROV 1.1 VIAL
Tigecycline injection	N/A	J3243	INJECTION TIGECYCLINE 1 mg
Actemra 80 mg (20 mg/mL) 4mL vial	Actemra? 80 mg (20 mg/mL) 4mL vial	J3262	INJECTION TOCILIZUMAB 1 mg
TREPROSTINIL SODIUM	REMODULIN	J3285	INJECTION TREPROSTINIL 1 mg
TRELSTAR 3.75 mg	TRELSTAR 3.75 mg	J3315	INJ TRIPTORELIN PAMOATE 3.75 mg
STELARA 130 mg/26 mL (5 mg/mL)	STELARA 130 mg/26 mL (5 mg/mL)	J3358	USTEKINUMAB FOR INTRAVENOUS INJECTION 1 mg
Entyvio 300 mg Vial	Entyvio 300 mg Vial	J3380	INJECTION VEDOLIZUMAB 1 mg
FIBRINOGEN	RIASTAP	J7178	INJECTION HUMAN FIBRINOGEN CONC NOS 1 mg
Iluvien	Iluvien	J7313	INJECTION FA INTRAVITREAL IMPL ILUVIEN 0.01 mg
Monovisc inj per dose	N/A	J7327	HYALURONAN/DERIVATIVE MONOVISC IA INJ PER DOSE

IMFINZI, 120 mg	IMFINZI, 120 mg	J9173	INJECTION DURVALUMAB 10 mg
Ceftriaxone for Injection, USP 1g / 15mL (25 pack)	Ceftriaxone for Injection, USP 1g / 15mL (25 pac	J9179	INJECTION ERIBULIN MESYLATE 0.1 mg
Onivyde 43 mg/10ML per vial	Onivyde 43 mg/10ML per vial	J9205	INJECTION IRINOTECAN LIPOSOME 1 mg
IXABEPILONE 15 mg Vial	IXABEPILONE 15 mg Vial	J9207	INJECTION IXABEPILONE 1 mg
VANTAS (HISTRELIN ACETATE) IMPLANT	VANTAS (HISTRELIN ACETATE) IMPLANT	J9225	HISTRELIN IMPLANT VANTAS 50 mg
Yervoy	Yervoy	J9228	INJECTION IPILIMUMAB 1 mg
PACLITAXEL 100 mg/16.7ML INJ VIAL	PACLITAXEL 100 mg/16.7ML INJ VIAL	J9264	INJ PACLITAXEL PROTBND PARTICL 1 mg
Oncaspar (pegaspargase) Injection, 3750 IU/5mL	Oncaspar (pegaspargase) Injection, 3750 IU/5mL	J9266	INJ PEGASPARGASE SINGLE DOSE VIAL
KEYTRUDA 100 mg INJ LIQUID INNER PACK	KEYTRUDA 100 mg INJ LIQUID INNER PACK	J9271	INJECTION PEMBROLIZUMAB 1 mg
Mitomycin for Injection 20 mg/50mL	Mitomycin for Injection 20 mg/50mL	J9280	INJECTION MITOMYCIN 5 mg
Inj, olaratumab, 10 mg	N/A	J9285	INJECTION OLARATUMAB 10 mg
Opdivo	Opdivo	J9299	INJECTION NIVOLUMAB 1 mg
GAZYVA 1000 mg/40mL 1 VIAL	GAZYVA 1000 mg/40mL 1 VIAL	J9301	INJECTION OBINUTUZUMAB 10 mg
PANITUMUMAB	VECTIBIX	J9303	INJECTION PANITUMUMAB 10 mg
PEMETREXED DISODIUM	ALIMTA	J9305	INJECTION PEMETREXED 10 mg
Herceptin 150 mg (10mL) Vial	Herceptin 150 mg (10mL) Vial	J9306	INJECTION PERTUZUMAB 1 mg
CYRAMZA	CYRAMZA	J9308	INJECTION RAMUCIRUMAB 5 mg
SODIUM CHLORIDE	SODIUM CHLORIDE	J9312	INJECTION RITUXIMAB 10 mg
TEMSIROLIMUS	TEMSIROLIMUS	J9330	INJECTION TEMSIROLIMUS 1 mg
YONDELIS (TRABECTEDIN) 1 mg	YONDELIS (TRABECTEDIN) 1 mg	J9352	INJECTION TRABECTEDIN 0.1 mg
Herceptin 150 mg (10mL) Vial	Herceptin 150 mg (10mL) Vial	J9355	INJECTION TRASTUZUMAB EXCLUDES BIOSIMILAR 10 mg
FULVESTRANT	FASLODEX	J9395	INJECTION FULVESTRANT 25 mg
FERUMOXYTOL	FERUMOXYTOL	Q0138	INJ FERUMOXYTOL IDA 1 mg NON ESRD
Infliximab-dyyb	Inflectra	Q5103	INJECTION INFLIXIMAB-DYYB BIOSIMILAR 10 mg
RENFLEXIS 100 mg INJ INNER PACK	RENFLEXIS 100 mg INJ INNER PACK	Q5104	INJECTION INFLIXIMAB-ABDA BIOSIMILAR 10 mg
Fulphila 6 mg/0.6mL PFS 1PK	Fulphila 6 mg/0.6mL PFS 1PK	Q5108	INJECTION PEGFILGRASTIM-JMDB BIOSIMILAR 0.5 mg
NAFCILLIN SODIUM	NAFCILLIN SODIUM	S0032	INJECTION NAFCILLIN SODIUM 2 GRAMS
Tocilizumab Injection	Actemra	J3262	Injection, tocilizumab, 1 mg
TRIPTORELIN PAMOATE	Trelstar	J3315	INJ TRIPTORELIN PAMOATE 3.75 mg
FA INTRAVITREAL	N/A	J7313	INJECTION FA INTRAVITREAL IMPL ILUVIEN 0.01 mg
DERIVATIVE MONOVISC	N/A	J7327	HYALURONAN/DERIVATIVE MONOVISC IA INJ PER DOSE
THYROTROPIN .9 mg	THYROGEN	J3240	INJ THYROTROPIN .9 mg PROV 1.1 VIAL
PEGLOTICASE 1 mg	KRYSTEXXA	J2507	INJECTION PEGLOTICASE 1 mg

IMPLANT VANTAS	VANTAS (HISTRELIN ACETATE) IMPLANT	J9225	HISTRELIN IMPLANT VANTAS 50 mg
PEGASPARGASE SINGLE	Oncaspar	J9266	INJ PEGASPARGASE SINGLE DOSE VIAL

SECTION 12: DISPUTE RESOLUTION

MEMBER GRIEVANCES AND APPEALS

There are two ways to report or solve problems involving health care, treatment, or services for Members. A grievance (or complaint) is when a Member has a problem with Health Plan or a Provider, or with the health care or treatment they got from a Provider. An appeal is when there is disagreement with Health Plan's decision to change services or not to cover them. Members may also appeal an adverse determination of a non-coverage related grievance resolution.

Members have the right to file grievances and appeals with Health Plan to notify about the problem. Solving Member issues assists Health Plan to improve care for all Members.

Members should always contact Health Plan first to notify them of their problem. They may call between 8:00 a.m. to 5:00 p.m. at 1-888-936-7526, TTY 711.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-936-PLAN (7526), TTY 711** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

The California Department of Health Care Services Medi-Cal Managed Care Ombudsman can also help. The Ombudsman Program is available to assist members in investigating and resolving any grievances about Health Plan. If members wish to use the services of the DHCS to help with a grievance, they may call the Ombudsman Program toll-free Monday through Friday, between 8:00 a.m. and 5:00 p.m., at 1-888-452-8609.

Members may also file a grievance with their county eligibility office about their Medi-Cal eligibility. If Members are unsure who they can file their grievance with, they should call 1-888-936-PLAN (7526), TTY 711.

There is no time limit to file a grievance. Grievances may be submitted to Health Plan in person, by mail, fax, telephone or electronically through Health Plan's website by the Member, Member representative or Provider on behalf of Member. Grievances may be submitted to Health Plan via any of the methods outlined below, or at any contracted Provider's office (provider offices should make the complaint forms available to Members).

- In person: Visiting any one of Health Plan's locations in French Camp, Modesto, or Placerville to report a grievance.

- By phone: Calling Health Plan at 1-888-936-PLAN (7526), TTY 711 between 8:00 a.m. - 5:00 p.m. Give their Health Plan ID number, their name, and the reason for their grievance.
- By mail: Calling Health Plan at 1-888-936-7526, TTY 711 and ask to have the form mailed to them. When they receive the form, they should fill it out. Members should include their name, Health Plan ID number and the reason for the grievance. Tell Health Plan what happened and how we can assist.

  Mail the form to:
  Health Plan of San Joaquin/Mountain Valley Health Plan
  Attention: Grievance and Appeal Department
  7751 South Manthey Road French Camp, CA 95231
- Online: Visit Health Plan's website at www.hpsj.com/member-grievance-form/
- By fax: Fax grievance form to 1-209-942-6355.
- By email: File complaint via email at Grievances@hpsj.com

If a Member needs help filing their grievance, Health Plan can help and can also provide free language services. Members should call 1-888-936-7526, TTY 711.

Within five (5) calendar days of receiving a complaint, Health Plan will send a letter to confirm receipt. Within thirty (30) calendar days of receiving a grievance, Health Plan will send another letter to notify the Member of how the problem was resolved. If the Member calls Health Plan about a grievance that is not about health care coverage, medical necessity, or experimental or investigational treatment, and their grievance is resolved by the end of the next business day, they may not get a letter.

If the Member has an urgent matter involving a serious health concern, Health Plan may start an expedited (fast) review and provide a decision to the Member within 72 hours. To ask for an expedited review, Members may call 1-888-936-7526, TTY 711. Within 72 hours of receiving the grievance, Health Plan will decide how to handle the grievance and whether to expedite it. If Health Plan determines that it will not expedite the grievance, Health Plan will notify the Member that it will resolve the grievance within 30 days. Members may contact the DMHC directly for any reason, including if they believe their concern qualifies for an expedited review, or Health Plan does not respond within the 72-hour period.

Grievances related to Medi-Cal Rx pharmacy benefits are not subject to Health Plan's grievance process or eligible for Independent Medical Review. Members can submit complaints about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273 (TTY 1-800-977-2273 and press 5 or 711) or going to medicalrx.dhcs.ca.gov/home/. However, complaints related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. DMHC's toll-free telephone number is 1-888-466-2219 and the TTY line is 1-877-688-9891. Members can find the Independent Medical Review/Grievance form and instructions online at the DMHC's website at: www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewandComplaintReports.

Failure on the part of the Provider to respond to member grievances from the grievance team may result in the case being resolved in Member's favor based upon the available records.

SECTION 12: DISPUTE RESOLUTION

Health Plan Providers may not dismiss, discriminate, or retaliate against a Member because they filed a Grievance. Health Plan complies with all non-discrimination policies set forth by State and Federal Law as described in APL 21-004 found at DHCS website www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx. Members will not be required to file discrimination grievances with Health Plan prior to filing directly with DHCS' Office of Civil Rights (OCR) or with the Department of Health and Human Services' (HHS) OCR.

All grievances alleging discrimination will be forwarded timely to DHCS. This includes, and is not limited to the following: language access grievances, failure to reasonably accommodate a Member under the requirements of the American Disability Act (ADA), and discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups (see CA Penal Code section 422.56).

Provider grievances which are not related to Member or enrollee must go through the Provider services inquiry process.

All standard Grievances are acknowledged in writing and postmarked within five (5) calendar days of receiving the Grievance. Any grievance deemed urgent/expedited by a clinical staff Member is acknowledged within 24 hours from receipt of the grievance in writing, over the phone, or another method. A grievance letter is sent to the Provider outlining the grievance, any requests for medical records, and/or a written response. The Grievance Coordinator/QI Nurses gather information and investigate the grievances. After completion of the investigation, the case is forwarded to the Medical Director or Peer Physician Reviewer for severity coding, leveling, and final resolution. All grievances are fully investigated and resolved before closing them with the severity level and point values. As part of the investigation, if the member grievance is against a provider or practitioner, the plan sends an enquiry to the provider or calls the provider to request information related to the grievance. Providers are required to respond to the grievance investigation to ensure appropriate resolution of the members grievance. Members may appeal an adverse determination of a non-coverage related grievance.

Grievance Corrective Action Plan (CAP): CAPs allow the Provider office the opportunity to work collaboratively with Health Plan in order to improve areas of concern.

CAPs are implemented based on providers who meet or exceed thresholds for grievances related to Access, Quality of Care, and Quality of Service. These are the highest reported categories for grievances. The thresholds for each of these categories are: Access (3 per 1000), Quality of Care (3 per 1000), Quality of Service (5 per 1000). If a Provider meets any of the category's threshold, a Corrective Action Plan (CAP) will be issued to the Provider and/or presented at Peer Review & Credentialing Committee (PR&CC).

CAPs are also based on meeting severity points. All grievances are reviewed and are assigned severity level and point values when the grievance is closed. The accumulation of grievance cases by any Provider with severity level points or any combination of cases totaling 16 points or more during a rolling 12 months will be subject to case presentation at the PR&CC except for cases closed with either a score C0 or S0. Providers with 48 or more cases with a level of C-0 or S-0 in a

rolling 12-month period will be subject to presentation at the Grievance Committee for possible CAP and/or review at PR&CC.

- 48 cases with a level of C-0 and S-0
- 12 cases with a leveling of C-1 and S-1
- 6 cases with a leveling of C-2
- 1 case with a leveling of C-3 or C-4 (automatic referral to the applicable Peer Review Committee)
- C-0 and S-0 are 0 points. C1 and S1-1 point, C2- 2 points, C3-3 points, C4- 4

Call to Action Letters will be issued for any case level C-1 and above and S-1 at the discretion of the Medical Director. If the same issue continues to occur, and the provider receives 3 letters over any 6-month period, the provider will be subject to a CAP.

At the discretion of the Medical Director, a CAP can be issued based on the severity of the case.

Appeals

A coverage or benefit appeal is different from a non-coverage grievance or appeal. A coverage or benefit appeal is a request for Health Plan to review and change a decision made about the Member's service(s). If Health Plan sends the Member a Notice of Action (NOA) letter telling them that we are denying, delaying, changing or ending a service(s), and they do not agree with our decision, the Member can ask us for an appeal. The Member's PCP or other Provider can also ask Health Plan for an appeal on behalf of the Member with the Member's written permission. Members may ask for an appeal within 60 days from the date on the NOA received from Health Plan. If Health Plan decides to reduce, suspend, or stop service(s) the Member is currently receiving, the Member can continue getting service(s) while they wait for their appeal to be decided. This is called Aid Paid Pending. To receive Aid Paid Pending, the Member must ask us for an appeal within 10 days from the date on the NOA or before the date the service(s) will stop, whichever is later. When an appeal is requested under these circumstances, the service(s) will continue.

Members, Member representative or Provider on behalf of Member may submit an appeal to Health Plan via any of the methods outlined below:

- In person: Visiting any one of Health Plan's locations in French Camp, Modesto, or Placerville to report a grievance.
- By phone: Calling Health Plan at 1-888-936-PLAN (7526), TTY 711 between 8:00 a.m. – 5:00 p.m. Give their name, Health Plan ID number, and the service they are appealing.
- By mail: Calling Health Plan at 1-888-936-PLAN (7526), TTY 711 and ask to have form mailed to them. When they get the form, they should fill it out. Members should include their name, Health Plan ID number and the service they are appealing.

  Mail the form to:

  Health Plan of San Joaquin/Mountain Valley Health Plan
  Attention: Grievance and Appeal Department
  7751 South Manthey Road French Camp, CA 95231

Provider offices should also have appeal forms available.

- Online: Members can visit Health Plan's website by going to www.hpsj.com/grievances-appeals/ if they need help asking for an appeal or with Aid Paid Pending, Health Plan can help and can provide free language services by calling 1-888-936-PLAN (7526), TTY 711.
- By fax: Fax Appeal form to 1-209-942-6355.
- By email: File Appeal via email at Grievances@hpsj.com

Within 5 days of receiving an appeal, Health Plan will send a letter to confirm receipt. Health Plan will notify the Member within 30 days of receipt of the appeal about the appeal decision via a Notice of Appeal Resolution (NAR) letter. If Health Plan does not provide Member with the appeal decision within 30 days, Members can request a State Hearing and an IMR with the DMHC. But if a State Hearing is requested first, and the hearing has already happened, Members cannot ask for an IMR. In this case, the State Hearing Is the final level of appeal.

If a Member or their doctor wants Health Plan to make a fast decision because the time it takes to decide an appeal would put a Member's life, health or ability to function in danger, the Member can ask for an expedited (fast) review. To ask for an expedited review, call 1-888-936-PLAN (7526), TTY 711. Within 72 hours of receiving the appeal, Health Plan will make a decision about how to handle the appeal and whether to expedite. If Health Plan determines that it will not expedite the appeal, Health Plan will notify the Member that it will make a decision and resolve the appeal within 72 hours.

If a Member requested an appeal and got a NAR letter telling them Health Plan did not change their decision, or Member never got a NAR letter and it has been past 30 days, they can:

- Ask for a State Hearing from the California Department of Social Services (CDSS), and a judge will review their case.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have Health Plan's decision reviewed or ask for an Independent

If an Independent Medical Review (IMR) is requested from the DMHC, an outside doctor who is not part of Health Plan will review the Member's case. DMHC's toll-free telephone number is 1-888-466-2219 and the TTY line is 1-877-688-9891. Members can find the Independent Medical Review/Complaint form and instructions online at DMHC's website: www.dmhc.ca.gov.

Members will not have to pay for a State Hearing or an IMR.

Members are entitled to both a State Hearing and an IMR. But if a Member asks for a State Hearing first, and the hearing has already happened, they cannot ask for an IMR. In this case, the State Hearing has the final say. The sections below have more information on how to ask for a State Hearing and an IMR. Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by Health Plan. Members can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273.However, complaints and appeals related to pharmacy benefits that are not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. If Members do not agree with a decision related to their Medi-Cal Rx pharmacy benefit, they may ask for a State Hearing. Medi-Cal Rx

pharmacy benefit decisions are not subject to the IMR process with the DMHC.

Complaints and Independent Medical Reviews (IMR) with the Department of Managed Health Care

An IMR is conducted by an outside doctor who is not part of the Member's health plan and was not part of the initial case review. The IMR process provides an impartial review of medical decisions made by Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. If the Member wants an IMR, the Member must first file an appeal with Health Plan. If the Member does not hear from Health Plan within 30 calendar days, or if the Member is unhappy with the Health Plan's decision, then they may request an IMR. The Member must ask for an IMR within 6 months from the date on the notice of the appeal decision, but the Member only has 120 days to request a State Hearing so if the Member wants an IMR and a State hearing they must submit their complaint as soon as possible. If the Member asks for a State Hearing first, and the hearing has already happened, the Member cannot ask for an IMR. In this case, the State Hearing is the final level of appeal.

The Member may be able to get an IMR right away without filing an appeal first. This is applicable to cases where the health concern is urgent, such as those involving a serious threat to the Member's health.

If the Member's complaint to DMHC does not qualify for an IMR, DMHC will still review the complaint to make sure Health Plan made the correct decision when the Member appealed its denial of services. Health Plan must comply with DMHC's IMR and review decisions.

How Members Can Request an IMR:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-936-PLAN (7526), TTY 711** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If the you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

State Hearings

A State Hearing is a meeting with people from the California Department of Social Services (CDSS). A judge will help the Member to resolve their problem or tell them that Health Plan made the correct decision. The Member has a right to ask for a State Hearing if they have already asked for an appeal with Health Plan and they are still not happy with the decision, or if the Member

does not get a decision on their appeal after 30 days.

The Member must ask for a State Hearing within 120 days from the date on Health Plan's NAR letter. However, if Health Plan gave the Member Aid Paid Pending during their appeal, and the Member wants it to continue until there is a decision on their State Hearing, they must ask for a State Hearing within 10 days of Health Plan's NAR letter, or before the date specified their service(s) will stop, whichever is later. If the Member needs help making sure Aid Paid Pending will continue until there is a final decision on their State Hearing, they may contact Health Plan between 8:00 a.m. – 5:00 p.m. by calling 1-888-936-PLAN (7526). If the Member cannot hear or speak well, they may call TTY 711. The Member's PCP can ask for a State Hearing on behalf of the Member with their written permission.

In some instances, the Member can ask for a State Hearing without completing Health Plan's appeal process. For example, the Member can request a State Hearing without having to complete our appeal process if we did not notify them correctly or on time about their service(s). This is called Deemed Exhaustion. Examples of Deemed Exhaustion include when Health Plan:

- Did not make a NOA letter available to the Member in their preferred language
- Made a mistake that affects any of the Member's rights
- Did not give the Member a NOA letter
- Made a mistake in the NAR letter
- Did not decide the Member appeal within 30 days
- Decided the Member's case was urgent but did not respond to their appeal within 72 hours

Members may ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov
- By phone: Calling 1-800-743-8525.This number can be very busy. Member may get message to call back later. If member cannot speak or hear well, please call TTY/TDD 1-800-952-8349.
- By mail: Filling out the form provided with their appeals resolution notice and sending it to:

  California Department of Social Services State Hearings Division
  P.O. Box 944243, Mail Station 09-17-433
  Sacramento, CA 94244-2430
- Fax: 1-916-309-3487 or toll free at 1-833-281-0903

If Members need help asking for a State Hearing, Health Plan can help and can provide free language services by calling 1-888-936-PLAN (7526), TTY 711.

At the hearing, the Member and Health Plan can both provide information on the case. It could take up to 90 days for the judge to decide the Member case. Health Plan must follow what the judge decides.

If a Member wants the CDSS to make a fast decision because the time it takes to have a State Hearing would put the Members life, health or ability to function fully in danger, the Member or

the Member's PCP can contact the CDSS and ask for an expedited (fast) State Hearing. For expedited requests, CDSS must make a decision no later than 3 business days after it gets the Member's complete case file from Health Plan.

PROVIDER DISPUTE RESOLUTION (PDR)

Health Plan maintains a dispute resolution process to support the review and resolution of Provider concerns including, but not limited to, disputes regarding claim payments and/or denials, utilization management decisions (authorizations) and recoupment requests.

Provider Dispute Resolution (PDR) request must be submitted as detailed below:

- **Contracted Providers** must submit a Provider dispute online through the Provider Portal/Doctors Referral Express (DRE) provider.hpsj.com/dre/default.aspx
- **Non- Contracted Providers** must mail in Provider disputes to the attention of the Claims Department at: Health Plan of San Joaquin/Mountain Valley Health Plan, P.O. Box 30490, Stockton, CA 95213-30490 with the appropriate **Health Plan Provider Dispute Resolution (PDR)** form. Located at www.hpsj-mvhp.org

***Note**: Failure to submit the Provider dispute through DRE or on Health Plan's PDR form will be returned for completion and may result in a delay of processing and potentially could fall outside of the dispute processing guidelines set by DMHC.*

TYPES OF DISPUTES

Provider Dispute Resolution (PDR) should only be submitted for the following reasons:

- **Contract Dispute**: Original claim did not pay per contract or MCL rate.
- **Appeal of Medical Necessity/Utilization Management Decision**: Original claim denied because of a denied authorization or partially denied authorization and requires additional documentation to determine medical necessity.
- **Seeking Resolution of a Billing Determination**: Do not agree with claim or claim line denial.
- **Recovery Dispute**: A letter was received regarding an identified overpayment, and you do not agree with the determination.
- **Seeking Resolution of a Supplement Payment**: Do not agree with the amount supplemental and/or denial of supplemental payment.

Note: *Claim must be finalized before submitting a PDR*

REQUIREMENTS FOR A COMPLETE PDR

A **Complete PDR** is a detailed request form. The required information depends on the dispute type (see list above).

All PDRs require the following:

SECTION 12: DISPUTE RESOLUTION

Provider Information

- Rendering Provider/Facility Name
- NPI
- Pay To Affiliate Name
- Provider Billing Address
- Contact Name & Phone Number

Member Information

- Patient Name
- Health Plan ID#
- Patient Date of Birth
- Patient Account Number

Claim Information

- Health Plan-issued claim number Additional information required by dispute type:

Appeal of Medical Necessity/Utilization Management Decision

- Authorization Number
- If Inpatient Claim: Denied Days and/or Level of Care Review
- If Outpatient Claim: Denied services with CPT Code and description
- Relevant clinical documentation to support disputed denial

Contract Dispute

- Contract Rate/Fee Schedule
- Claim/Claim Line(s) amount disputing
- Expected amount
- Type of Service (i.e. transportation)

Seeking Resolution of a Billing Determination

- Denial description identifying line(s) denied with justification for payment

Note: *If claim/claim line denied for additional documentation, submit via Correspondence.*

Recovery Request Dispute

- Recovery Request Number (RU#)
- Detailed reason for dispute (i.e. check/recoupment already applied)
- Supporting documentation
- Copy of Recovery Request Letter

SECTION 12: DISPUTE RESOLUTION

PDR SUBMISSION TIMELINES

Health Plan's timely filing guidelines for PDR submissions is three hundred and sixty-five (365) days from the paid date of the claim. PDRs submitted electronically (through the Provider portal) will be acknowledged within two (2) working days of receipt. PDR's submitted by mail will be acknowledged within fifteen (15) working days of receipt.

Note: *If the Provider wishes to contest (**Recovery Request Dispute**) the notice of reimbursement of overpayment request it must be within thirty (30) working days.*

If additional information is required and requested through the dispute process the additional information requested must be received within thirty (30) working days of the notice date.

PDR DETERMINATION NOTIFICATION

Upon submission of a Complete PDR and/or receipt of additional information requested, Health Plan will resolve and issue a written determination within forty-five (45) working days.

Note: *Failure to submit complete and accurate information may result in a delay in processing and potentially could fall outside of the dispute processing guidelines set by DMHC.*

OTHER INFORMATION

If the Provider is trying to submit corrections on a claim, follow the **Corrected Claim** submission guidelines.

If a claim or claim line was denied or lack of supporting documentation, submit documentation as **Correspondence** with the requested information.

If a claim was denied as a duplicate and you feel it was denied in error, make sure it was submitted with the appropriate documentation, modifiers, or correct claim submission indicator before submitting a dispute.

Note: *Appeals filed by the Provider on behalf of the beneficiary (Member) require written consent from the beneficiary. See additional information under Grievances & Appeals www.hpsj.com/grievances-appeals*

If the Provider is disputing a **Pre-Service Authorization Denial** an UM Appeal can be submitted via telephone, mail, fax or online through the Utilization Management Department. UM Appeals do not go through the claims dispute process. **See additional information under Utilization Management.*

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE)

QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) OVERVIEW

Health Plan offers a constellation of care, programs and services designed to meet Quality, Health Equity and Population Health standards set forth by the California Department of Healthcare Services (DHCS) contract to improve quality, equity, population health, access and availability and selected California Advancing and Innovating Medi-Cal (Cal AIM) requirements stated in the Department of Health Care Services (DHCS) Contract, the Department of Managed Health Care (DMHC) regulations, and the National Committee for Quality Assurance (NCQA) standards. In order to deepen the commitment to health equity and reducing health disparities, Health Plan achieved NCQA Health Equity Accreditation in 2025.

Health Plan is accredited for Health Plan Accreditation by NCQA, which demonstrates a commitment to quality management and continuous improvement. Health Plan staff, Members, Providers, and representatives from the communities work to continuously meet the highest goals and objectives in health care delivery and quality.

Our Quality Improvement and Health Equity (QIHE) Program supports our mission through the development and maintenance of, and close collaboration with a quality-driven Provider network. The QIHE program is a coordinated, comprehensive, equitable, and continuous framework to monitor and improve Member safety and performance in all care and services provided.

DEFINITION OF QUALITY

Health Plan aligns with the Institute of Medicine's (IOM) definition of quality as an extension of Health Plan's vision and to evaluate healthcare quality through the "**STEEEP**" definition lens.

- Safe- Avoiding harm to patients from the care that is intended to help them.
- Timely- Reducing waits and potentially harmful delays for both those who receive and those who provide care.
- Effective- Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.
- Efficient- Avoiding waste, including waste of equipment, supplies, ideas and energy
- Equitable- Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status.
- Patient Centered- providing care that is respectful of and responsive to individual patient preferences, needs and values.

Health Plan participates in collaborative activities with DHCS and the Institute for Healthcare Improvement (IHI) to improve issues at the forefront of concern when it comes to health. IHI is a leading, globally recognized not-for-profit health care improvement organization that has been applying evidence-based quality improvement methods to meet current and future health care challenges for more than 30 years. **IHI's Quadruple Aim** expands on the original IHI Triple Aim by adding a crucial fourth goal that addresses the well-being of healthcare providers. It includes:

1. **Improving the patient experience of care** – focusing on quality, safety, and satisfaction.
2. **Improving the health of populations** – promoting prevention and managing – promoting prevention and managing chronic conditions.
3. **Reducing per capita costs of healthcare** – increasing efficiency and reducing waste.

4. **Improving the work life of healthcare providers** – supporting clinician well-being, engagement, and reducing burnout.

In short, the **Quadruple Aim** recognizes that achieving better care, health, and value depends on caring for the people who deliver that care.

How Quality Is Measured in Health Care

Quality in health care is assessed using standardized measures that evaluate whether care is safe, effective, patient-centered, timely, efficient, and equitable.

These measures typically fall into **three main categories** (from the Donabedian model) and member's experience:

Structure Measures

Evaluate the **environment and capacity** in which care is delivered.

Examples:

- Provider-to-patient ratio
- Access to a robust network in proximity to Members and timely availability of appointments
- Availability of electronic health records (EHR) and effective data sharing between payer and provider of the care and service data contained in those same medical records
- Staff training and certification levels
- Facility accreditation status and sites that comply with regulatory standards

Process Measures

Assess **what is done** during care delivery — the actions that are expected to lead to good outcomes.

Examples:

- Percentage of patients receiving appropriate preventative care and routine cancer screenings for high prevalence cancers severity cancers
- Rate of follow-up after hospital discharge and after emergency care
- Use of evidence-based clinical guidelines for the management of chronic conditions

Outcome Measures

Reflect the **results of care** — how health care affects patient health and well-being.

Examples:

- Hospital readmission rates
- Mortality rates
- Patient functional status improvement
- Control of chronic conditions (e.g., blood pressure, HbA1c levels)

Patient

Patient Experience & Engagement

Increasingly, health care quality also includes **how patients perceive their care** and their level of involvement in decision-making.

Examples:

- CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey results
- Patient and provider generated expressions of dissatisfaction, grievances and appeals

Population Health & Equity

Modern frameworks, like the **IHI Triple Aim** and **Quadruple Aim**, extend quality measurement to the **population level**, focusing on:

- Improving overall community health
- Reducing disparities across demographics
- Enhancing provider well-being

Health Plan's quality and equity guiding document is called the Quality Improvement and Health Equity Transformation Program (QIHETP). The QIHETP is designed to outline the system, structure and process for monitoring, evaluating, and taking timely action to address necessary improvements in the quality of care delivered by all its providers in any setting and take action to improve equity. It is comprehensive and addresses both the quality and safety of medical and behavioral health care provided to our members and participants of the Medi-Cal line of business. QIHETP companion document explanations can be found in Utilization Management, and Care Coordination sections.

Full service Behavioral Health (BH) care benefits are offered to all Medi-Cal members *(Please refer to Section 15 Behavioral Health for more information).* Members who meet criteria for mild to moderate intervention may seek services through any contracted in person or virtual or Health Plan behavioral health providers. Behavioral health services for members who meet criteria for specialty mental health services or substance use disorder services, are "carved out" of the contractual agreement with the state for administration by the County Behavioral Health System and can be coordinated through our Behavioral Health Case Management team. Individuals, under the age of 21, in need of Behavioral Health Treatment (BHT) or Applied Behavioral Analysis (ABA) are required to obtain a referral by their PCP or a Licensed Psychologist and services will be coordinated through our Behavioral Health Plan staff.

SCOPE OF THE QIHETP PROGRAM

The QIHETP monitors and improves an array of indicators to measure critical clinical and service processes and outcomes while removing barriers to care and meeting the cultural, linguistic diverse preferences and needs of Members through an annual work plan. Work plan components are addressed in the scope of the QIHETP below. The QIHETP outlines the delivery system programs and quality metrics that enable Health Plan Members to maintain or improve optimal health status and remediate or manage the debilitation caused by emerging or apparent chronic medical or behavioral illness or disability.

QIHETP activities include but are not limited to:

- Alignment between Quality, Equity and Population Health initiatives
- Ensuring Health Plan Quality objectives align with DHCS whereby priority Managed Care Accountability Set (MCAS), The DMHC Health Equity and Quality Measure Set (HEQMS) and the NCQA Health Plan Rankings Measures meet the National Medicaid Managed Care 50th percentile as identified by the NCQA Quality Compass.
- Ensuring Preventive Health programs, quality, and equity strategies address quality of care and access for children less than 21 years of age to include:
    - Promotion of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings.
    - Bright Futures/American Academy of Pediatrics (AAP) preventive services to Members and their families.
    - Identifying and addressing underutilization and disparities of children's preventive services, plan equity-focused interventions to address over/under utilization of physical and behavioral healthcare services, including but not limited to, EPSDT services such as well child visits, developmental screenings and immunizations.
        - Providing information to all Network Providers regarding the Vaccine for Children Program (VFC) Program and to promote and support enrollment of applicable Network Providers in the VFC program to improve access to immunizations.
    - Ensure proper screening for women and pregnant persons to ensure individuals at high risk are given appropriate follow up.
    - Identify and facilitate equitable care for children with special healthcare needs, and that seniors and persons with disabilities receive care and treatment according to identified risk and need.
    - Ensure Network Providers receive standardized training on EPSDT utilizing the developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit.
    - Identify Members who have not utilized EPSDT screening services or Bright Futures/AAP preventive services and ensuring outreach to these Members in a culturally and linguistically appropriate manner.
    - Monitor processes and outcomes with achieving compliance with preventive guidelines.
    - Engage in planned Health equity focused interventions to address gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services.
    - Engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for members less than 21 years of age.

- Ensure quality and equity activities align with clinical practice guidelines
    - Ensure quality programs promote physical and behavioral health care through the design of programs which focus on medical and behavioral health conditions.
    - Quality and equity activities align with appropriate utilization.
- Behavioral health care programs that focus on the following:
    - Prevention and screening for evaluation of cognitive development, neurodivergent disabilities, functional and social impairment, substance use, and abuse
    - Programs that support, recovery, resiliency, and rehabilitation
    - Exchange of information
    - Appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care
    - Monitoring of psychotropic medications
    - Primary and secondary behavioral health programs
- Access to primary and specialty health care providers and services:
    - Member disengagement with primary care.
    - Accessibility of practitioners and providers
    - Availability of routine, regular, non-urgent and urgent and medical, ancillary, specialty, and behavioral health appointments
    - Language accessibility at the time of appointment
- Continuity of Care and Coordination across settings and at all levels of care, including
    - Referrals between members and community-based organizations (CBOs)
    - Transitions of care, with the goal of establishing consistent Provider-Patient relationships,
        - When member transition between practitioners
        - When members move across care settings
- Member experience with respect to clinical quality, access, and availability, and culturally and linguistically competent health care and services, continuity, and Care Coordination.
- Population Health Activities that are designed to address
    - Keeping members healthy by focusing on wellness and prevention programs
        - Equitable care for birthing individuals and their children
        - Focusing on Members less than 21 years of age
    - Identify and manage Emerging Risks for high and rising risk members
        - Members with biometric indicators or high-risk behaviors that are known to increase risk for chronic conditions.
        - Members with increased risk of declining medical and/or behavioral health conditions.
    - Ensure effective transition planning across delivery systems or settings through Care Coordination and other means to minimize patient risk and ensure appropriate clinical outcomes for members
    - Offer Case and Disease management programs that facilitate healthcare system

navigation
    - Complex Case Management for members with multiple acute and chronic conditions
    - Enhanced Case Management for members with multiple complex medical and behavioral health conditions and concurring social determinants of health
- Identify and mitigate Member access, experience and clinical outcome disparities by race, ethnicity and language to advance Health Equity

Goals of the QIHETP Program:

- Promote an organization-wide commitment to equality of care and service through strong leadership involvement in improving quality
- Link goals from DHCS' Comprehensive Quality Strategy to Health Plan Corporate QI Objectives and performance improvement activities via quality improvement initiatives
- Address, prevent, and resolve health disparities within the network through monitoring quality data and implementation of targeted interventions
- Enhance continuity and coordination of care among behavioral healthcare and primary health care providers
- Respond actively to customer expectations and patient feedback concerning the quality of patient care delivered and services provided
- Define, oversee, evaluate, and improve the care and service delivered by our staff, network providers, and delegated entities by:
    - Promoting member/patient safety as a high-level priority through mechanisms designed to minimize patient and organizational risk of adverse occurrences
    - Improving and enhancing the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and implementation of improvement actions
    - Promoting processes to ensure the availability of "safe, timely, effective, efficient, equitable, patient-centered care" and provide oversight within the network
- Comply with legislative regulations, accreditation standards, and professional liability requirements
- Ensure that medically necessary covered services are:
    - Available and accessible
    - Provided in a culturally and linguistically appropriate manner
    - Provided in an equitable manner
    - Provided by qualified, competent practitioners and providers who are committed to Health Plan's mission and vision
- Promote collaborative relationships between Health Plan, providers, delegates, and community partners
- Promote and create condition specific health education and disease prevention materials that are age, culturally, and linguistically appropriate and that encourages optimal health behaviors for members, participants, and staff
- Maintain an appropriate number of credentialed network practitioners to meet the access

needs of our members
- Ensure that Network Providers, Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors participate in the QIHETP and Population Needs Assessment
- Ensure that members' protected health information (PHI) is protected, utilized, and released in accordance with state and federal law and regulation
- Follow all accreditation, regulatory, and licensure survey key recommendations within 90 days of identification of improvement opportunity
- Continue implementation of adequate computerized information management systems to support complete data entry, aggregation, display, analysis, and reporting needs for all quality management activities
- Incorporate responsibilities for quality management and improvement into management performance standards

Other areas that have impact on the QIHETP Program include:
- Provider credentialing and recredentialing

Provider performance
- Pharmacy management
- Facility site reviews

QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) PROCESS

The QIHETP process includes a comprehensive array of clinical and service indicators that provide information about the systems, processes, and outcomes of clinical care and service delivery. Clear, well-defined quality indicators represent what is most important to Health Plan in measuring and evaluating quality. The measures are developed using sound methodological principles and are rooted in best practice guidelines. Measured performance data is assessed to ensure reliability so that decisions can be made with confidence.

Quality indicators are reflective of areas that are high risk, high volume, problem prone specific populations, and specific conditions, as well as industry standard measures. Most indicators are rate-based outcome measures. Indicators are measurable and have a goal against which to measure performance. Indicators are developed with input from the CMO, CHEO and the QIHEC.

To understand and properly implement QIHEC-related practices and projects, there are approaches being utilized. Such models help collect and analyze data for test change, provide guidance for effort and improvement in efficiency, member safety, or quality outcomes. These models include:
- Plan-Do-Study-Act (PDSA)
- Performance Improvement Projects (PIPs)
- Regional Quality and Health Equity Improvement Projects

Plan-Do-Study-Act (PDSA)

The PDSA methodology is a rapid cycle, continuous QI process designed to perform small tests of change, which allows more flexibility throughout the improvement process. As part of this

approach, Health Plan performs real-time tracking and evaluation of its interventions. PDSAs are the most common continuous quality improvement model utilized by Health Plan and have four major elements or stages:

A. **Plan**: The first step involves identifying preliminary opportunities for improvement. At this point the focus is to analyze data to identify concerns and ideas for improving process and to determine anticipated outcomes. Key stakeholders and/or people served are identified, data compiled, and solutions proposed.
B. **Do:** This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.
C. **Study:** At this stage, data is again collected to compare the results of the new process with those of the previous one.
D. **Act, Adopt or Adapt:** This stage involves making the changes a routine part of the targeted activity. It also means "Acting" to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow-up.

Health Equity Program

The Health Equity Program Description supports Health Plan's mission and vision through the development and maintenance of a quality driven, health equity focused, network of care for all lines of business. The Chief Health Equity Officer works with various internal and external teams and stakeholders to continuously monitor and implement activities to improve Health Equity and reduce Health Disparities among Health Plan's membership. This work aligns with the California DHCS's Bold Goals to impact Health Disparities, DMHC's Quality and Equity requirements, the plan's corporate goals and the requirements for NCQA Health Plan Accreditation and Health Equity Accreditation. Health Plan has a matrix Health Equity Framework that has four key Pathways. The Pathways run concurrently and are specific to the key stakeholders for Health Plan:

1. Internal Pathway focused on Health Plan Employees, Leadership and Culture
2. Member Pathway focused on impacting members' health disparities
3. Partner Pathway focused on all key stakeholder partners
4. Community Pathway focused on system collaboration and overall community health equity efforts

Reporting to the Chief Health Equity Officer is the Cultural and Linguistics, the Population Health Management, and Health Education Teams.

The QIHETP Program includes a comprehensive array of clinical and service indicators that provide information about the systems, processes, and outcomes of clinical care and service delivery. The quality indicators emphasize areas representing risk and need across the continuum of care. Indicators are developed with input from the Chief Medical Officer (CMO) and the Quality Improvement and Health Equity (QIHE) Committee which include key Members of the Provider community. These indicators include, but are not limited to:

- All cause hospital readmissions
- Emergency room (ER) utilization
- Ambulatory care utilization
- Primary and Urgent care utilization

QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) AND SUBCOMMITTEES

The key to Health Plan's quality management success is integration of information. Health Plan's committees may function separately, but it is an expectation that data and information be readily available to and from all who are actively involved in Health Plan's performance improvement processes. Committee information and data is validated, coordinated, aggregated, communicated, reported, and acted upon in a timely manner to ensure success with all performance improvement and quality initiatives. All committee Members are required to note their attendance for each meeting and sign an annual "Conflict of Interest" statement. Committee Members cannot vote on matters where they have an interest and must abstain until the issue has been resolved. Written minutes are maintained by each committee for each meeting. Many of Health Plan's QIHE committees require the participation of Providers.

Quality Improvement and Health Equity Committee (QIHEC) – Governing Board of Quality and Health Equity Transformation Program (QIHETP)

The Quality Improvement and Health Equity Committee (QIHEC) is responsible for the implementation and ongoing monitoring of the Quality Improvement and Health Equity Transformation Program (QIHETP). The QIHEC:

- Approves the annual QIHETP Description, Annual Plan and Evaluation
- Recommends policy decisions or oversees recommendations and revisions to the Quality
- Improvement and Health Equity Activities
- Reviews, analyzes, evaluates, and makes recommendations regarding the progress and outcome of quality improvement QI and Health Equity projects and activities
- Ensures that quality performance standards are met and makes recommendations for improvements
- Institutes actions to address performance deficiencies, identifies necessary actions and ensures follow-up according to plan
- Assists in establishing the strategic direction for all quality and healthy equity initiatives
- Receives subcommittee reports, identifies performance improvement opportunities, and makes recommendations to be incorporated into the QIHETP work plan
- Ensures Provider communication, education and follow-up related to Quality of Care issues
- Ensures Provider participation in the QIHETP through planning, design, implementation, or review
- Confirms and reports to the Commission that Health Plan activities comply with all state, federal, regulatory, and NCQA standards
- Reports to the Commission any variance from quality performance goals and the plan to

correct

- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting
- Presents to the Commission an annual reviewed and approved *QIHETP Description and Work Plan* and prior year evaluation
- Annually reviews and approves medical review criteria and *Clinical Practice Guidelines*
- Oversees QI and Health Equity activities that validate quality management effectiveness through customer feedback reporting including:
- Provider and Member satisfaction/experience surveys
- Reviews and approves the annual Healthcare Effectiveness Data and Information Set (HEDIS) and Managed Care Accountability Set (MCAS) and HEQMS rates and provides feedback about improvement initiatives
- Reviews and approves the annual Consumer Assessment of Health care Providers and Systems (CAHPS) survey results and provides feedback about improvement initiatives
- Reviews and approves the annual Behavioral Health Member Experience survey results and provides feedback about improvement initiatives.
- Promotes education activities on QI for Providers
- Maintains compliance with standards for mandated reporting of diseases or conditions to the local health department
- Review and provide feedback on Quality and Equity policies

Committee Members include:

- Physicians specializing in:
    - Obstetrics/Gynecology
    - Family Practice
    - General Surgery
    - Psychiatry
    - Pediatrics
    - Internal Medicine
- Practitioners:
    - RN Clinical Director Regional Center
- Community Partners
    - Deputy Director, Standards & Compliance San Joaquin General Hospital
- Health Plan Staff:
    - Executive Director, Clinical Operations
    - Executive Director, Quality Improvement and Health Equity
    - Director, Pharmacy
    - Director, Provider Relations
    - Director, Customer Service
    - Director of Delegate and Provider Relations

- Director, Compliance
- Director, Equity
- Director, HEDIS and Accreditation
- Director, Utilization Management
- Director, Case Management
- Director, Clinical Analytics
- Director, Behavioral Health and Social Work
- HEDIS and NCQA Manager(s)
- Quality Manager(s)
- Manager of Case Management
- Concurrent Review Manager
- Health Education Manager
- Quality Supervisors
- Utilization Management Supervisor
- Administrative Assistant(s)

Quality & Health Equity Operations Committee (QHEOC)

The QIHEOC is designated by Health Plan's executive team to provide oversight and guidance for organization-wide quality improvement and health equity activities performed by Health Plan's QIHETP to the QIHEOC. The QIHEOC develops and recommends policies, analyzes and evaluates the progress, results, and outcomes of all quality improvement activities, implements needed actions, and ensures appropriate and timely follow-up.

The QIHEOC strives to improve the quality of health care and service by developing, implementing, and evaluating processes, programs, and measurement activities and by making recommendations to the QIHETP Committee. These activities include development and oversight of:

- National Committee for Quality Assurance (NCQA) Health Plan and Health Equity Accreditation
- HEDIS, MCAS and HEQMS
- Quality Improvement Projects (QIP), and Plan Do Study Act (PDSA) initiatives
- DHCS Quality and Health Equity (QIHE) initiatives
- Review and approval of all quality improvement corrective action plans (CAP)
- Wellness and preventive health programs
- Health Education, and Health promotion actions
- Population Health Management
- Member and Provider experience survey results
- Provider access and availability
- Network adequacy
- Grievances and Appeals
- Performance Improvement Projects (PIP)

- Wellness and preventative health programs
- Health education standards/guidelines
- Policy and procedures
- Network adequacy
- Appeals and grievances
- Facility Site Reviews and Credentialing
- Feedback and annul review process of the HPSJ Provider Manual and any new or revised policies and procedures.

The QIHEOC generally meets at least quarterly, with a minimum of four (4) meetings per year. The QIHEOC reports to the QIHEC Committee by summary report no less than quarterly. The QIHEOC submits to the QIHEC Committee approved, signed minutes reflecting the committee decisions and actions of each meeting.

The QIHEOC is chaired by the Executive Director of Quality Improvement and Health Equity or Designee. The Committee Chair facilitates and manages the committee meetings. The Chief Medical Officer (CMO) serves as the committee sponsor.
Committee Members include, but are not limited to:

- Chief Medical Officer (CMO)
- Executive Director, Quality Improvement & Health Equity (CHEO)
- Compliance Director
- Medical Director or designee
- Director of Delegate and Provider Relations
- Directors of Utilization and Case Management
- Directors of Clinical, Analytics, and Pharmacy
- Director of HEDIS and Accreditation
- Director of Customer Service
- Quality Manager(s)

Ad Hoc Members of the QOC include:

- Director of Claims
- Director of IT
- Director of Community, Market and Member Engagement

Peer Review and Credentialing Committee (PRCC)

The PRCC is a “Medical Peer Review” committee. PRCC Members are appointed by the Commission to which the committee also reports. The PRCC is chaired by the CMO and is composed of Providers representing primary and specialty care, as well as other health care practitioners. The Committee meets at least quarterly and reports to the QIHEC.

The PRCC:

- Oversees and evaluates Health Plan’s credentialing and recredentialing process for evaluating and selecting Providers

- Reviews the qualifications of new and continuing Providers
- Ensures a fair and effective Peer-Review process to make recommendations regarding credentialing decisions
- Reviews Provider quality service and performance data, including Member complaints, Facility Site Reviews, and identifies opportunities for improvement
- Determines whether health care services were performed in compliance with standards of practice and directs corrective action measures when standards are not met
- Evaluates and makes recommendations on all Provider adverse actions and takes appropriate disciplinary action against Providers who fail to meet established standards and/or legal requirements as appropriate
- Ensures and oversees a formal and objective Provider appeal process
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting

Grievance and Appeals (G&A) Committee

The Director of Quality (DQ) serves as chair of the G&A Committee. The G&A Committee meets at least quarterly and reports to the QMUM Committee. Committee Members include the:

- QI Supervisor
- QI Manager
- Director of Quality or Designee
- CMO
- Medical Director
- Appeals Nurse
- QM Nurse
- UM Manager
- Compliance Director or designee
- Delegate and Provider Relations Director
- Customer Service Director
- Director of Behavioral Health and Social Work

Ad hoc Members of the G&A Committee include representatives from the following departments:

- Pharmacy

The G&A Committee:

- Oversees and ensures the integrity of the grievance and appeal process, including tracking for timeliness and resolution
- Evaluates grievances and potential quality issues (PQIs).
- Reviews and evaluates grievance and appeals (G&A) trend reports and identifies and makes recommendation for improvements
- Ensures compliance with regulatory and contractual requirements
- Submits to the QIHEOC and QIHE Committee approved, signed minutes reflecting the

committee decisions and actions of each meeting

Clinical Operations Committee (Clinical Ops)

- The Clinical Ops Committee is chaired by the Executive Director of Clinical Operations and the Chief Medical Officer and reports to the QIHEC. Clinical Ops Committee members include:
    - Director of Utilization Management
    - Director of Behavioral Health and Social Work
    - Director of Case Management
    - Manager of Health Education
    - Manager of Cultural and Linguistics
    - Medical Director(s)
- The committee provides oversight of quality improvement efforts focused on Continuity and Coordination of Medical and Behavioral Care, Disease Management, Case Management, Complex Case Management, Utilization Management, Timeliness of UM decisions, grievances and appeals, interrater reliability, referrals, over and underutilization, and member and provider satisfaction with the utilization management process.

Compliance Committee (CC)

- The CC is appointed and chaired by the Chief Regulatory Affairs & Compliance Officer, and reports to Health Plan's CEO and Board of Directors. Internal departments represented as Members of the CC include:
    - Chief Executive Officer
    - Chief Administrative Officer
    - Chief Financial Officer
    - Chief Information Officer
    - Chief Operations Officer
    - Chief Medical Officer
    - Deputy Chief Medical Officer
    - Executive Director, Clinical Operations
    - Executive Director, Quality & Health Equity

Behavioral Health and Social Work

The CC is charged with assisting the Health Commission Board of Directors in overseeing Health Plan's Compliance Program with respect to:

- Compliance with the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) contracts, laws and regulations applicable to regulatory requirements
- Compliance with policies, as applicable to the Medi-Cal and D-SNP programs, by employees, officers, directors, and other agents of the company; and
- Measures that prevent and detect, and correct fraud, waste and abuse or other incidents of non-compliance.

Community Advisory Committee (CAC)

CAC Members (including a Commissioner, a Provider, and Health Plan Members) are selected by CAC coordinators and reviewed with the Commission. Factors such as racial ethnic representation, language, demography, occupation, and geography are considered in the selection of the committee's Members. At least fifty percent (50%) of the CAC is comprised of Health Plan Members.

The CAC reports directly to the Commission through the Chief Medical Officer. It establishes and monitors Health Plan's relevant public policies:

- Transportation availability
- Language requirements
- Cultural issues
- Member health education needs

The CAC also reviews and makes recommendations on Health Plan's:

- Health education activity
- Population Needs Assessment Requirements
- Health Plan Member website

Health Plan solicits feedback including but not limited to the Community Advisory Committee and Quality Improvement Committee to inform the development of Provider manual and review policies and procedures.

To maintain and ensure ongoing community engagement through the CAC, Health Plan shall:

- Routinely engage with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporate results into policies and decision-making when appropriate.
- Maintain the process for incorporating Health Plan Member and family input policies and decision-making.
- Monitor and measure the impact of the above.
- Maintain processes to share with Members and families on how their input impacts Health Plan policies and decision-making.

The CAC submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting.

Pharmacy and Therapeutics Advisory (P&TA) Committee

The P&TA Committee is chaired by the Director of Pharmacy and is comprised of in-house pharmacists and pharmacy Providers, PCPs, and Specialists. The P&TA Committee meets quarterly and reports to the Commission.
The P&TA Committee:

- Reviews, oversees, and approves Health Plan's prescription drug formulary
- Identifies processes to evaluate pharmacy safety and effectiveness

- Ensures the reliable function and maintenance of a notification system for drug alerts
- Develops, approves, and maintains pharmacy criteria, policies and procedures that ensure safe and effective formulary management and authorization processes
- Reviews pharmacy data and reports and makes recommendations for improvement
- Establishes and oversees specialty advisory panels, as necessary, to provide expert opinion on clinical matters for P&TA Committee consideration
- Develops and approves Member and Provider education to address patient safety
- Oversees the Pharmacy Benefit Manager (PBM) to ensure practices meet Health Plan's quality standards
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting

NETWORK PROVIDER COMMITTEE PARTICIPATION

Contracted Providers are expected to cooperate with Health Plan's quality improvement and health equity activities to improve the quality of care and service, to reduce health disparities and to improve Member experience. Cooperation includes collection and evaluation of data and participation in Health Plan's QIHE programs. Practitioners understand that Health Plan may use practitioner performance data for quality improvement activities.

All Providers who participate on our QIHE committees or subcommittees receive a stipend for each meeting attendance. If you have an interest in being a participant on one of these committees, please call the CMO at 1-209-800-2178

QUALITY OF CARE ISSUES

Potential Quality of Care issues may include any of the following types of cases:

- An issue that reflects a health care delivery system problem
- A clinical issue or judgment that affects a Member's care and has the potential for mild to moderate adverse effect
- A clinical issue or judgment that affects a Member's care and has the potential for serious adverse effect
- A clinical issue with a significant outcome, including:
    - Unnecessary prolonged treatment, complications, or readmission; or,
    - Member management or lack of treatment that results in significantly diminished health status, impairment, disability, or death
- An unexpected occurrence involving death or serious physical or psychological injury
- A service issue resulting in inconvenience or dissatisfaction of the Member
- A service issue resulting in the Member seeking a change of Provider or disenrollment from a health network
- Unexpected death

MONITORING OF QUALITY OF CARE ISSUES

Health Plan has a process for identifying and receiving reports of potential Quality of Care issues.

Health Plan uses licensed personnel to perform case reviews, investigate potential Quality of Care issues, and determine the severity of the issue. Based upon these investigations, Health Plan will determine the appropriate follow-up action required for individual cases. Health Plan will also aggregate potential Quality of Care issues data to help identify problems within the Provider network.

REPORTING A POTENTIAL QUALITY OF CARE ISSUES (PQI)

Members, Providers, and Health Plan staff may report PQI issues. A PQI can be reported to a Quality Management Nurse using the Administrative or Clinical PQI report form *Clinical Potential Quality Issue Report Form*. Providers and Members can also report PQI issues by contacting the Customer Service Department at 1-888-936-7526.

Processing of PQI

- Upon receipt of a *Potential Quality Issue Report Form*, Health Plan's Quality Management (QM) staff will date stamp, log, and document/evaluate the reasons/screening criteria for PQI and ensure that all supporting documentation is gathered and included.
- PQIs are prioritized based on the urgency of review.
- The QM nurse initiates an investigation of the PQI by requesting and reviewing pertinent medical records and eliciting input from Member and Providers involved.
- All PQIs are reviewed by the Medical Director or designee to substantiate if the case can be closed or is determined to be a quality issue.
- PQIs are assigned an action code directing the course for resolution and/or escalation to PRCC review.

Communication to Provider or Party Filing the Complaint

- Each PQI is reviewed by a Medical Director who designates an action code that indicates requirement to complete Provider notification by letter.

HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS consists of a set of performance measures utilized by health plans to compare how well a plan performs in the following areas:

- Quality of Care
- Effectiveness of Care, Prevention, Screening, Care Coordination
- Access and Availability of Care
- Experience With Care
- Utilization
- Health Plan Descriptive Information

Managed Care Accountability Set (MCAS) and Health Equity, Quality, Measure Set (HEQMS) MCAS and HEQMS are a subset of HEDIS measures coupled with non-HEDIS quality metrics that are generated by DHCS and DMHC for the purpose of holding Health Plan accountable to contractual requirements around quality and equity. These metrics are the highest priority metrics for Health Plan and are prioritized accordingly.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE)

Improving a practice's HEDIS scores has benefits for Providers and Members. Consistently performing well in HEDIS measures can help save Providers time while also potentially reducing health care costs. By proactively managing Members' care, Providers can effectively monitor Members' health, prevent further complications and identify issues that may arise with their care. Providers may also benefit financially because Health Plan currently provides financial incentives based on Provider's HEDIS scores. Health Plan has tools that can be made available to PCPs to increase and improve HEDIS measures. Please contact the Provider Services Department at 1-209-942-6340 for information on HEDIS tools and incentives.

TIPS FOR IMPROVING HEDIS SCORES

- Keep accurate, legible, and complete medical records for all Members. Each document in the medical record must contain the Member name and DOB to be acceptable for HEDIS
- If paper charts are used, document the Member's full name and DOB on the front and back of every page.
- Send out reminders and follow up with Members for all USPSTF Grade A and B and APA Bright Futures Guidelines preventative services.
- Encourage and Remind Members to keep appointments for appropriate preventive services.
- Document in the Members chart when preventative or other services are declined.
- Make sure that staff is familiar with HEDIS measures to understand which measures health plans are required to report.
- Enter vaccine information into the California Immunization Registry and Regional Vaccine Registry

CLINICAL PRACTICE GUIDELINES

Providers can access *Clinical Practice Guidelines* on Health Plan's website at www.hpsj-mvhp.org. *Clinical Practice Guidelines* are guidelines about a defined task or function in preventive care and clinical practice, such as desirable diagnostic tests or the optimal treatment regimen for a specific diagnosis; generally based on the best available clinical evidence.

MEMBER EXPERIENCE SURVEY

Annually and quarterly, Health Plan administers an industry standard survey instrument utilizing a contracted certified survey vendor targeting a statistically significant number of Members enrolled with Health Plan. The questions are carefully selected to measure access, quality, and satisfaction with Health Plan. The results are then analyzed by Health Plan's HEDIS and Accreditation teams and reported to the QIHEOC. Quarterly, surveys are sent to members who have had ambulatory care visits in the prior 6 months. These surveys evaluate the member's experience with care and services provided by individual providers. Quarterly, results are trended and when patterns emerge, action plans are formalized into service expectations which are evaluated quarterly, progress against goals are monitored and activities are prioritized for the following year. The results are then measured each year to document Health Plan's commitment to serving our communities health care needs.

PROVIDER SATISFACTION SURVEY

Each year, Health Plan Providers are surveyed by an independent survey company that surveys all PCPs, and a random selection of Primary, Specialists and ancillary Providers. Results are reviewed by both Health Plan leadership and various departments within Health Plan. Action plans are incorporated into goals and objectives for the following year to address issues identified by the Provider community.

PATIENT SAFETY

Health Plan is committed to a culture of patient safety as a high-level priority. On an ongoing basis, Health Plan fosters a patient safety culture that is communicated throughout the organization. Health Plan is committed to developing and implementing activities to improve patient safety and clinical practice.

Health Plan defines Patient Safety as "freedom from accidental injury caused by errors in medical care." Medical errors refer to unintentional, preventable mistakes in the provision of care that have actual or potential adverse impact on Members.

Members, their families, Providers, and Health Plan staff, are able to report errors or close calls without fear of reprisal and where errors can be viewed as opportunities for improvement.

Health Plan's commitment to patient safety is demonstrated through the identification and planning of appropriate patient safety initiatives. The patient safety initiatives promote safe health practices through education and dissemination of information for decision-making and collaboration between our practitioners and Members, and through:

- Evaluation of pharmacy data for Provider alerts about drug interactions, recall, and pharmacy over and under-utilization
- Education of Providers regarding the availability and use of clinical practice guidelines. Members are educated about the use of guidelines using Member facing health education materials.
- Education of Providers regarding improved safety practices in their practice through the Provider newsletter, Member profiles, and Health Plan website
- Evaluation for safe clinic environments during office site reviews and dissemination of information regarding Facility Site Review findings and important safety concerns to Members and Providers
- Education to Members regarding safe practices at home through health education and incentive programs
- Intervention for safety issues identified through case management, care management, and the grievance and clinical case review processes
- Evaluation and analysis of data collected regarding hospital activities relating to Member safety, including but not limited to the rate of hospital-acquired infections and all cause readmissions within thirty (30) days of discharge
- Collaboration and exchanges information between the Hospital and PCP when Members are admitted to and discharged from acute care facilities
- Dissemination of information to Providers and Members regarding activities in the network related to safety and quality improvement

- Monitoring Hospital safety scores using publicly reported *Leapfrog* data: www.leapfroggroup.org/cp

Health Plan receives information about actual and potential safety issues from multiple sources including, Member and Provider grievances, potential quality issues (PQI), pharmacy data, and through Facility Site Review (FSR) Corrective Action Plans.

SECTION 14: PHARMACY SERVICES

PHARMACY SERVICES

Health Plan's Pharmacy Department is dedicated to providing high quality, cost-effective pharmaceutical care to Members and to working with Providers to achieve the best clinical outcomes.

PHARMACY CLAIMS SUBMISSION

Under the guidance of California Governor Gavin Newsom's Executive Order N-01-19, DHCS has transitioned all outpatient pharmacy dispensing services from the managed care (MC) plans to Medi-Cal Rx. This was to provide standardization of the Medi-Cal pharmacy benefit statewide, under one pharmacy benefit manager, Prime Therapeutics. Additional resources and information for Providers can be found at https://medi-calrx.dhcs.ca.gov/provider/. .

As a result of this transition, all outpatient pharmacy drugs will be covered by Medi-Cal Rx. Pharmacies will submit all claims to Medi-Cal Rx for adjudication. Providers can submit direct inquiries to the Medi-Cal Rx Call Center Line, 1-800-977-2273 TTY/TDD 711, 24/7 or visit www.Medi-CalRx.dhcs.ca.gov.

Health Plan remains responsible for the processing and payment of all pharmacy services billed on medical and institutional claims. This includes the cost of facility-administrated drugs, depending on the case history, for major organ transplants, as well as Physician Administered Drugs (PADs).

CLINICAL PROGRAMS

Health Plan's Pharmacy Department has developed several clinical programs to help ensure safe, effective, and efficient use of medications. From time-to-time the Provider, the individual, or their pharmacy may receive written notification about opportunities for improvement in the Member's care. These areas may include (but are not limited to) diabetes care, asthma care, antidepressant care, transition of care (TOC), Medication Therapy Management (MTM) high risk medications, and/or medication adherence.

For questions or for more information about any of Health Plan's clinical programs, please contact the Provider Services Department at 1-209-942-6340.

SECTION 15: BEHAVIORAL HEALTH

BEHAVIORAL HEALTH PROGRAM

As a Medi-Cal Managed Care Plan, Health Plan has the responsibility to administer non-specialty mental health services. These services require no prior authorization for in-network providers, with one exception for Transcranial Magnetic Stimulation. Our behavioral health program also coordinates any necessary specialty mental health services and substance use disorder services with the County Mental Health Plan.

BEHAVIORAL HEALTH BENEFITS

All eligible Medi-Cal HMO Members receive the following mental health benefits administered through Health Plan:

- Mental health evaluation and treatment, including individual, group and family psychotherapy
- Psychological and neuropsychological testing, when clinically indicated to evaluate amental health condition
- Outpatient Services for the purpose of monitoring drug therapy
- Outpatient laboratory, supplies, and supplements
- Psychiatric consultation
- Dyadic Behavioral Health
- Transcranial Magnetic Stimulation

As part of Health Plan's maternal mental health program, the Me & My Baby Program, members are eligible to receive:

- At least one maternal mental health screening to be conducted during pregnancy;
- At least one additional screening to be conducted during the first six weeks of the postpartum period; and
- Additional postpartum screenings, if determined to be medically necessary and clinically appropriate by the treating provider.

Specialty mental health services for Members of all ages with moderate to severe impairment are provided by the County Mental Health Plan in which they reside.

BEHAVIORAL HEALTH TREATMENT (BHT) COVERAGE FOR MEMBERS UNDER 21

Consistent with Medi-Cal guidelines under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Health Plan provides Member Covered Services for children under the age of twenty-one (21) years old who have received a recommendation for BHT/ABA by a licensed physician or psychologist as medically necessary, and reviewed through the prior authorization process. The role of the PCP is of vital importance in order to provide medical follow-up for co- occurring medical disorders that may complicate treatment and can offer a referral for BHT. All requests and referrals should be arranged by Health Plan at 1-888-581-7526.

SERVING MEMBER'S BEHAVIORAL HEALTH NEEDS

PCPs are expected to provide behavioral health services that are within the scope of their practice, as

well as conduct various screenings as recommended by DHCS which includes but is not limited to:

- Adverse Childhood Experience Screening (ACES)
- Annual Cognitive Assessment for members age 65 and older
- Depression Screening
- Developmental Screenings, including Autism Spectrum Disorder screening
- Dyadic Care Services
- Substance Use Disorder Screenings, brief intervention, and referral to treatment

In addition, PCPs can refer Members with suspected moderate to severe impairment due to a mental illness or substance use disorder to the County Mental Health Plan. Medi-Cal Members with mild or moderate mental illness are to be referred to Health Plan and the services will be provided through Health Plan's Provider network. However, this is not required, as Members can self-refer for such services and are encouraged to contact Health Plan directly for accessing the appropriate level of care of need.

BEHAVIORAL HEALTH MEDICATIONS

Psychotropic drugs are carved out to traditional fee-for-service (FFS) Medi-Cal.

SUBSTANCE USE DISORDER BENEFITS FOR MEMBERS

Primary Care Providers are eligible and encouraged to complete appropriate screening and assessments for substance use disorders, offer a brief intervention and referral to treatment.

Substance Abuse Disorder Benefits are carved out of the Medi-Cal HMO. This benefit is administered by the Medi-Cal Alcohol and Drug Abuse system. All eligible Medi-Cal HMO Members receive the following substance abuse disorder benefits administered by the County Mental Health Plan:

- Voluntary inpatient detoxification
- Intensive outpatient treatment services
- Residential treatment services
- Outpatient drug free services

Members who need treatment for substance abuse disorders receive services in San Joaquin, Stanislaus, Alpine and El Dorado counties, through Medi-Cal's Alcohol and Drug Abuse program through the County Mental Health Plan.

INITIAL HEALTH APPOINTMENT

The Department of Health Care Services (DHCS), requires that all PCPs have Members complete an Initial Health Assessment (IHA) within one hundred twenty (120) days of Enrollment or within the AAP Bright Futures Guidelines Periodicity Schedule for Children under 18 months of age and periodically thereafter. An IHA:

- Must be performed by a Provider within the primary care medical setting.
- IHA s not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous

12 months.

- Must be provided in a way that is culturally and linguistically appropriate for the Member.
- Must be documented in the Member's medical record.

An IHA must include all of the following:

- A history of the Member's physical and mental health;
- An identification of risks; including substance use disorders
- An assessment of need for preventive screens or services;
- Health education; and
- The diagnosis and plan for treatment of any diseases with appropriate follow up performed within 60 days of identification of the condition or sooner if the conditions warrants sooner treatment.

ALCOHOL MISUSE SCREENING AND BEHAVIORAL COUNSELING INTERVENTIONS

Members who have a positive screen for alcohol abuse problem during the IHA are to receive an Alcohol Misuse Screening. The Alcohol Misuse Screening is a detailed screening and a brief intervention as recommended by the U.S. Preventive Services Task Force (USPSTF). It enables a PCP to identify, reduce, and prevent problematic use, abuse and dependence on alcohol.

- PCPs must review the Member's response to the alcohol questions. PCPs must offer an expanded alcohol screening questionnaire to all Medi-Cal Members identified with risk, such as the AUDIT or AUDIT-C, which is billable to The Plan.
- For all Members who answer "yes" to the alcohol question, the PCP must offer an "alcohol use brief intervention" or refer Members with a potential alcohol abuse disorder for treatment to the County for services. The contact information for the County Mental Health Plans are as follows:

County	Specialty Mental Health Services	Substance Use Services (SUDS)
Alpine	367 Creekside Drive Markleeville, CA 96120 1-209-753-2831 TTY/TDD 711 Crisis Line: 1-800-318-8212	Markleeville, CA 96120 1-530-694-1816 TTY/TDD 711 Crisis Line: 1-800-318-8212

El Dorado	South Lake Tahoe Mental Health Clinic 1900 Lake Tahoe Blvd. South Lake Tahoe, CA 96150) 1-530-573-7970 South Lake Tahoe Crisis Line: 1-530-544-2219 West Slope Mental Health Clinic 768 Pleasant Valley Rd., Ste. 201 Diamond Springs, CA 95619 1-530-621-6290 1-800-929-1955 (24/7) TTY/TDD 711 24/7 Crisis Line: 1-530-622-3345	South Lake Tahoe Office 1900 Lake Tahoe Blvd., South Lake Tahoe, CA 96150 (8:00 a.m. – 5:00 p.m.) 1-800-929-1955 (24/7) TTY/TDD 711 1-530-621-6290, press 5 (8:00 a.m. – 5 p.m.) West Slope Office 929 Spring St. Placerville, CA 95667 (8:00 a.m. – 5:00 p.m.) 24/7 Crisis Line: 1-530-622-3345
San Joaquin	Mental Health Services 1212 N. California St. Stockton CA 95202 1-209-468-8700	Substance Abuse Services Administration 630 Aurora Street Suite #1 Stockton, CA 95202 1-209-468-3800
Stanislaus	Stanislaus County Behavioral Health & Recovery Services 800 Scenic Drive Modesto, CA 95350 1-888-376-6246 (24/7 Crisis Line)	Stanislaus County Behavioral Health & Recovery Services 800 Scenic Drive Modesto, CA 95350 1-888-376-6246 (24/7 Crisis)

This grid summarizes how behavioral health services should be handled for Medi-Cal patients of all ages:

Type of Referral	Health Plan	County Mental Health Plan
Non-Specialty mental health Services	X	
Specialty Mental Health Services		X
Substance Abuse Treatment		X
Behavioral Health Treatment (BHT) (ages 0 < 21)	X	

SECTION 16: REGULATORY COMPLIANCE

REGULATORY COMPLIANCE

Providers are subject to a broad range of compliance regulatory requirements to ensure ethical operations and patient safety. These requirements are established by federal and state laws, accreditation bodies, and Health Plan guidelines. Key responsibilities include:

- Adherence to Federal and State Laws: Providers must observe statutes such as the Health Insurance Portability and Accountability Act (HIPAA) for patient privacy, the False Claims Act to prevent fraudulent billing, the Anti-Kickback Statute, and other relevant healthcare regulations.
- Accurate Documentation and Billing: Medical records and billing should accurately reflect the services provided, supported by documentation that satisfies legal and Health Plan requirements.
- Protecting Patient Information: Protocols are established to maintain the confidentiality and integrity of patient health information through secure storage, restricted access, and appropriate disposal of records.
- Staff Training and Education: Ongoing compliance training is necessary so that all staff understand applicable laws, policies, procedures, and reporting processes for potential violations.
- Internal Monitoring and Auditing: Regular audits and assessments help identify compliance issues and address them prior to regulatory action.
- Prompt Reporting and Corrective Action: Any suspected non-compliance or misconduct, including fraud, waste, and abuse (FWA), is to be reported through designated compliance channels. Corrective actions and documentation of any remediation are used to demonstrate compliance with regulations.

Following these regulatory requirements helps providers manage legal and financial risks, as well as support consistent standards of patient care. Routine review of compliance standards and attention to regulatory updates are part of ongoing compliance efforts in healthcare settings.

COMPLIANCE POLICY

Health Plan enforces a strict zero-tolerance policy regarding fraud, waste, abuse, and any inappropriate activities. Any individual found participating in such behaviors whether independently or in concert with an employee, Member, or Provider will face legal action and immediate disciplinary measures, up to and including termination of employment or contract. Health Plan has implemented comprehensive fraud prevention and detection programs to safeguard our Members, the government, and the organization from incurring undue costs for services.

FRAUD, WASTE, AND ABUSE (FWA)

Health Plan is committed to full compliance with all applicable federal and state laws relating to fraud, waste, and abuse. The organization enforces policies and procedures designed to detect and prevent instances of fraud, waste, and abuse in claims submitted to federal and state healthcare programs and ensures protection for individuals who report actual or suspected violations in good faith.

SECTION 16: REGULATORY COMPLIANCE

Per State/Federal laws, applicable All Plan Letters (APL) including but not limited to DHCS APL 15-026, 42 CFR § 455.12 – 455.23, and DHCS contractual requirements, Health Plan is required to cooperate with the DHCS to identify and prevent Medi-Cal fraud, waste and abuse (FWA). Health Plan enforces policies and procedures designed to detect and prevent instances of fraud, waste, and abuse in claims submitted to federal and state healthcare programs and ensures protection for individuals who report actual or suspected violations in good faith.

FWA Defined

Fraud refers to the deliberate act of deceiving, concealing, or misrepresenting information in order to unlawfully acquire money or property from any health care benefit program.

Waste is overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program.

Abuse is performing actions that directly or indirectly result in unnecessary costs to any health care benefit program. Abuse can also include any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards.

The difference depends on circumstances, intent, and knowledge.

FWA Case Handling

Health Plan performs audits to monitor compliance with standards, including, but are not limited to, billing requirements, adherence to appropriate coding guidelines, and DHCS clinical policies. These audits can be used to identify the following examples of activities:

- Inappropriate "unbundling" of codes
- Inappropriate use of modifiers
- Claims for services not provided
- Up-Coding/Incorrect coding
- Potential overutilization
- Coding (diagnostic or procedural) not consistent with the Member's age/gender
- Improper use of benefits
- Use of exclusion codes
- High number of units billed
- Provider exclusion from Federally funded health care programs

Health Plan maintains a 24/7 online reporting system available to employees, Members, providers, and Commissioners to submit compliance and FWA issues to the Chief Regulatory Affairs and Compliance Officer or their designee. Every effort will be made to maintain confidentiality of the reporting to the extent permitted by law. Reporters wishing to remain anonymous are issued a PIN that enables them to follow up or get the status of an existing report. Reports can be submitted to the Compliance Hotline at 1-855-400-6002 or at www.lighthouse-services.com/hpsj.

Providers can also email Health Plan's Program Integrity Unit (PIU) at piu@hpsj.com to report suspected FWA cases. Issues and concerns can also be reported directly to the Chief Regulatory

Affairs Compliance Officer or any Health Plan Compliance staff.

Providers must report suspected FWA cases to Health Plan as soon as possible so that Health Plan can comply with its requirement to file a preliminary report with DHCS within ten (10) working days of the discovery or notice of such FWA cases. Once a complaint is received, Health Plan conducts a full investigation. Providers are expected to cooperate and respond to Health Plan requests for information within 30 days. Requests may include but are not limited to:

- Medical records
- Electronic data
- Copies of claims, invoices and other supporting documents.
- Allowing access to all involved office staff or subcontracted personnel for interviews, consultation, conferences, hearings, and for any other activities required in an investigation.
- Other requests associated with the FWA investigation

Health Plan may additionally report the subjects of FWA cases to state licensing boards and/or through the California Department of Consumer Affairs.

Other Regulations That Govern FWA

False Claims Act

The False Claims Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system.

"Knowingly" means:

- Actual knowledge of the information.
- Deliberate ignorance of the truth or falsity of the information.
- Reckless disregard of the truth or falsity of the information.
- Doesn't require proof of specific intent to defraud.

California False Claims Act (FCA) is more stringent than the Federal False Claims Act, because the FCA permits the Attorney General to bring a civil law enforcement action to recover treble damages and civil penalties against any person who knowingly makes or uses a false statement or document to either obtain money or property from the State or avoids paying or transmitting money or property to the State.

Under the civil FCA, each instance of an item or a service billed to Medicare or Medi-Cal counts as a claim. California penalties start at $10,000 per claim.

There also is a criminal FCA. Criminal penalties for submitting false claims include imprisonment and criminal fines.

The federal False Claims Act protects employees who report a violation under the False Claims Act from discrimination, harassment, suspension, or termination of employment as a result of reporting possible fraud. Employees who report fraud and consequently suffer discrimination may be awarded:

- Two (2) times their back pay plus interest.
- Reinstatement of their position without loss of seniority.
- Compensation for any costs or damage they incurred.

Anti-Kickback Statutes 42 U.S. Code §1320a–7b

Federal and California State Anti-Kickback laws establish criminal penalties for individuals and entities that knowingly solicit or receive any remuneration in exchange for referring an individual to a Provider for services covered by Medi-Cal programs. Remuneration may include money, goods, or services of value, and such exchanges are prohibited under these statutes.

Stark Law and Physician Self-Referral Provisions 42 U.S. Code §1395nn

The Federal Physicians Self-Referral Law, commonly known as the "Stark Law," prohibits physicians from referring Medi-Cal patients for health services to entities in which they have a financial interest such as ownership, investment, or structured compensation arrangements unless a specific exception applies.

Under the Stark Law, entities are also barred from submitting claims or bills for services rendered as a result of prohibited referrals.

Violations of the Stark Law may result in civil monetary penalties and exclusion from participation in Medi-Cal programs.

Suspected violations must be reported to the California Department of Health Care Services (DHCS) through the established self-disclosure protocol.

FWA Compliance Requirements for First Tier, Downstream, Related Entities (FDRs), Subcontractors, and Downstream Subcontractors

Health Plan is committed to ensuring that all contracted subcontractors comply with applicable state and federal regulations. These entities provide administrative and healthcare services to our Members, and Health Plan remains ultimately responsible for meeting applicable laws and regulations, and the terms of our contracts with regulators including CMS and DHCS.

To uphold these standards, Health Plan requires each FDR and Affiliate to adhere to compliance and fraud, waste, and abuse (FWA) expectations. Upon entering into a contract and annually thereafter, an authorized representative from each organization must complete an attestation confirming compliance with standards of conduct, compliance policies, exclusion screenings (OIG, GSA/SAM, OMIG), and the publication of FWA and compliance reporting mechanisms.

Health Plan must also report offshore subcontractor information to DHCS and attest to the protection of beneficiary protected health information (PHI). Therefore, FDRs and Affiliates must disclose the name, address, and delegated function of any offshore subcontractors used for Health

Plan business.

If an FDR or Affiliate is found to be non-compliant with any of these requirements, Health Plan will require that they develop and submit a Corrective Action Plan (CAP). Health Plan will support the entity in resolving the identified issues.

Additionally, FDRs and Subcontractors are responsible for ensuring that their downstream and related entities comply with applicable requirements in the contract between the FDR/Subcontractor and Health Plan, applicable Health Plan policies, and all applicable federal and state laws and regulations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), CONFIDENTIALITY MEDICAL INFORMATION ACT (CMIA) & CALIFORNIA CONSUMER PRIVACY ACT OF 2018 (CCPA)

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires Health Plan and all network Providers to protect the security and maintain the confidentiality of Member's Protected Health Information (PHI), whereas the Confidentiality Medical Information Act (CMIA) is a California state law that offers extra safeguards for Member's PHI. PHI includes, but is not limited to, a Member's name, address, phone number, medical information, social security number, ID Card number, date of birth, and other types of personal information. Additionally, Health Plan considers Member Personal Information (PI), such as, race/ethnicity, language, gender identity, and sexual orientation the same as PHI and applies the same safeguards.

In addition to Health Insurance Portability and Accountability Act (HIPAA) 45 CFR Parts 160 and 164, Health Plan's contracted Providers are also required to abide by the applicable laws and regulations imposed on Health Plan by both state and federal government agencies listed below:

1. Health Information Technology for Economic and Clinical Health Act (HITECH Act)
2. Confidentiality of Medical Information Act (CMIA) section 56 et al
3. Department of Health Care Services (DHCS) Contract as amended
4. The Knox-Keene Health Care Service Plan Act of 1975, as amended
5. California Consumer Privacy Act of 2018 Section 1798.100
6. Information Practices Act (IPA) at California Civil Code section 1798.3(a)
7. The Privacy Act 5 U.S.C. 552a, as amended
8. California Department of Health Care Services (DHCS) Contract

When this Manual refers to "PHI/PI", it is collectively referring to PHI and PI including race/ethnicity, language, gender identity, and sexual orientation.

Protecting PHI/PI at Provider Sites

Providers are additionally required by 45 CFR parts 160 and 164 and DHCS Contract, Exhibit G, to implement a comprehensive program to avoid unpermitted disclosure of PHI/PI. Providers are required to implement a training program, and to have detailed office policies and procedures in place in order to comply with HIPAA requirements. These policies and procedures should include,

but are not limited to:

- Keeping medical records secure and inaccessible to unauthorized access
- Limiting access of information to only authorized personnel, Health Plan, and any regulatory agencies
- Ensuring that confidential information is not left unattended in a reception or patient care area
- Safeguarding discussions in front of other patients or unauthorized personnel
- Providing secure storage for medical records
- Using encryption procedures when transmitting patient information
- Maintaining computer security
- Securing fax machines, printers, and copiers
- Having published Privacy Practices

Treatment, Payment and Operations

Member PHI/PI can be appropriately disclosed for treatment, payment and operations. Below are examples that apply. (This is not an all-inclusive list):

- Verifying eligibility and enrollment
- Authorization for covered services
- Claims processing activities
- Member contact for appointments
- Investigating or prosecuting Medi-Cal cases (i.e., fraud)
- Monitoring quality of care
- Medical treatment
- Case management/disease management
- Providing information to public health agencies permitted by law
- In response to court orders or other legal proceedings
- Appeals/grievances
- Requests from State or Federal agencies or accreditation agencies
- Providers must obtain specific written permission to use PHI/PI for any reason other than the ones listed above

Member Rights to Confidential Communications 45 CFR Part 164.522

Providers are required to take specified steps to protect the confidentiality of a Members medical information:

- An individual's reasonable request for communications to be sent to an alternative mailing address, email address, or telephone number should be accommodated by a Provider.
- If an individual clearly states that a disclosure of all or part of their PHI could endanger them, then the Provider must accommodate the reasonable request made by the individual to receive communications about his/her PHI by alternative means or at alternative locations.
- Providers are not allowed to require an explanation from an individual as to what the basis

is for the request of confidential communications as a condition of honoring the confidential communications request.

Additional Protections for Sensitive Health **Services**
Providers are required to adhere to additional laws for protecting the confidentiality of PHI related to sensitive health services. The following areas of health services qualify as sensitive health services: mental or behavioral health, drug and alcohol abuse, communicable diseases, sexual and reproductive health, sexually transmitted infections, substance use disorder (SUD), gender-affirming care, and intimate partner violence.

Per the Confidentiality of Medical Information Act (CMIA), under California Civil Code Section 56, providers are required to take the following specified steps to protect the confidentiality of a member's medical information regarding the sensitive health services they have received:

- All communications related to sensitive health services for the protected individual need to be sent directly to the protected individual, not the policyholder.
- A protected individual's request for communications related to sensitive health services to be sent to an alternative mailing address, email address, or telephone number should be honored.
- Medical information related to sensitive health services shouldn't be disclosed to anyone other than the protected individual (unless the protected individual has provided their expressed written authorization to do so).
- Providers need to recognize that the definition of medical information includes reproductive or sexual health application information. If a health care provider offers a reproductive or sexual health digital service to a consumer for a purpose of allowing that individual to manage their information or for the diagnosis, treatment, or management of a medical condition, then that health care provider will be subject to the requirements of the Confidentiality of Medical Information Act.

Additionally, California law requires additional protections for sensitive services for minors as specified in the California Family Codes 6924, 6925, 6926, 6928, 6929, 6930, and 7550. Minors under age 18 do not need parent/guardian consent to receive certain outpatient services if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the services. Below are the specific provisions for minor consent and disclosure for sensitive services. Health Plan, providers, and subcontractors are prohibited from disclosing any information relating to sensitive services without the express consent of the minor Member.

- **Minors under 12 years old** do not need parent/guardian consent to receive:
    - Pregnancy and pregnancy related services
    - Family planning services
    - Sexual assault services
- **Minors 12 years and older** do not need parent/guardian consent to receive:
    - Pregnancy and pregnancy related services
    - Family planning services
    - Sexual assault services
    - Infectious, contagious, or communicable disease diagnosis and treatment

- Sexually transmitted diseases prevention (or infections), diagnosis, and treatment
- Drug and alcohol abuse treatment and counseling
- Outpatient mental health treatment and counseling. Minors may obtain outpatient mental health services, if in the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.
- Intimate partner violence services

HIPAA Part 2 Final Rule Confidentiality of Substance Use Disorder Patient Records (SUD)

HIPAA Part 2 Final Rule for Substance Use Disorder (SUD) has additional provisions that provide an added layer of protection with regard to services and treatment for SUD. These protections align the confidentiality requirements of SUD treatment records more closely with standard HIPAA regulations to improve patient care coordination, while maintaining specific, stricter privacy protections.

- A single consent from a member is sufficient for Providers to use for all future uses and disclosures for treatment, payment, and health care operations. Providers who receive records under this consent are allowed to redisclose records in accordance with HIPAA regulations.
- Providers are permitted to disclose records without member consent to public health authorities, if the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule.
- Providers are not allowed to use the records and testimony in civil, criminal, administrative, and legislative proceedings against members, absent the members' consent or a court order.
- Providers are not allowed to combine member consent for the use and disclosure of records for civil, criminal, administrative, legislative proceedings with member consent for any other use or disclosure.
- Providers are required to obtain a specific separate consent from members to disclose their SUD clinician notes analyzing the conversation in a SUD counseling session. SUD Clinician notes cannot be used or disclosed based on a broad TPO consent.

Psychotherapy Notes Disclosure Requirements 45 CFR §164.508

Under HIPAA, Psychotherapy notes receive heightened confidentiality. Psychotherapy notes are the private, separate records created by a mental health professional to document observations, thoughts, and feelings during a counseling session, distinct from a Member's general medical record. Therapy records for survivors of sexual violence are an example of psychotherapy notes. Psychotherapy notes require a Member's explicit written authorization for disclosure on a separate and independent document. However, in cases of legal requirements or serious threats to health or safety they can be disclosed without a Member's permission. They are also required to be kept separate from the rest of a member's medical record.

In order to disclose a Members psychotherapy notes, a Provider must obtain a separate written authorization from the Member specific to the disclosure of psychotherapy notes, that includes the following requirements:

- A description of the information to be disclosed
- The identity of the person or class of persons who may disclose the information
- To whom the information may be disclosed
- A description of the purpose of the disclosure
- The expiration date for the authorization
- The signature of the person authorizing the disclosure as well as the date it was signed

Access, Inspect, and Obtain Medical Records 45 CFR §164.524

Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever the Member seeks services. Member medical records should be maintained in a way that facilitates an accurate system for follow-up treatment and permits effective medical review or audit processes.

Medical records should be provided to Members upon reasonable request and should be organized, legible, signed, and dated.

Minimum Necessary Rule 45 CFR 164.502(b) and 164.514(d)

The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information (PHI). The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose.

BREACHES OR UNAUTHORIZED DISCLOSURES OF PHI

Reporting a Suspected or Confirmed Breach 45 CFR §164.400–164.414
A breach is an unauthorized disclosure of PHI/PI that is not permitted by Federal or State laws or PHI/PI that is reasonably believed to have been acquired by an unauthorized person. This could include, but is not limited to:

- Release of a Member's PHI/PI to unauthorized persons.
- Misplacing or losing any electronic devices (e.g., thumb drive, or laptop) that contain PHI/PI.
- Unsecured PHI/PI, if the PHI/PI is reasonably believed to have been accessed or acquired by an unauthorized person.
- Any suspected privacy or security incident which risks unauthorized access to PHI/PI and/or other confidential information.
- Any intrusion or unauthorized access, use or disclosure of PHI/PI; or
- Potential loss of confidential information.

Provider/Subcontractor Reporting Obligations

Notify Health Plan

If a Provider or Subcontractor becomes aware of a suspected breach, the Provider must notify Health Plan within 24 hours of discovery of the incident/breach by emailing or calling the Privacy

Officer at the following email or phone number:

Privacy Officer Email: piu@hpsj.com
Telephone: 1-855-400-6002 (Compliance Hotline)

Providers may report to Health Plan in the form of a completed Privacy Incident Report.

The Provider should complete the following actions upon discovery of a suspected or confirmed incident/breach, security breach, intrusion, unauthorized access, use, or disclosure of PHI/PI:

1. Immediately investigate such security incident or breach.
2. Take prompt action to mitigate any risks or damages involved with the security incident or breach, which should include attempting to retrieve the PHI/PI if possible.
3. Act as required by applicable Federal and State law.

In addition to the 24-hour required reporting of the incident/breach, Providers will need to provide Health Plan with an update/final report within ten (10) working days of the discovery of the suspected security incident or breach. This update/final report must include the following:

1. An assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable Federal and State laws.
2. A detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure.
3. If DHCS requests additional information the Provider will make reasonable efforts to provide DHCS with such information.

More information about DHCS Privacy Incident reporting can be found at www.dhcs.ca.gov/formsandpubs/laws/priv

Provider/Subcontractor may have other contractual obligations under its Business Associate Agreement with Health Plan. Please refer to the applicable Business Associate Agreement for more information.

Please note that Provider/Subcontractor may be subject to other requirements and obligations under HIPAA and other applicable federal and state laws and regulations that are outside of its contractual obligations to Health Plan. Such obligations and requirements may include, but are not limited to, preparing and paying for reports to regulators and notifications to affected Members. For example, under HIPAA, Providers must report breaches to Health and Human Services, Office of Civil Rights (OCR) at the appropriate interval per the number of affected Members (<500 Members report within 60 days after the end of the calendar year, and >500 Members report within 60 days of discovery of the breach).

Reporting to OCR
Providers and Members can also report a suspected breach directly to OCR. Complaints must be filed within 180 days of your discovery of the violation occurring. OCR investigates complaints against health plans, healthcare Providers, healthcare clearinghouses, and business associates of these entities. You can submit a complaint in one of the following ways:

Online

- Use the OCR Complaint Portal to file electronically.

Mail or Email

- Send a written complaint to:

  U.S. Department of Health and Human Services Office for Civil Rights
  200 Independence Avenue
  S.W. Washington, D.C. 20201
  Email: OCRComplaint@hhs.gov

Law Enforcement Hold on Notification of Breach
If the Provider has received notification from law enforcement that requires a delay, the Provider will delay notification to individuals of the security incident, breach, or unauthorized use or disclosure of PHI or confidential data.

This direction will occur if or when such notification would impede a criminal investigation or damage national security and whether such notice is in writing, and whether Section 13402 of the HITECH Act (codified at 42 U.S.C. §17932), California Civil Code §1798.29 or §1798.82, or any other federal or state laws requiring individual notifications of breaches are triggered.

If Providers have any questions, they should email piu@hpsj.com.

TRAINING

Required trainings and/or attestations for providers include the following:

- Fraud, Waste & Abuse
- General Compliance Training
- Health Insurance Portability and Accountability Act (HIPAA)
- Cultural Competency and Sensitivity
- Timely Access
- Overview of Quality, Utilization, Prior Authorization and Case management
- Behavioral Health Referral Process
- Language Attestation
- CMS contract requirements and applicable federal and state statutes, regulations, and notices
- Review of information contained in the Provider Manual
- Explanation of Doctors Referral Express (DRE)
- Assistance in setting up DRE access
- Guidance on electronic claims submission and online authorization
- Guidance on coordinating preventive services (HEDIS) and standards, if applicable
- Enrollees' Rights and Responsibilities, including Advanced Directives, including the Enrollee Grievance and Appeals Process

- Provider Rights and Responsibilities, including the Provider Dispute Process
- Answers to any questions you may have regarding working with us

Providers will need to furnish documentation to Health Plan as proof that the trainings were completed within 30 days of becoming newly effective with Health Plan and annually thereafter. Provider Services will send out a courtesy reminder when annual trainings are due. It is the duty of the Provider to submit proof to Health Plan that training was completed within 30 days of hire for new employees, and annually thereafter. For new hires, proof of training should be submitted to Health Plan upon completion throughout the year.

Providers must provide the following to the Health Plan:

- Training source
- Training date
- List of other Providers in practice with NPIs
- Employees trained
- Attestation of completion

The source of the training can be one of three options; stream or download a pdf of Health Plan trainings from our website at this link www.hpsj-mvhp.org/provider-trainings or use other training. If the training source is other, an outline of the content, or a copy of the training, or a URL link to the training source must be provided.

For each training providers must complete an attestation stating the trainings were completed. The attestation links can be found here www.hpsj.com/provider-trainings.