SERVICE AGREEMENT

This Agreement is entered into, by, and between the San Mateo Health Commission, Health Plan of San Mateo ("HPSM") and the County of San Mateo, Health System, Family Health Services Division (FHS), as of November 1, 2015 ("Effective Date") and through March 31, 2018.

RECITALS

A. WHEREAS, HPSM is a County Organized Health System formed pursuant to Welfare and Institutions Code section 14087.51 and Sections 2.68.010, 2.68.030 of the San Mateo County Ordinance Code;

B. WHEREAS, HPSM contracts directly with the California Department of Health Care Services (DHCS) to provide health care services to eligible enrollees of California Children's Services (CCS);

C. WHEREAS, HPSM has contracted with DHCS to arrange and pay for family centered and whole child health care services to eligible Medi-Cal recipients under the CCS Demonstration Project as defined in the contents of Agreement Number 11-88291;

D. WHEREAS, HPSM is to ensure and monitor appropriate and timely access of enrollees with CCS eligible medical conditions to a CCS approved Provider;

E. WHEREAS, FHS has developed expertise in arranging for and managing delivery of services provided to eligible enrollees of CCS and FHS has operated the CCS Program for HPSM beneficiaries for over 25 years;

F. WHEREAS, the parties hereto desire to enter into this Agreement to identify their respective rights and responsibilities in connection with the provision of CCS benefits to eligible enrollees by a CCS PROVIDER during the term hereof;

G. NOW THEREFORE, in consideration of the mutual promises and agreement hereinafter contained, HPSM and FHS hereby agree as follows:

ARTICLE I

DEFINITIONS

A. **Care Coordination** means the assessment, linkage, and/or review of provided and needed medical treatment and ancillary services.

B. **California Children Services (CCS) Eligible Conditions** means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR) Section 41800.

C. **California Children Services (CCS) Program** means the public health program that assures delivery of specialized diagnosis, treatment and therapy services to financially and medically eligible children under the age of twenty one (21) years of age who have CCS eligible conditions.

D. **Confidential Information** means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

E. **Contracting Providers** means a Physician, Nurse, technician, hospital, home health agency, nursing home, or any other individual or institution that contracts with HPSM to provide medical services to Members.

F. **County Organized Health System (COHS)** means a health plan that contracts with the State Department of Health Care Services to arrange and pay for comprehensive health care to all eligible CCS beneficiaries and other eligible beneficiaries residing in the county, and that is operated directly by a public entity established by a county government pursuant to Welfare and Institutions (W&I) Code, Section 14087.51 or 14087.54, or H&S Code, Chapter 3 (commencing with Section 101675) of Part 4 of Division 101.

G. **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

H. **Demonstration Project (DP)** means the CCS pilot program awarded to HPSM through the California Department of Health Care Services (DHCS) under Section 1115 of the Social Security Act.

I. **Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the Federal Medicaid (referred to Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP) Child Health and Disability Prevention Program (CHDP) and other health related programs.

J. **Department of Managed Health Care (DMHC)** means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

K. **Eligible Beneficiary** means any CCS beneficiary who has a county code in HPSM's Service Area.

L. **Encounter** means any single medically related service rendered by (a) medical provider(s) to a Member enrolled in HPSM during the date of service. It includes, but is not limited to, all services for which HPSM incurred any financial liability.

M. **Enrollment** means the process by which an Eligible Beneficiary becomes a Member of HPSM.

N. **Fraud** means an intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (Title 42 CFR 455.2; W&I Code 14043.1(i).

O. **Grievance** means an oral or written expression of dissatisfaction made by a Member or Provider about any matter other than a Notice of Action. Examples of grievances are complaints related to quality of care, access problems, or provider interactions.

P. **Knox-Keene Health Care Service Plan Act of 1975** means the law that regulates HMOs and is administered by the DMHC (H&S Code 1340).

Q. **Member** means any Eligible Beneficiary who is enrolled with HPSM. For the purposes of this Agreement, "Enrollee" shall have the same meaning as "Member".

R. **Non-Physician Medical Practitioners (Mid-Level Practitioner)** means a nurse practitioner, certified nurse midwife, or a physician assistant authorized to provide Primary Care under Physician supervision.

S. **Notice of Action** means a formal letter informing a Member's family of any action taken to deny, defer, or modify authorization of a requested medical service by a Provider.

T. **Nurse (or a "Participant")** means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

U. **Physician** means a person duly licensed as a Physician by the Medical Board of California.

V. **Timely Access** means compliance with the California regulations that establish specific, time-elapse standards regarding the maximum time period a patient has to wait to receive health care services, in accordance with 28 CCR 1300.67.2.

W. **Urgent Care** means an episodic physical or mental condition perceived by a managed care beneficiary as a serious but not life threatening that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

X. **Vaccines for Children (VFC) Program** means the federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age eighteen (18) or younger and distributes immunization updates and related information to participating providers. Providers contracting with HPSM are eligible to participate in this program.

ARTICLE II

DUTIES OF HPSM

HPSM and FHS shall collaborate to fulfill the requirements of HPSM's agreement with DHCS to be a Contractor under the CCS Demonstration Project. Exhibit A of the HPSM agreement with DHCS, "Scope of Work," shall be incorporated and made a part of this agreement by this reference. This document is attached as "Exhibit 1." Responsibilities specifically belonging to HPSM shall include:

A. **Family Centered Care** – HPSM shall ensure that delivery of medically necessary health care is done in ways that supports the development of trusting relationships between Providers and family members. Consideration must be given to factors such as promoting continuity of Providers and allowing adequate time at visits to encourage Provider-family dialogue and the management of care coordination issues. HPSM may not prohibit, or otherwise restrict, Health Care Practitioners (HCP) acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient. FHS shall ensure that the list of core elements of family-centered care are integrated into Provider practices:
    1. Respect and dignity: HCPs listen to and honor patient and family perspectives and choices.
    2. Information sharing: HCPs communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
    3. Participation: Patients and families are encouraged and supported in participating in care and decision-making at all levels.
    4. Collaboration: HCPs collaborate with patients and families at all levels of health care, including: Care of an individual child; program development, implementation and evaluation; and policy formation.

B. **Referrals** – HPSM will implement policies and procedures to identify Medi-Cal beneficiaries who are potential enrollees with special health care needs that may be eligible for CCS covered services at time of enrollment into the health plan and on a regular periodic basis thereafter. When a potential enrollee has been identified as with a CCS-eligible medical condition, HPSM has the responsibility for referral to the county for confirmation to ensure identification is appropriate.

C. **Enrollment into Demonstration Project**
    1. HPSM will accept as Demonstration Project Members, Medi-Cal beneficiaries with a CCS-eligible condition. Enrollment is mandatory for CCS clients meeting the medical eligibility criteria and who:
        i. Do not have other health care coverage as defined in 22 CCR 53845(e); and
        ii. Are not in foster care placement.
    2. CCS clients in foster care placement may voluntarily enroll in a DP if they otherwise meet the eligibility requirements of the specific model.
    3. Enrollment Process - Eligible beneficiaries residing within the service area of HPSM will be identified as eligible CCS clients by the local CCS county level program and referred to HPSM on a monthly basis. Eligible beneficiaries shall be accepted by HPSM in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.

D. **Scope of Services**

1. The services covered by this agreement include **all** medically necessary covered services for enrollees in the DP. This includes medically necessary covered services both related to the CCS condition, and not related to the CCS condition. Covered services are those services set forth in 22 CCR, Chapter 3, Article 4, beginning with Section 51301, and 17 CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS Contract with HPSM.
2. These services must include all medically necessary primary and preventive health care services, diagnostic assessments, treatment, rehabilitation and follow-up care in addition to the care coordination and case management that are necessary for the appropriate treatment of the CCS-eligible condition.
3. "Medically necessary" services are all covered services that are reasonable and necessary to protect life, prevent significant illness or disability, and alleviate severe pain through the diagnosis or treatment of disease, illness or injury, (22 CCR 51303(a)) or are services necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by a HCP operating within the scope of their practice as long as the services are medical in nature and are not requested solely for the convenience of the beneficiary, family, Physician or another Provider of services (22 CCR 51340(e)(3)(A)).
4. Covered Services – A complete list of the covered and excluded services is in Exhibit 1, "Scope of Work," page 27 to 42.

E. **Transition Planning** – HPSM will partner with and provide oversight of FHS's provision of transition planning services, as outlined in Exhibit 1, "Scope of Work," page 2.

F. **Service Network and Access to Care** - HPSM shall ensure and monitor appropriate and timely access of enrollees to CCS approved Providers with the necessary expertise to provide comprehensive care, including the prevention, diagnosis and treatment of the full range of medical conditions experienced by enrollees with CCS-eligible medical conditions, pursuant to Title 28 California Code of Regulations (CCR) Sections 1300.67.2 and 1300.67.2.2. HPSM will implement and maintain procedures to ensure that enrollees have access to routine primary care, periodic health assessments, urgent care, specialist care, inpatient care, emergency care, minor consent, and sensitive services for adolescents. A complete list and description of the comprehensive care is in Exhibit 1, "Scope of Work," page 3 to 5.

G. **Provider Network**

1. The Contractor shall maintain and submit a complete network of CCS-approved health care Providers and health care facilities. For Primary Care Physicians, Board Certification/Board Eligibility is acceptable in place of CCS approval. The network shall provide the full scope of benefits required of children enrolled in the DP and shall ensure access to these Providers. The Contractor shall ensure that the treatment of the enrollee's medical care is performed by CCS-approved and/or Board Certified/Board eligible Providers. The Contractor will monitor and increase the capacity of the network as necessary to accommodate enrollment growth. The Provider network shall include:
    i. Primary Care Physicians
    ii. Pediatric Medical Specialties and Subspecialties
    iii. Pediatric Surgical Specialties and Subspecialties
    iv. Other Physician Providers

v. Other Health Care Professionals
vi. Hospital Facilities
vii. Inpatient Special Care Centers
viii. Outpatient Special Care Centers
ix. Other Healthcare Providers

A complete description of the Provider network is in Exhibit 1, "Scope of Work," page 6 to 8.

2. Provider to Member Ratios
    i. HPSM shall ensure that networks continuously satisfy the following full-time equivalent Provider to Member ratios:
        1. PCPs 1:2,000
        2. Total Physicians 1:1,200
3. Out-of-Network Providers
    i. If HPSM's network is unable to provide necessary services covered under the DHCS Contract to a particular Member, then HPSM must adequately and timely cover these services out of network for the Member, for as long as HPSM is unable to provide them.
    ii. Out-of-network Providers must coordinate with HPSM with respect to payment. HPSM must ensure that cost to the Member is not greater than it would be if the services were furnished within the network.
4. Provider Grievances - HPSM shall have a formal procedure to accept, acknowledge, and resolve Provider grievances. A Provider of medical services may submit to HPSM a grievance concerning the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to contracting, subcontracting, and non-contracting Providers.
5. Provider Manual - HPSM shall issue a Provider manual and updates to the Providers of Medi-Cal services. The manual and updates shall serve as a source of information to contracting and subcontracting health care Providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member grievance, appeal, and State fair hearing process. The Provider manual shall include the following Member's rights information:
    i. Member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing;
    ii. Member's right to file grievances and appeals and their requirements and timeframes for filing;
    iii. Availability of assistance in filing;
    iv. Toll-free numbers to file oral grievances and appeals; and
    v. Member's right to request continuation of benefits during an appeal or State fair hearing.
6. Provider Network Report - HPSM shall submit to DHCS a report summarizing changes in the Provider Network.

H. **Provider Reimbursement**

HPSM is the payor for all medically necessary CCS services, with the exception of those children and young adults in CCS who are not HPSM members.

HPSM shall compensate all network Providers as HPSM and the Provider negotiate and agree on compensation for services rendered. Complete details on provider reimbursement are in Exhibit 1, "Scope of Work," page 16 to 18.

I. **Physician Credentialing and Re-Credentialing**

1. HPSM will develop and maintain written policies and procedures for credentialing, re-credentialing, recertification and reappointment of Providers in its network. HPSM shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. HPSM shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body. In accordance with W&I Code, Section 14182.2(b)(5), HPSM shall ensure that children enrolled in the model receive care for their CCS-eligible medical conditions from CCS-approved and/or Board Certified/Board Eligible Providers (in the case of Primary Care Providers) consistent with the CCS standards of care.
2. As defined in Section B.2.a-d., these Physician Providers are all CCS-approved and/or Board Certified/Board Eligible (in the case of Primary Care Providers) in the appropriate specialty or subspecialty.
3. HPSM must ensure that network Physicians are credentialed every three (3) years.

J. **Personal Physician**

1. Each enrollee shall be assigned a network Personal Physician (PP) during the enrollment process. The PP may be a PCP, a pediatric medical specialist or subspecialist appropriate to the child's CCS-eligible medical condition.
2. The PP will assume the responsibility for directly overseeing all aspects of the enrollee's health care. The latter includes primary care, preventive services, assessment, diagnosis and treatment of illness and conditions unrelated to the treatment of the CCS-eligible medical condition; determining the medical services necessary to correct, treat and/or ameliorate the enrollee's CCS-eligible medical condition, working with the family to develop the care plan; working with the assigned Care Coordinator (CC) to assure appropriate referral and arranging access to Pediatric Specialists and subspecialists and other services as needed; and participating in all aspects of the case management system including multidisciplinary care conferences.

K. **PCP Provider Education and Quality Assurance** - HPSM will work with FHS to assure that assigned PCPs have received the training necessary to fulfill their roles and responsibilities. Specifically, HPSM shall have written policies and procedures pertaining as to how the Provider network will be informed/educated regarding the DP's requirements and how compliance with the stated standards will be monitored and an effective action plan implemented if the standards are not met. HPSM must disseminate the policies and procedures to all affected providers (this may be accomplished through the provider contract and Contractor's Provider Manual) and, upon request, to enrollees and potential enrollees.

L. **Access Requirements** - HPSM shall establish acceptable accessibility requirements in accordance with 28 CCR 1300.67.2 and as specified below. DHCS will review and approve requirements for reasonableness. HPSM shall ensure that contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the Provider serves only Medi-Cal Members. HPSM shall communicate, enforce, and monitor Providers' compliance with these requirements. A complete list and description of the access requirements is in Exhibit 1, "Scope of Work," page 21 to 24.

M. **Medical Home** - HPSM will implement a medical home model. HPSM will ensure care coordination at two levels – one by the enrollee's designated PP and the second by FHS's Care Coordinators (CC). HPSM will partner with and provide oversight of FHS's care coordination services, chronic

care management and disease management services that support the PP and the enrollee and family.

N. **Care Coordination** – HPSM will partner with and provide oversight of FHS's provision of care coordination services, as outlined in Exhibit 1, "Scope of Work," page 44 to 46.

O. **Utilization Management and Review** – HPSM has a Utilization Management and Review program, as outlined in the attached Exhibit 2, "Utilization Management Program." HPSM will update this document to incorporate the CCS DP. HPSM will partner with and provide oversight of FHS to implement HPSM's Utilization Management program for CCS DP patients. HPSM updates this document on an annual basis, and will share updated documents with FHS.

   The Utilization Management program is in line with the Utilization Management and Review provision as outlined in Exhibit 1, "Scope of Work," page 46 to 49.

P. **EPSDT Private Duty Nursing Authorization Requests** - The EPSDT benefit provides comprehensive screening, diagnostic, treatment, and preventive health care services for children under age 21 who are enrolled in Medi-Cal, and is key to ensuring that children who are eligible for EPSDT services receive appropriate preventive, dental, mental health, developmental, and specialty services.

   As a CCS Carve-in County, HPSM has the responsibility to provide and cover EPSDT services for Medi-Cal patients with CCS. For CCS DP patients with EPSDT needs, FHS authorizes all EPSDT services for these patients.

   Historically, for EPSDT private duty nursing requests, FHS would gather all the required documentation, and would send it to the DHCS Systems of Care Division (SCD). SCD would review the required documentation, and would provide FHS their recommendation on the appropriate level of care and hours that is appropriate for the patient. FHS would then create an authorization based upon SCD's recommendation.

   In May 2015, SCD notified HPSM and FHS that SCD will no longer provide this service. HPSM will assume the responsibilities that SCD performed for the EPSDT private duty nursing requests.

Q. **Abuse Reporting** – HPSM staff with direct member contact acknowledge their status as mandated reporters and will adhere to all State of California abuse reporting requirements.

R. **Demonstration Project Staff**
   1. HPSM will provide a Medical Director for the Demonstration Project, who will review CCS cases for medical necessity and oversee any clinical quality improvement projects.
   2. HPSM will also provide a Director of the Demonstration Project who will oversee general operations of the project.
   3. Through Member Services, contracted translation services, and the Grievance and Appeals departments, HPSM will retain proper staffing levels and vendor relationships in order to address member requests or concerns in the language most appropriate for the client.
   4. HPSM shall ensure separation of medical decisions from fiscal and administrative management to assure medical decisions are not influenced by fiscal and administrative management.

S. **Quality Improvement Project** – HPSM will provide support, data, and resources for quality improvement projects through the Quality Improvement Department and through the provision of the Medical Director of the Demonstration Pilot and the Director of the Demonstration Project.

T. **Evaluations**
   1. DHCS may utilize an "intervention and comparison group" design or other appropriate evaluation method to determine or assess the effects of the DPs as they relate to key research questions. An independent evaluation team selected by the Department will work with DHCS officials and Pediatric Specialists and subspecialists representing the Contractor to create a comparison group of patients with similar diagnoses, co-morbidities and annual baseline expenditures who are age- and gender- matched to those patients who are enrolled at the intervention sites. HPSM will cooperate with the independent evaluation team and Department representatives as necessary to ensure successful implementation of the evaluation methodology.
   2. HPSM may perform an evaluation of the DP to determine or assess the effects of the DP.

U. **Demonstration Project Advisory Committee** – HPSM will establish a Demonstration Project Advisory Committee consisting of community stakeholders and parents of children with CCS eligible conditions for the purposes of quality improvement and guidance related to the development of family-centered care processes.

V. **Information Technology/MIS** – HPSM will maintain an accurate CCS claiming process as well as the technology infrastructure to enable efficient authorization and payment for Demonstration Project services. HPSM shall maintain technology infrastructure to ensure the capability to capture, edit, and utilize data elements for internal management use, as well as meet the data quality and timeliness requirements of DHCS' encounter data submission. In addition, the technology infrastructure shall provide data on member eligibility, medical home assignments and needs assessments, services authorizations, provider claims, encounter data, provider network capacity, and financial information. HPSM shall have processes that support compatible, efficient and successful interactions amongst those data elements as well as between those data elements and quality management/improvement functions. The technology infrastructure shall also have the capacity for report generation.

ARTICLE III

DUTIES OF FAMILY HEALTH SERVICES

HPSM and FHS shall collaborate to fulfill the requirements of HPSM's agreement with DHCS to be a Contractor under the CCS program. Exhibit A of the HPSM agreement with DHCS, "Scope of Work," shall be incorporated and made a part of this agreement by this reference. This document is attached as "Exhibit 1."

Responsibilities specifically belonging to FHS shall include:

A. **Family Centered Care** – FHS shall ensure that delivery of medically necessary health care is done in ways that supports the development of trusting relationships between Providers and family members. Consideration must be given to factors such as promoting continuity of Providers and allowing adequate time at visits to encourage Provider-family dialogue and the management of care coordination issues. FHS may not prohibit, or otherwise restrict, Health Care Practitioners acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient. FHS shall ensure that the list of core elements of family-centered care are integrated into Provider practices:
   1. Respect and dignity: HCPs listen to and honor patient and family perspectives and choices.
   2. Information sharing: HCPs communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
   3. Participation: Patients and families are encouraged and supported in participating in care and decision-making at all levels.
   4. Collaboration: HCPs collaborate with patients and families at all levels of health care, including: Care of an individual child; program development, implementation and evaluation; and policy formation.

B. **Referrals** – FHS will implement policies and procedures to accept and evaluate referrals from HPSM for patients who may be potential CCS enrollees.

C. **Enrollment and Disenrollment into Demonstration Project**
   1. Enrollment Process - Eligible beneficiaries residing within the service area of HPSM will be identified as eligible CCS Demonstration Project clients by the local CCS county level program and referred to HPSM on a monthly basis.
   2. Disenrollment Process – FHS will disenroll the beneficiary from the CCS Demonstration Project if the beneficiary no longer meets the enrollment criteria. The disenrollment criteria are outlined in Exhibit 1, "Scope of Work," page 59 to 61.

D. **Scope of Services**
   1. The services covered by this agreement include **all** medically necessary covered services for enrollees in the DP. This includes medically necessary covered services both related to the CCS condition, and not related to the CCS condition. Covered services are those services set forth in 22 CCR, Chapter 3, Article 4, beginning with Section 51301, and 17 CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS Contract with HPSM.
   2. These services must include all medically necessary primary and preventive health care services, diagnostic assessments, treatment, rehabilitation and follow-up care in addition to

the care coordination and case management that are necessary for the appropriate treatment of the CCS-eligible condition.

3. "Medically necessary" services are all covered services that are reasonable and necessary to protect life, prevent significant illness or disability, and alleviate severe pain through the diagnosis or treatment of disease, illness or injury, (22 CCR 51303(a)) or are services necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by a HCP operating within the scope of their practice as long as the services are medical in nature and are not requested solely for the convenience of the beneficiary, family, Physician or another Provider of services (22 CCR 51340(e)(3)(A)).
4. Covered Services – A complete list of the covered and excluded services is in Exhibit 1, "Scope of Work," page 27 to 42.

E. Medical Home

1. FHS will provide support to the medical home by providing care coordination services, chronic care management and disease management services that support the PP and the enrollee and family. Care coordination activities will include providing assistance to families needing social services and coordination with other program supports such as the MTP. Referral and active coordination with disease management programs appropriate to an enrollee's condition(s) will be provided with a "whole child" focus.
2. Each enrollee in the DP will be assigned to a PP, who with support provided by HPSM and FHS, will function as the enrollee's medical home. Physicians that may serve as an enrollee's PP include General Pediatricians, Family Physicians, and Internists for enrollees over fourteen (14) years of age, specialty Physicians, or qualified sub-specialty Physicians appropriate to the enrollee's condition.
3. The medical home is responsible, working with the FHS CCs and the family, for the development of an individual plan of care that will serve as the basis for ensuring enhanced access to timely and appropriate services across the entire continuum of care and providing family-centered care coordination services. FHS shall support HPSM to ensure that the individual plan of care is completed and updated on a regular basis. The FHS CCs will incorporate the individual plan of care into the individualized family-centered care plan in collaboration with the family and the medical home PP. It is the responsibility of the medical home to stay apprised of all condition-related services and assure appropriate coordination of those services.
4. The medical home is responsible for ensuring that the enrollee receives needed services timely and in an appropriate setting. FHS shall support HPSM to ensure that the medical home fulfills this role.

F. Care Coordination

1. FHS shall counsel Members on their right to confidentiality and FHS shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to 22 CCR 51009.
2. FHS will employ CCs to work in partnership with the PP and other agencies to ensure the Member's care is coordinated and well managed.
    i. These other agencies include, but are not limited to:
        1. Specialty Providers
        2. Hospitals
        3. California Children's Services Medical Therapy Program
        4. Mental Health Providers/Behavioral Health and Recovery Services
        5. Agencies serving enrollees with Developmental Disabilities
        6. Agencies providing Early Intervention Services

7. Local Education Agency Services
8. Dental Services
9. Targeted Case Management (TCM) Services
10. Local School Districts

3. The CCs shall have experience working with enrollees with special health care needs.
4. Care coordination for enrollees with special health care needs shall include both face-to-face and telephone contacts.
5. FHS will utilize the initial needs assessment of the enrollee and their family's needs to determine the level and frequency of the care coordination required.
6. An initial needs assessment by the CC will be initiated within thirty (30) days of enrollment for all new enrollees in the DP and will help inform the choice of an appropriate medical home for the enrollee and ensure continuity of care and services and a smooth transition from FFS to the DP.
7. Initial and subsequent assessments shall be performed using a standardized tool provided by DHCS. This tool shall be developed with input from participating plans and stakeholders.
8. Subsequent assessments shall be performed at recertification and/or at a frequency determined by the ranking on the initial assessment.
9. The CC will be responsible for the following key functions:
    i. Assessment of an enrollee's medical, behavioral, psychosocial and functional needs;
    ii. Assessment of the family's functional needs;
    iii. Development and implementation of an individualized family-centered care plan in collaboration with the family and medical home Provider;
    iv. Development of an individualized family support plan;
    v. Facilitation of meetings and/or team conferences with family, enrollee and relevant and appropriate Providers of services;
    vi. On-going monitoring and evaluation of the care plan, including re-assessments upon a change in condition or status;
    vii. Coordination of care among systems and Providers;
    viii. Member education and advocacy, including research of and linkage to resources, services and support for the family;
    ix. Referral into disease and chronic care management programs, ongoing monitoring of the enrollee's status in these programs and coordination and linkage with or to other appropriate Providers or resources;
    x. Making referrals and ensuring authorization of services;
    xi. Transition planning;
    xii. Coordination with the evaluation activities to obtain enrollee and family feedback regarding their experiences of health care; and
    xiii. FHS shall inform Members that EPSDT services are available for Members under twenty-one (21) years of age.
10. FHS shall support HPSM to ensure that enrollees in the DP shall receive an initial health assessment (IHA) by the designated PP within sixty (60) days of enrollment, if the enrollee was not previously receiving primary and preventive care services from the PP.
    i. The IHA shall include performance of CHDP program's age appropriate assessment, including the provision of all immunizations necessary to ensure that the enrollee is up-to-date for age, and an age appropriate health education behavioral assessment.
11. While HPSM may not be financially responsible for a range of special services, such as those provided through regional centers, HCBS waiver, behavioral health, medical therapy through the MTP, residential and institutional care services and dental services, FHS will be responsible for ensuring coordination of all the care the enrollee receives.
12. Out-of-Plan Case Management and Coordination of Care

i. FHS shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services.
ii. FHS shall implement protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records.
iii. FHS shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

G. **Care Transition** – FHS will ensure that all enrollees, with a medical condition expected to last beyond the twenty-first (21) birthday, receive the services necessary to make transitions to adult health care as seamless as possible. It will be necessary to work with enrollees and their families to prepare them for how their future health care needs will be met once eligibility for the California Children's Services (CCS) program ceases at the twenty-first (21) birthday.

FHS will ensure that enrollees will have a transition plan completed on an annual basis beginning at fourteen (14) years of age, prepared in conjunction with the enrollees and family.

FHS will work with the enrollees' family to ensure that families have considered applying for conservatorship for the enrollees prior to their eighteenth (18th) birthday.

H. **Utilization Management and Review** – FHS shall implement HPSM's UM program that ensures appropriate processes are used to review and approve the provision of all medically necessary covered services, including CCS and non-CCS conditions. FHS is responsible to ensure that the UM program includes:

1. Utilization Management
    i. HPSM is responsible for the UM program. FHS shall provide qualified staff to support the UM program. .
    ii. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.
    iii. FHS shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.
    iv. Established criteria for approving, modifying, deferring, or denying all requested services – inpatient, outpatient, and other services. The established criteria include HPSM's Utilization Management guidelines as well as the CCS Utilization Management guidelines. FHS shall utilize these evaluation criteria and standards to approve, modify, defer, or deny services.
    v. FHS shall help communicate to HCP the procedures and services that require prior authorization and ensure that all contracting HCPs are aware of the procedures and timeframes necessary to obtain prior authorization for these services.
    vi. FHS shall support HPSM's specialty referral system to track and monitor referrals requiring prior authorizations. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting Providers.
2. Pre-Authorizations and Review Procedures – FHS shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

i. Decisions to deny or authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.
ii. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified Physician or HPSM's Pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the plan Medical Director, in collaboration with the plan Pharmacy and Therapeutics committee or its equivalent.
iii. There is a set of written criteria or guidelines for utilization review that is based on standards of clinical practice for enrollees with CCS-eligible medical conditions, and is consistently applied, regularly reviewed, and updated.
iv. Reasons for decisions are clearly documented.
v. Notification to Members regarding denied, deferred or modified referrals is made. Enrollees and their families and Providers shall be advised of the appeals procedures.
vi. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.
vii. Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
viii. Records, including any Notice of Action (NOA), shall meet the retention requirements.
ix. FHS must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be orally or in writing.

3. Timeframes for Medical Authorization
   i. Emergency care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
   ii. Concurrent review of authorization for treatment regimen already in place: Within twenty-four (24) hours of the decision, consistent with urgency of the Member's medical condition and in accordance with H&S Code, Section 1367.01(h)(3).
   iii. Retrospective review: Within thirty (30) calendar days in accordance with H&S Code, Section 1367.01(h) (1).
   iv. Pharmaceuticals: Twenty-four (24) hours on all drugs that requires prior authorization in accordance with W&I Code, Section 14185(a) (1).
   v. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with H&S Code, Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Member or the Member's Provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

vi. Expedited authorizations: For requests in which a Provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than three (3) working days after receipt of the request for services. The Contractor may extend the three (3) working days' time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
vii. Post-stabilization: Upon receipt of an authorization request from an emergency services Provider, the Contractor shall render a decision within thirty (30) minutes or the request is deemed approved, in accordance to 28 CCR 1300.71.4.
viii. Non-urgent care following an exam in the emergency room: Response to request within thirty (30) minutes or deemed approved.
ix. Therapeutic enteral formula for medical conditions in infants and children: Timeframes for medical authorization of medically necessary therapeutic enteral formulas for infants and children and the equipment and supplies necessary for delivery of these special foods are set forth in Numbered Letter 22-0805, Enteral Nutrition Products as a CCS Benefit, W&I Code, Section 14103.6 and H&S Code, Section 1367.01.
x. Hospice inpatient care: Twenty-four (24) hour response.

4. Review of Utilization Data
    i. FHS shall work with HPSM to develop mechanisms to detect both under and over-utilization of health care services within the UM program. The Contractor shall include internal reporting mechanisms used to detect enrollees' utilization patterns. Reports shall be submitted to DHCS upon request.
5. Second Opinion
    i. FHS shall work with HPSM to ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

I. **EPSDT Private Duty Nursing Authorization Requests** - FHS shall receive all CCS DP EPSDT Private Duty Nursing requests. The CCS PHN will:

1. Ensure that the request is medically necessary
2. Collect all required documents, such as but not limited to:
    i. Initial request
    ii. Service Authorization Request (SAR) or Treatment Authorization Request (TAR)
    iii. Plan of Treatment (POT) by the physician that is signed within 30 working days of the initial request
    iv. Signed prescription
    v. Nursing assessment within 30 calendar days
    vi. 60 day summary
3. Recommend the level of Care
4. Submit all documents and recommended level of care to HPSM so that HPSM can determine the appropriate nursing hours
5. Obtain other reports as necessary for HPSM to make the nursing hours determination

J. **PCP Provider Education and Quality Assurance** – FHS will work with HPSM to assure that assigned PCPs have received the training necessary to fulfill their roles and responsibilities.

K. **CCS Orientation** – FHS shall provide orientation of CCS policy and process changes to Providers and staff.

L. **Quality Improvement Projects** – FHS agrees to participate and cooperate in HPSM's quality improvement system. FHS will provide data and resources for quality improvement projects through the CCS nurses and administrative staff, and through the provision of the CCS Medical Director and the CCS Administrator.

M. **Evaluations**

1. DHCS may utilize an "intervention and comparison group" design or other appropriate evaluation method to determine or assess the effects of the DPs as they relate to key research questions. An independent evaluation team selected by the Department will work with DHCS officials and Pediatric Specialists and subspecialists representing the Contractor to create a comparison group of patients with similar diagnoses, co-morbidities and annual baseline expenditures who are age- and gender- matched to those patients who are enrolled at the intervention sites. FHS will cooperate with the independent evaluation team and Department representatives as necessary to ensure successful implementation of the evaluation methodology.
2. HPSM may perform an evaluation of the DP to determine or assess the effects of the DP. FHS will cooperate with the HPSM evaluation team to ensure successful implementation of the evaluation methodology.

N. **Encounter Data Submittal** – FHS shall provide service level data to HPSM, which allows HPSM to meet its administrative functions and the requirements set forth in Exhibit 1, "Scope of Work." HPSM shall have in place mechanisms, including edits and reporting systems sufficient to assure service level data is complete and accurate prior to submission to DHCS.

Upon written notice by DHCS that the encounter data is insufficient or inaccurate, FHS will assist HPSM to ensure that corrected data is resubmitted within fifteen (15) days of receipt of DHCS' notice. Upon HPSM's written request, DHCS may provide a written extension for submission of corrected encounter data.

O. **Information Technology (IT)** - FHS will provide IT services to support its staff, including, but not necessarily limited to, facilitating a secure data connection between HPSM and FHS, enabling secure email and file sharing. Additionally, FHS agrees that FHS staff will work with HPSM staff to transition to HPSM utilization management and care management systems. The timelines for these transitions shall be mutually agreed to by HPSM and FHS leadership.

P. **Family Advisory Subcommittee of the Demonstration Project Advisory Committee** – FHS will establish a Demonstration Project subcommittee consisting of parents of CCS enrollees or CCS consumers for the purposes of quality improvement, education and guidance related to the development of family-centered care processes. FHS will also participate in meetings of the Demonstration Project Advisory Committee.

Q. **Demonstration Project Staff** –

1. FHS Medical Director will determine eligibility for the CCS program and will collaborate with the Demonstration Project Medical Director to ensure quality care and be responsible for clinical oversight of the CCS Medical Therapy Units.

2. FHS will also provide a CCS Administrator, 50% of whose time will be dedicated to the DP, and who will supervise the Care Management Team and any FHS administrative staff. FHS will retain staffing that properly addresses the language needs of the population served.
3. FHS will provide qualified staff with experience working with enrollees with special health care needs at a level that is sufficient to conduct the care management, utilization management, and other services for the DP, as described in this contract.
4. FHS will confer with HPSM about the hiring of any Demonstration Project staff.

R. **Staff Training:** FHS will ensure that CCS staff completes training related to ethics, HIPAA, and other mandatory State and Federal training, and that staff licenses are in good standing.

S. **Abuse Reporting** – FHS staff with direct client contact acknowledge their status as mandated reporters and will therefore adhere to all State of California abuse reporting requirements.

ARTICLE IV

ENSURING PATIENT ACCESS

A. **Linguistic and Cultural Access** – HPSM and FHS shall work together to ensure that communication and/or cultural barriers will not inhibit enrollees and their families from obtaining services from the health care system.
    1. Linguistic Access and Communication
        i. Communication Impairments
            1. HPSM and FHS shall establish methods for communicating effectively with enrollees and their families who have a range of communication-affecting conditions, including cognitive, vision or hearing impairments, to ensure that enrollees and their families can make informed decisions.
            2. Standard informational and/or education materials shall be made available to enrollees and their families in alternative formats, (e.g., written, Braille, audio/video tape, etc.). Sign language interpretation for English speaking hearing impaired individuals shall also be available upon request.
        ii. Non-English Speaking Enrollees and Families
            1. Interpreter services shall be made available for planned encounters with enrollees or families with limited proficiency in comprehending English to ensure that enrollees and their families are afforded full access to DP services and benefits. In addition, interpretation services shall be made available on an ad hoc basis for unplanned or emergency contacts.
            2. These services shall include the ability to orally translate commonly used medical terminology from English to languages used by enrollees and their families and from the enrollee's or family's language to the English language.
            3. Written materials, including commonly used forms and informational materials, shall be available in languages appropriate to the enrolled population. Sign language interpretation for non-English speaking hearing impaired individuals shall be made available upon request.
    2. Linguistic Services
        i. HPSM and FHS shall comply with 22, CCR, Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) enrollees receive twenty-four (24) hour oral interpreter services at all key points of contact, either through Interpreters or telephone language services.
        ii. HPSM and FHS shall provide, at minimum, the following linguistic services at no cost to enrollees/members:

1. Oral interpreters, signers, or bilingual Providers and Provider staff at all key points of contact. These services shall be provided in all languages spoken by enrollees and not limited to those that speak the threshold concentration standards languages.
2. Fully translated written informational materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. The Contractor shall provide translated written informational materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's service area. DHCS will notify the Contractor of the threshold or concentration languages in the Contractor's service area.
3. Referrals to culturally and linguistically appropriate community service programs.
4. Telecommunications Device for the Deaf (TTY/TDD)

3. Access to Culturally Appropriate Care
    i. HPSM and FHS shall provide a mechanism to ensure that health care services provided through the DP are designed and delivered in a manner which is sensitive and responsive to the varying cultural needs of the enrollees and their families.
    ii. This mechanism shall, at a minimum, address:
        1. Staffing that reflects the racial and ethnic makeup of the population served, and is familiar with the cultural backgrounds of enrollees.
        2. Written polices stating the importance of culturally competent care and acknowledging differing cultural definitions of "family" and respecting differing views of medical care.
        3. Provision for asking each family who should attend conferences, what kind of translation services are needed, what are the family's concerns and what added assistance is needed to gain access to care.
        4. Provision for working with family and Providers when the enrollee's and/or family's view of the illness and treatment differs substantially from the Physician's.
        5. Protocols for defining and removing practices which are found to be barriers to care for enrollees.

B. Access for Disabled Members

All of HPSM and FHS's facilities shall comply with the requirements of Title III of the Access for Disabled Clients Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

C. Civil Rights Act of 1964

HPSM and FHS shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d and 45 CFR Part 80) that prohibit recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

D. Federal Nondiscrimination Requirements

HPSM and FHS shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC 794) Nondiscrimination under federal grants and programs; 45 CFR 84 Nondiscrimination on the basis of handicap in programs or activities receiving federal financial assistance; 28 CFR 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1972 (regarding education programs and activities); 45 CFR 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

ARTICLE V
PAYMENTS AND CLAIMS PROCESSING

In consideration of the services provided by FHS in accordance with all terms, conditions, and specifications set forth in this Agreement, HPSM shall make payment to FHS based on the rates and in the manner specified as follows:

HPSM shall reimburse FHS for actual costs for providing all services as described above. The following process will be followed:

i. FHS shall invoice DHCS for CCS Administration costs within 60 days after the end of each quarter. Within five business days of sending the invoice to DHCS, FHS shall provide HPSM a copy of the invoice and related back-up in order for HPSM to accrue expected costs.
ii. FHS will invoice HPSM for HPSM's share within 10 business days of receipt of the revised claim and payment from DHCS. Invoicing dates may vary due to the fact that FHS receives the revised claim from DHCS at various times.
iii. The amount that HPSM pays FHS shall be the amount remaining following DHCS reimbursement, which shall be approximately 70% of claimed costs. FHS shall be reimbursed 100% of claimed CCS Administration costs by DHCS and HPSM.
iv. HPSM will provide payment within 30 days of receiving FHS's invoice.

In no event shall HPSM total fiscal obligation under this Agreement exceed seven million, two hundred and fifty thousand dollars ($7,250,000). In the event that HPSM makes any advance payments, FHS agrees to refund any amounts in excess of the amount owed by HPSM at the time of contract termination or expiration.

ARTICLE VI

RECORDS AND REPORTS

A. **Maintenance of Records** - FHS shall maintain, and require any of its Downstream Entities, contractors, or subcontractors to maintain, documentation of all activity conducted under this Agreement, including Claims processed, for a minimum of seven (7) years from the close of the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created. Such documentation, including books and records, shall be in a format and media deemed appropriate by FHS and HPSM, and sufficient to accommodate periodic auditing of records to evaluate the quality, appropriateness, and timeliness of services performed by FHS under this Agreement. This shall include maintenance of encounter data for a period of at least seven (7) years.

Records pertaining to goods or services furnished under this agreement shall be accessible

to HPSM upon thirty (30) days prior written notice for annual audits, or sooner if required by the circumstances or state or local oversight agencies.

B. **Use of Information** - FHS and HPSM may use, reproduce, or adapt information obtained in connection with this Agreement, including Claims data information and eligibility information, in any manner they deem appropriate, except that each party and its agents, employees, and contractors shall maintain the confidentiality of this information to the extent required by applicable Law, including the provisions of the Health Insurance Portability and Accountability Act of 1996, Subtitle F – Administrative Simplification, (referred to in this Agreement as "HIPAA"), and may not use the information in any way prohibited by Law. Each party shall be solely responsible for its own use of the information, and shall indemnify and hold the other party harmless for, from and against any and all costs, losses, and damages incurred by such other party as a result of such use.

C. **Right to Audit Records** - FHS agrees to permit access to, for inspection, examination or copying, by HPSM, the California Department of Managed Health Care, the California Department of Health Care Services, the California Department of Health and Human Services, or the California Department of Justice, and or their designees, at all reasonable times, all records and documents maintained or utilized by FHS in the performance of this Agreement. HPSM and representatives of a regulatory or accreditation agency may each inspect and audit, at least once quarterly or as required, FHS' business records that directly relate to billings made to HPSM for Claims. FHS may inspect and audit, or cause to be inspected and audited, once annually, the books and records of HPSM directly relating to this Agreement, including the existence and number of Members. HPSM and FHS shall fully cooperate with and assist and provide information to representatives of each other, independent accountants hired by either party, and representatives of any regulatory or accreditation agency, to conduct any such inspection or audit. To the extent that HPSM and/or FHS have control of the following, such audits shall be at the auditing party's sole expense and shall only be made during normal business hours, following thirty (30) days written notice, without undue interference to the audited party's business activity, and in accordance with reasonable audit practices. Where a regulatory or accreditation agency imposes demands that do not meet the above standards for conducting an audit, HPSM and FHS will cooperate with the requirements of the auditing agency to the extent possible. An audit of FHS' records may be conducted at FHS's office where such records are located and shall be limited to transactions under the seven (7) year period preceding such audit unless the document retention period is extended according to applicable law. If a completed audit reveals a discrepancy in the results and the previous calculations of the audited party, then the auditing party shall deliver written notice setting forth in reasonable detail the basis of such discrepancy. The parties shall use reasonable efforts to resolve the discrepancy within thirty (30) days following delivery of the notice, and such resolution shall be final, binding, and conclusive upon the parties. Upon a final and conclusive determination of a discrepancy revealed by an audit procedure under this Agreement, the party that owes money shall pay such sums to the other party within thirty (30) days of the delivery of the conclusive audit findings.

D. **Records Related to Recovery for Litigation** - Upon request by DHCS, HPSM and FHS shall gather in a timely manner, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in HPSM or FHS' possession, relating to threatened or pending litigation by or against DHCS. HPSM or FHS retain and may assert that requested documents are privileged, by identifying such documents and stating the privilege that supports withholding them.

E. **Reporting** - Family Health Services will provide data to support HPSM's compliance with State regulatory agencies or private accreditation requirements. Specific reports or information, which may not be set forth in this Agreement, may be required of HPSM by State or federal regulatory agencies or private accreditation organizations from time to time. FHS shall provide such data or reports to HPSM in a mutually agreeable time and manner that enables HPSM to meet its obligations.

ARTICLE VII

Grievances and Appeals Process

FHS shall utilize HPSM's Grievance and Appeals system when a HPSM member or provider is dissatisfied with his/her experience accessing or utilizing the CCS DP. HPSM will accept Grievances and Appeals in writing, by phone, or through email or other electronic means.

Appeals - Members shall have ninety (90) days from the date on a Notice of Action to file an appeal of the Notice of Action with FHS or HPSM. Members may simultaneously request a State fair hearing regarding the Notice of Action. During the appeal, the Member must have a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member must be given the opportunity before and during the appeals process to examine their case file, including medical records and any other documents and records considered during the appeals process. FHS differentiates between standard Appeals and expedited Appeals. FHS processes an Appeal on an expedited basis when the standard timeframe for processing an appeal could seriously jeopardize the member's life, health, or ability to regain maximum function.

Grievances - Members shall have one hundred and eighty (180) days from the date of the incident or action which caused the Member to be dissatisfied, to file a grievance with HPSM. FHS shall participate in the grievance process by 1) resolving grievances and notifying HPSM of the grievance details and resolution; and/or 2) by referring members to HPSM to file a grievance, or by forwarding grievance details to HPSM on behalf of the member.

Provider Grievances - FHS shall utilize HPSM's Grievance and Appeals system to accept, acknowledge and resolve Provider grievances. Provider grievances may concern the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member, or the processing of a payment or non-payment of a claim by HPSM.

FHS shall forward to HPSM all Appeals or Grievances received through CCS or through other avenues within FHS related to the CCS program within five (5) business days. Standard Appeals and Grievances shall be resolved within thirty (30) calendar days from the date of receipt. Expedited Appeals shall be resolved within seventy-two (72) hours from the time of receipt.

ARTICLE VIII

TERM AND TERMINATION

Term - The term of this Agreement shall commence on November 1, 2015, and shall continue in full force and effect, subject to the following provisions for termination:

Termination Without Cause - FHS or HPSM may terminate this Agreement without cause upon providing the other party with sixty (60) days prior written notice.

Termination for Material Breach - Either party shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party if the party to whom such notice is given is in material default under this Agreement. The party claiming the right to terminate hereunder shall set forth in the notice of intended termination required hereby the effective date of such termination and the facts underlying its claim that the other party is in breach of this Agreement. If FHS or HPSM remedies such alleged breach within twenty (20) days of the receipt of such notice, the Agreement shall remain in effect for the remaining term and such termination notice shall no longer be in effect. Notwithstanding the other provisions of this paragraph, the HPSM may immediately suspend this Agreement pending completion of applicable termination procedures, if the HPSM makes a reasonable determination, supported by written findings, that the health and welfare of Members is jeopardized by continuation of the Agreement.

Both parties shall notify the State of California, in writing, thirty (30) days prior to termination of this Agreement.

Effect of Termination

1. As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect, and each of the parties shall be relieved and discharged from performance, except as specified in Paragraph 2 of this Section.

2. HPSM shall remain liable for payment of all CCS services rendered to HPSM's Member up to the termination of this Agreement.

3. FHS agrees to assist HPSM in the transfer of care pursuant to Exhibit E, Provision 49 (Phaseout Requirements), in the event of the termination of the DHCS contract.

4. FHS agrees to assist HPSM in the transfer of care in the event of the termination of this agreement for any reason.

5. FHS agrees to notify DHCS in the event the agreement with HPSM is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

6. Contract Materials: At the end of this Agreement, or in the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and other written materials (collectively referred to as "contract materials") prepared by FHS under this Agreement shall become the property of HPSM and shall be promptly delivered to HPSM. Upon termination, FHS may make and retain a copy of such contract materials if permitted by law.

ARTICLE IX

INSURANCE

A. **General Requirements** – HPSM and FHS shall not commence work or be required to commence work under this Agreement unless and until all insurance required under this Section has been obtained and such insurance has been approved by County's Risk Management, and HPSM and

FHS shall use diligence to obtain such insurance and to obtain such approval. HPSM and FHS shall furnish to each other certificates of insurance evidencing the required coverage, and there shall be a specific contractual liability endorsement extending HPSM and FHS's coverage to include the contractual liability assumed by HPSM and FHS pursuant to this Agreement. These certificates shall specify or be endorsed to provide that thirty (30) days' notice must be given, in writing, to HPSM and FHS of any pending change in the limits of liability or of any cancellation or modification of the policy.

B. **Workers' Compensation and Employer's Liability Insurance** – HPSM and FHS shall have in effect during the entire term of this Agreement workers' compensation and employer's liability insurance providing full statutory coverage. In signing this Agreement, HPSM and FHS certifies, as required by Section 1861 of the California Labor Code, that (a) it is aware of the provisions of Section 3700 of the California Labor Code, which require every employer to be insured against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and (b) it will comply with such provisions before commencing the performance of work under this Agreement.

C. **Liability Insurance** - HPSM and FHS shall obtain (to the extent not already possessed) and maintain, with respect to the activities in which HPSM and FHS engages pursuant to this Agreement, commercial general liability insurance of not less than $1,000,000 per occurrence for bodily injury and property damage liability combined. The commercial general liability insurance policy shall include coverage for liabilities arising out of premises, operations, independent contractors, products, completed operations, personal and advertising injury, and liability assumed under the insured agreement.

ARTICLE X

INDEMNITY

A. **FHS Indemnification**

1. HPSM - FHS agrees to indemnify, defend and hold harmless HPSM, its agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with any negligence in connection with FHS' operations or its services hereunder including the operations and services of FHS' affiliates, Subcontractors/Vendors and their respective employees and agents. This provision is not intended to, nor shall it be construed to, require FHS to indemnify HPSM for any HPSM liability independent of that of FHS, nor to cause FHS to be subject to any liability to any third party (either directly or as an indemnitor of HPSM or its agents, officers and employees) in any case where FHS liability would not otherwise exist. Rather, the purpose of this provision is to assure that HPSM and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against HPSM or such agents, officers, or employees resulting from the actions or other omissions of FHS, its affiliates, Subcontractors/Vendors and their respective employees and agents in connection with their operations and services relating to this Agreement
2. State and Members - FHS agrees to hold harmless both the State and Members in the event HPSM cannot or will not pay for services performed by FHS pursuant to this agreement.

B. **HPSM Indemnification** – HPSM agrees to indemnify, defend and hold harmless FHS, Its agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with any negligence in connection with HPSM's operations or its services hereunder including the operations and services of HPSM's affiliates, Subcontractors/Vendors and their respective agents. This provision is not intended to, nor shall it be construed to, require HPSM to indemnify FHS for any FHS liability independent of that of HPSM, nor to cause HPSM to be subject to any liability to any third party (either directly or as an indemnitor of FHS or its agents, officers employees) in any case where HPSM liability would not otherwise exist. Rather, the purpose of this provision is to assure that FHS and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against FHS or such agents, officers, or employees resulting from the actions or other omission of HPSM, its affiliates, subcontractors/vendors and their respective employees and agents in connection with their operations and services relating to this Agreement.

C. **Third Party Liability** – In the event that FHS renders services to Members for injuries or other conditions resulting from the acts of other parties, the HPSM will have the right to recover from any settlement, award or recovery from any responsible third party the value of all services which have been rendered by FHS pursuant to the terms of this Agreement.

ARTICLE XI

MISCELLANEOUS

A. **Entire Agreement** – This Agreement (together with all Exhibits hereto) contains the entire Agreement between the parties relating to the rights herein granted and the obligations herein assumed. It is the express intention of the FHS and the HPSM that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Agreement which are not expressly set forth herein shall be of no further force, effect or legal consequence after the Effective Date hereunder.

B. **Amendments** – This Agreement and any Exhibits hereto may be amended only by an instrument in writing, duly executed by both parties in accordance with applicable provisions of State and Federal law and regulations.

C. **Approval of Agreement/Amendments By DHCS** – This Agreement or Amendments entered into by HPSM shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Agreement and has failed to approve or disapprove the proposed Agreement within sixty (60) calendar days of receipt. Amendments shall be submitted to DHCS for prior approval at least (30) days before the effective date of any proposal governing compensation, services or term.

D. **Notices**

1. Notices to HPSM and FHS: Any notice required to be given pursuant to the terms and provisions of this Agreement, unless otherwise indicated in this Agreement, shall be in

writing and shall be sent by certified mail, return receipt requested, postage prepaid, or courier service (Federal Express, UPS, etc.) or other means which can provide written proof of delivery, to HPSM at:

Maya Altman, Chief Executive Officer
Health Plan of San Mateo
801 Gateway Blvd, Suite 400
South San Francisco, CA 94080

and FHS at:

Louise F. Rogers, Chief
Health System
San Mateo County Health System
225 37th Avenue
San Mateo, CA 94403

2. Notice to DHCS: FHS agrees to notify DHCS in the event the Agreement with HPSM is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

E. **Waiver of Obligations** – No obligation under this Agreement or an Exhibit hereto may be waived by any party except by an instrument in writing, duly executed by the party waiving such obligations. All waivers shall specify the provisions being waived, and no waiver of any provision of this Agreement extends or implies the extension of the waiver to any other provisions of this Agreement unless so specified in writing.

F. **Counterparts** – This Agreement may be executed in counterparts, each of which shall be considered to be an original; however, all such counterparts shall constitute but one and the same Agreement. This Agreement may be executed by facsimile or PDF signature, all of which taken together constitute a single agreement between the parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (such as facsimile and PDF), will be considered as legally effective as an original signature.

G. **Headings** – The headings or titles of articles and sections contained in this Agreement are intended solely for the purpose of facilitating reference, are not a part of the Agreement and shall not affect in any way the meaning or interpretation of this Agreement.

H. **Governing Law** – This Agreement will be governed by and construed in accordance with the laws of the State of California, without regard to any conflict of law principles applied therein. Any suit or proceeding relating to this Agreement shall be brought only in the state or federal courts located in California, and all Parties hereby submit to the personal jurisdiction and venue of such courts will be the County of San Mateo.

This Agreement shall be governed by and construed in accordance with all laws and applicable regulations governing the HPSM contract with DHCS, Agreement Number 11-88291.

I. **Confidentiality** - For the purposes of this Agreement, “Confidential Information” means any software, data, business, financial, operational, customer, or other information disclosed by one

party to the other and not generally known by or disclosed to the public. Confidential Information shall include any and all Personal Information, defined as any information that is or includes personally identifiable information. Personal Information includes, but is not limited to, name, address and any unique personal identification number. Notwithstanding anything herein to the contrary, Confidential Information shall not include information that is: (a) already known to or otherwise in the possession of a party at the time of receipt from the other party, provided such knowledge or possession was not the result of a violation of any obligation of confidentiality; (b) publicly available or otherwise in the public domain prior to disclosure by a party; (c) rightfully obtained by a party from any third party having a right to disclose such information without breach of any confidentiality obligation by such third party; or (d) developed by a party independent of any disclosure hereunder, as evidenced by written records. Each party shall maintain all of the other party's Confidential Information in strict confidence and will protect such information with the same degree of care that such party exercises with its own Confidential Information, but in no event less than a reasonable degree of care. If a party suffers any unauthorized disclosure, loss of, or inability to account for the Confidential Information of the other party, then the party to whom such Confidential Information was disclosed shall promptly notify and cooperate with the disclosing party and take such actions as may be necessary or reasonably requested by the disclosing party to minimize the damage that may result therefrom. Except as provided in this Agreement, a party shall not use or disclose (or allow the use or disclosure of) any Confidential Information of the other party without the express prior written consent of such party. If a party is legally required to disclose the Confidential Information of the other party, the party required to disclose will, as soon as reasonably practicable, provide the other party with written notice of the applicable order or subpoena creating the obligation to disclose so that such other party may seek a protective order or other appropriate remedy. In any event, the party subject to such disclosure obligation will only disclose that Confidential Information which the party is advised by counsel as legally required to be disclosed. In addition, such party will exercise reasonable efforts to obtain assurance that confidential treatment will be accorded to such Confidential Information. Access to and use of any Confidential Information shall be restricted to those employees and persons within a party's organization who have a need to use the information to perform such party's obligations under this Agreement or, in the case of HPSM, to make use of the services, and are subject to a contractual or other obligation to keep such information confidential. A party's consultants and subcontractors may be included within the meaning of "persons within a party's organization," provided that such consultants and subcontractors have executed confidentiality agreements with provisions no less stringent than those contained in this section. Such signed agreements shall be made available to the other party upon its request. Additionally, HPSM, may, in response to a request, disclose FHS Confidential Information to a regulator or other governmental entity with oversight authority over HPSM, provided HPSM (i) first informs FHS of the request, and (ii) requests the recipient to keep such information confidential. All of a party's Confidential Information disclosed to the other party, and all copies thereof, are and shall remain the property of the disclosing party. All such Confidential Information and any and all copies and reproductions thereof shall, upon request of the disclosing party or the expiration or termination of this Agreement, be promptly returned to the disclosing party or destroyed (and removed from the party's computer systems and electronic media) at the disclosing party's direction, except that to the extent any Confidential Information is contained in a party's backup media, databases and email systems, then such party shall continue to maintain the confidentiality of such information and shall destroy it as soon as practicable and, in any event, no later than required by such party's record retention policy. In the event of any destruction hereunder, the party who destroyed such Confidential Information shall provide to the other party written certification of compliance therewith within fifteen (15) days after destruction.

J. **Conflicts of Interest** – FHS shall ensure that its personnel do not have any conflicts of interest with respect to HPSM's "Conflict of Interest" policy including activities or relationships with other persons or entities that may result in a person or entity being unable or potentially unable to render impartial assistance or advice to HPSM or any Member or CCS Applicant, or the person's objectivity in performing the contract work is or might be otherwise impaired, or a person has an unfair competitive advantage.

K. **Inurement** - This Agreement shall be binding upon all assignees, heirs and successors-in-interest of either party.

L. **Assignment** – Neither HPSM nor FHS shall assign this Agreement without the written consent of the other party, and will be void unless prior written approval is obtained by DHCS.

M. **Compliance with Laws** – Parties agree to comply with all applicable State and Federal laws, regulations, and directives by regulatory agencies. It is understood and acknowledged by FHS that HPSM is a public entity and subject to all applicable open meeting and record laws, including but not limited to the California Public Records Act and the Ralph M. Brown Act.

Parties agree to comply with all applicable requirements specified in this Agreement, HPSM's Contract with DHCS (Agreement Number 11-88291), subsequent amendments to either agreement, Federal and State laws and regulations.

N. **Non-Discrimination and Other Requirements**

1. General Non-discrimination - No person shall be denied any services provided pursuant to this Agreement (except as limited by the scope of services) on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information.

2. Equal Employment Opportunity – HPSM and FHS shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. HPSM and FHS's equal employment policies shall be made available to either party upon request.

3. Section 504 of the Rehabilitation Act of 1973 – HPSM and FHS shall comply with Section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified individual with a disability shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of any services this Agreement. This Section applies only to entities who are providing services to members of the public under this Agreement.

4. Compliance with County's Equal Benefits Ordinance - With respect to the provision of benefits to its employees, HPSM and FHS shall comply with Chapter 2.84 of the County Ordinance Code, which prohibits Contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with

a spouse. In order to meet the requirements of Chapter 2.84, HPSM and FHS must certify which of the following statements is/are accurate:

For HPSM:

i. ☑ Entity complies with Chapter 2.84 by offering the same benefits to its employees with spouses and its employees with domestic partners.
ii. ☐ Entity complies with Chapter 2.84 by offering, in the case where the same benefits are not offered to its employees with spouses and its employees with domestic partners, a cash payment to an employee with a domestic partner that is equal to Contractor's cost of providing the benefit to an employee with a spouse.
iii. ☐ Entity is exempt from having to comply with Chapter 2.84 because it has no employees or does not provide benefits to employees' spouses.
iv. ☐ Entity does not comply with Chapter 2.84, and a waiver must be sought.

For FHS:

i. ☑ Entity complies with Chapter 2.84 by offering the same benefits to its employees with spouses and its employees with domestic partners.
ii. ☐ Entity complies with Chapter 2.84 by offering, in the case where the same benefits are not offered to its employees with spouses and its employees with domestic partners, a cash payment to an employee with a domestic partner that is equal to Contractor's cost of providing the benefit to an employee with a spouse.
iii. ☐ Entity is exempt from having to comply with Chapter 2.84 because it has no employees or does not provide benefits to employees' spouses.
iv. ☐ Entity does not comply with Chapter 2.84, and a waiver must be sought.

5. Discrimination Against Individuals with Disabilities - The nondiscrimination requirements of 41 C.F.R. 60-741.5(a) are incorporated into this Agreement as if fully set forth here, and Contractor and any subcontractor shall abide by the requirements of 41 C.F.R. 60–741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

6. History of Discrimination – HPSM and FHS must check one of the two following options, and by executing this Agreement, HPSM and FHS certifies that the option selected is accurate:

For HPSM:

i. ☑ No finding of discrimination has been issued in the past 365 days against HPSM or FHS by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or any other investigative entity.
ii. ☐ Finding(s) of discrimination have been issued against HPSM or FHS within the past 365 days by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or other investigative entity. If this box is checked, HPSM and FHS shall provide to the other party a written explanation of the outcome(s) or remedy for the discrimination.

For FHS:

iii. ☑ No finding of discrimination has been issued in the past 365 days against HPSM or FHS by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or any other investigative entity.

iv. ☐ Finding(s) of discrimination have been issued against HPSM or FHS within the past 365 days by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or other investigative entity. If this box is checked, HPSM and FHS shall provide to the other party a written explanation of the outcome(s) or remedy for the discrimination.

7. Reporting; Violation of Non-discrimination Provisions – HPSM and FHS shall report to the County Manager the filing in any court or with any administrative agency of any complaint or allegation of discrimination on any of the bases prohibited by this Section of the Agreement or Section 12, above. Such duty shall include reporting of the filing of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission, or any other entity charged with the investigation or adjudication of allegations covered by this subsection within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include a general description of the circumstances involved and a general description of the kind of discrimination alleged (for example, gender-, sexual orientation-, religion-, or race-based discrimination).

   Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject HPSM or FHS to penalties, to be determined by the County Manager, including but not limited to the following:

   i. termination of this Agreement;
   ii. disqualification of HPSM from being considered for or being awarded a County contract for a period of up to 3 years;
   iii. liquidated damages of $2,500 per violation; and/or
   iv. imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

   To effectuate the provisions of this Section, the County Manager shall have the authority to offset all or any portion of the amount described in this Section against amounts due to HPSM or FHS under this Agreement or any other agreement between HPSM and FHS.

O. **Compliance with County Employee Jury Service Ordinance** – HPSM and FHS shall comply with Chapter 2.85 of the County's Ordinance Code, which states that HPSM and FHS shall have and adhere to a written policy providing that its employees, to the extent they are full-time employees and live in San Mateo County, shall receive from HPSM and FHS, on an annual basis, no fewer than five days of regular pay for jury service in San Mateo County, with jury pay being provided only for each day of actual jury service. The policy may provide that such employees deposit any fees received for such jury service with HPSM or FHS, or that HPSM or FHS may deduct from an employee's regular pay the fees received for jury service in San Mateo County. By signing this Agreement, HPSM and FHS certifies that it has and adheres to a policy consistent with Chapter 2.85. For purposes of this Section, if HPSM and FHS has no employees in San Mateo County, it is sufficient for HPSM and FHS to provide the following written statement to

County: "For purposes of San Mateo County's jury service ordinance, Contractor certifies that it has no full-time employees who live in San Mateo County. To the extent that it hires any such employees during the term of its Agreement with San Mateo County, Contractor shall adopt a policy that complies with Chapter 2.85 of the County's Ordinance Code." The requirements of Chapter 2.85 do not apply if this Agreement's total value listed Section 3, above, is less than one-hundred thousand dollars ($100,000), but HPSM and FHS acknowledges that Chapter 2.85's requirements will apply if this Agreement is amended such that its total value meets or exceeds that threshold amount.

P. **Independent Contractor** - The relationship between HPSM and FHS is an independent contractor relationship. Neither FHS nor its employee(s) and/or agent(s) shall be considered to be an employee(s) and/or agent(s) of HPSM, and neither HPSM nor any employee(s) and/or agent(s) of HPSM shall be considered to be an employee(s) and/or agent(s) of FHS. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

Q. **Invalidity and Severability** - In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

R. **Electronic Signature**
If both HPSM and FHS wish to permit this Agreement and future documents relating to this Agreement to be digitally signed in accordance with California law and San Mateo County Health System's Electronic Signature Administrative Memo, both boxes below must be checked. Any party that agrees to allow digital signature of this Agreement may revoke such agreement at any time in relation to all future documents by providing notice pursuant to this Agreement.

For HPSM: ☑ If this box is checked by HPSM, HPSM consents to the use of electronic signatures in relation to this Agreement.

For FHS: ☑ If this box is checked by FHS, FHS consents to the use of electronic signatures in relation to this Agreement.

Signatures on Following Page

By signing below, I affirm that I am the duly authorized representative of the signing party and have authority to execute and bind the party for which I affix my signature.

Health Plan of San Mateo

Signature	Name	Title
	Maya Altman	Chief Executive Officer

Dated: November 4, 2015

County of San Mateo, Health System, Family Health Services

Signature	Name	Title

Dated: _____

Exhibit A
Scope of Work

A. Project Overview

1. Service Overview

   The Contractor agrees to provide to the Department of Health Care Services (DHCS) the services described herein:

   Provide health care services to eligible Medi-Cal recipients within the scope of Medi-Cal benefits as defined in the contents of this Contract.

2. Service Location

   The services shall be performed at all contracting and participating facilities of the Contractor.

3. Service Hours

   The services shall be provided during normal Contractor working days and hours, excluding national and State holidays.

4. Project Representatives

   The project representatives during the term of this Contract will be:

Department of Health Care Services Systems of Care Division Attention: Louis Rico Telephone: (916) 327-1400 Fax: (916) 327-1106 Email: Louis.Rico@dhcs.ca.gov	**San Mateo Health Commission** **dba: Health Plan of San Mateo** Attention: Maya Altman Telephone: (650) 616-0050 Fax: (650) 616-8038 Email: maya.altman@hpsm.org

   Direct all inquiries to:

Department of Health Care Services Systems of Care Division Attention: Contract Manager 1515 K Street, Suite 400, MS 8100 P.O. Box 997413 Sacramento, CA 95899-7413 Telephone: (916) 327-1400 Fax: (916) 327-1106 Email: Louis.Rico@dhcs.ca.gov	**San Mateo Health Commission** **dba: Health Plan of San Mateo** Attention: Larisa Beckwith 701 Gateway Blvd, Suite 400 South San Francisco, CA 94080 Telephone: (650) 616-2873 Fax: (650) 616-8038 Email: larisa.beckwith@hpsm.org

   Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this Contract.

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B. Family-Centered Care

1. Parental Involvement

   The Contractor shall ensure that delivery of medically necessary health care is done in ways that supports the development of trusting relationships between Providers and family members. Consideration must be given to factors such as promoting continuity of Providers and allowing adequate time at visits to encourage Provider-family dialogue and the management of care coordination issues.

   The Contractor may not prohibit, or otherwise restrict, Health Care Practitioners (HCP) acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient.

   The Contractor shall ensure that the list of core elements of family-centered care are integrated into Provider practices:

   a. Respect and dignity: HCPs listen to and honor patient and family perspectives and choices.

   b. Information Sharing: HCPs communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

   c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at all levels.

   d. Collaboration: HCPs collaborate with patients and families at all levels of health care, including: Care of an individual child; program development, implementation and evaluation; and policy formation.

2. Transition Planning

   The Contractor will ensure that all enrollees, with a medical condition expected to last beyond the twenty-first (21) birthday, receive the services necessary to make transitions to adult health care as seamless as possible. It will be necessary to work with enrollees and their families to prepare them for how their future health care needs will be met once eligibility for the California Children's Services (CCS) program ceases at the twenty-first (21) birthday.

   The Contractor will ensure that enrollees will have a transition plan completed on an annual basis beginning at fourteen (14) years of age, prepared in conjunction with the enrollees and family.

   The Contractor will work with the enrollees' family to ensure that families have considered applying for conservatorship for the enrollees prior to their eighteenth (18^{th}) birthday.

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C. Service Network and Access to Care

1. General

The Contractor shall ensure and monitor appropriate and timely access of enrollees to CCS approved Providers with the necessary expertise to provide comprehensive care, including the prevention, diagnosis and treatment of the full range of medical conditions experienced by enrollees with CCS-eligible medical conditions, pursuant to Title 28 California Code of Regulations (CCR) Sections 1300.67.2 and 1300.67.2.2. The Contractor will implement and maintain procedures to ensure that enrollees have access to routine primary care, periodic health assessments, urgent care, specialist care, inpatient care, emergency care, minor consent, and sensitive services for adolescents.

a. Preventive Care

The Contractor will maintain and operate a system of care which ensures the provision of preventive care including, but not limited to, immunizations, growth and development assessments, appropriate health screening, health care supervision and patient and parental counseling about health and psychosocial issues.

b. Primary Care

The Contractor shall provide access to health care services twenty-four (24) hours per day, seven (7) days per week, through a system which includes direct access to the enrollee's identified Personal Physician or the Physician's designee, who shall provide medical triage and management of the identified problems, including appropriate and timely referral for care. Recorded messages are unacceptable for this purpose.

c. Specialty Care

1) The Contractor shall maintain adequate numbers and types of CCS-approved Providers to ensure that all medically necessary specialty services are made available to enrollees in a timely manner.

2) The Contractor shall ensure that enrollees are referred to the appropriate CCS-approved special care center for medical management and coordination of multispecialty, multidisciplinary coordinated care when the enrollee has a CCS-eligible medical condition that includes, but is not limited to:

a) Congenital heart disease;

b) Cardiac conditions, such as cardiac myopathies or valvular disorders;

c) Metabolic disorders;

d) Chronic renal disease;

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Scope of Work

e) Cystic fibrosis and chronic pulmonary disease;

f) Malignant neoplasms;

g) Hemophilia;

h) Hemoglobinopathies;

i) Craniofacial anomalies, including cleft palate;

j) Endocrine disorders, including diabetes;

k) Human immunodeficiency virus (HIV), or other acquired and/or congenital immune deficiency disease;

l) Gastrointestinal conditions with complex medical/nutritional requirements;

m) Sensorineural hearing loss;

n) Limb defects and other disorders requiring intensive rehabilitation;

o) Meningomyelocele;

p) Rheumatic and connective tissue disorders; or

q) Infants discharged from a CCS-approved Neonatal Intensive Care Unit (NICU) at risk for developing a developmental disability and meeting the eligibility criteria for the CCS High Risk Infant Follow-Up (HRIF) program.

d. Emergency and After Hours Care

1) The Contractor will maintain a system able to provide:

a) Twenty-four (24) hours, seven (7) days per week, telephone access for families of enrollees in the Demonstration Project (DP) to personnel qualified to provide advice and triage access to emergency services. Recorded messages are unacceptable for this purpose.

b) Twenty-four (24) hours, seven (7) days per week, telephone access by Providers to obtain service authorization for medically necessary, non-emergency care.

2) The Contractor will maintain (directly or through subcontract and/or referral) sufficient numbers of inpatient hospitals, service sites and qualified personnel to ensure provision of all medical care necessary under emergency circumstances.

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a) The Contractor shall have, as a minimum, a designated emergency service facility, providing care on a twenty-four (24) hours, seven (7) days per week basis. This designated emergency service facility will have one or more Physicians and one nurse on duty in the facility at all times.

3) An appropriately qualified HCP working under the supervision of the DP's Medical Director shall be available twenty-four (24) hours per day and responsible for the timely authorization of medically necessary emergency care. The HCP, working with the Medical Director, shall coordinate the transfer of stabilized children from emergency departments (including those in the Provider network and non-Contractor emergency departments) and admission to the appropriate facility for inpatient care, as necessary.

4) The Contractor shall develop and maintain protocols for communicating and interacting with emergency departments in the designated geographic service area, which will include, at a minimum:

a) Procedures for emergency departments to report system and/or protocol failures and the process for ensuring corrective action.

b) Referral procedures (including after-hours instruction) which emergency department personnel can provide to families of enrollees who are present at the emergency department for non-emergency services.

e. Appointment Availability/Waiting Time

The Contractor must adhere to the following time frames in implementing the system of care:

1) All non-symptomatic office visits, (e.g., routine wellness/preventive care appointments, periodic visits for medication or management review, shall be available to the enrollee/family within ten (10) calendar days of request).

2) Symptomatic office visits which are non-emergent in nature shall be available within twenty-four (24) hours of request. Such visits may include care for symptoms or diagnoses which may or may not be related to the treatment of the CCS-eligible medical condition; such as, upper respiratory infection in an enrollee with moderately severe asthma, ear pain in an enrollee with cleft lip, and palate.

3) Urgent care appointments for conditions such as recurring high fever, moderate to severe nonspecific pain, hematuria or dyspnea, shall be available on a same day basis.

4) Emergency services shall be available seven (7) days per week, twenty-four (24) hours per day within thirty (30) minutes travel time from the enrollee's home. Emergency services shall not be subject to prior authorization by the DP.

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2. Provider Network

The Contractor shall maintain and submit a complete network of CCS-approved health care Providers and health care facilities. For Primary Care Physicians, Board Certification/Board Eligibility is acceptable in place of CCS approval. The network shall provide the full scope of benefits required of children enrolled in the DP and shall ensure access to these Providers. The Contractor shall ensure that the treatment of the enrollee's medical care is performed by CCS-approved and/or Board Certified/Board eligible Providers. The Contractor will monitor and increase the capacity of the network as necessary to accommodate enrollment growth. The Provider network shall include:

a. Primary Care Physicians

The Primary Care Physicians (PCPs) include CCS-approved and/or Board Certified/Board Eligible Pediatricians and Family Physicians and for enrollees age fourteen (14) and older, CCS-approved and/or Board Certified/Board Eligible Internists.

b. Pediatric Medical Specialties and Subspecialties

CCS-approved Physicians in the following pediatric medical specialties and subspecialties: adolescent medicine, behavioral/developmental pediatrics, cardiology, critical care medicine, endocrinology, gastroenterology, hematology-oncology, infectious disease, neonatology, nephrology, neurology, neurodevelopmental pediatrics, physical medicine and rehabilitation, psychiatry, pulmonology and rheumatology.

The Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with 22 CCR 53853(a) and California Welfare and Institutions (W&I) Code, Section 14182(c)(2).

c. Pediatric Surgical Specialties and Subspecialties

The CCS-approved Physicians in the following pediatric surgical specialties and subspecialties include cardiac surgery, otolaryngology, pediatric surgery, and urology.

d. Other Physician Providers

CCS-approved Physicians specializing in allergy and immunology, dermatology, neurosurgery, obstetrics and gynecology, ophthalmology, oral and maxillofacial surgery, orthopedics, otolaryngology, plastic surgery, thoracic surgery and urology.

e. The Contractor shall work with enrollees and their families to ensure that existing Provider relationships can continue, to the maximum extent possible if the CCS-approved Provider is not in the designated Provider network.

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f. Other Health Care Professionals

Other health care professionals with experience in treating enrollees with CCS-eligible medical conditions and their families, including, but no limited to, CCS-approved genetic counselors, marriage and family therapists, occupational therapists, physical therapists, speech and language pathologists, audiologists, dietitians, registered nurses (RN), psychologists and medical social workers/licensed clinical social workers (LCSW).

g. Hospital Facilities

CCS-approved inpatient hospital facilities that are capable of providing a full range of medically necessary hospital care appropriate to an enrollee's CCS-eligible medical conditions. The facilities must include CCS-approved tertiary hospitals in the DP's geographic service area.

h. Inpatient Special Care Centers

CCS-approved inpatient Special Care Centers (SCCs) including NICU, Pediatric Intensive Care Units and Pediatric Rehabilitation Centers. The NICUs must include, at a minimum, CCS-approved regional NICUs in the DP's geographic service area.

i. Outpatient Special Care Centers

CCS-approved outpatient Special Care Centers (SCCs) including:

1) Amputee Centers;

2) Bone Marrow Transplant Centers;

3) Burn Centers;

4) Cardiac Centers;

5) Communication Disorder Centers (CDC), Type C;

6) Craniofacial Centers;

7) Cystic Fibrosis and Pulmonary Disease Centers;

8) Gastrointestinal Centers;

9) Heart and Lung Transplant Centers;

10) Heart Transplant Centers;

11) Hematology/Oncology Centers;

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12) Hemophilia Centers,

13) HRIF Centers;

14) Immunology/Infectious Disease Centers;

15) Liver Transplant Centers,

16) Metabolic (including phenylketonuria) and Endocrine Centers;

17) Prosthetic/Orthotic Centers;

18) Renal Dialysis and Transplant Centers;

19) Rheumatology Disease Centers;

20) Selective Posterior Rhizotomy Centers;

21) Sickle Cell Disease Centers;

22) Specified Inherited Neurological Diseases Centers; and

23) Spina Bifida Centers.

j. Other Healthcare Providers

1) Licensed by the State of California

Pharmacies, hearing aid dispensers, home health agencies, durable medical equipment vendors, clinical diagnostic laboratories, medical supply vendors, and medical imaging (radiology, ultrasound, and magnetic resonance imaging) centers.

2) Prosthetists and Orthotists, certified by either the Board of Certification/Accreditation (in Orthotics and Prosthetics) or the American Board for Certification (in Orthotics, Prosthetics and Pedorthics).

k. Provider to Member Ratios

1) The Contractor shall ensure that networks continuously satisfy the following full-time equivalent Provider to Member ratios:

a) PCPs 1:2,000

b) Total Physicians 1:1,200

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l. Specialists

The Contractor shall provide accessibility to medically required specialists who possess a copy of a valid diploma or certificate of satisfactory completion of a specialty residency or fellowship program accredited by the Accreditation Council of Graduate Medical Education, through contracting or referral. The Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with W&I Code, Section 14182(c)(2). The Contractor shall provide a record/tracking mechanism for each authorized, denied, or modified referral. In addition, the Contractor shall offer second opinions by specialists to any Member upon request.

m. Network Provider Availability

The Contractor shall ensure that network Providers offer hours of operation to Members that are no less than the hours of operation offered to other patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries, if the Provider serves only Medi-Cal beneficiaries.

n. Out-of-Network Providers

If the Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, the Contractor must adequately and timely cover these services out of network for the Member, for as long as the Contractor is unable to provide them.

Out-of-network Providers must coordinate with the Contractor with respect to payment. The Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

o. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service Facilities (IHSF)

The Contractor shall meet federal requirements for access to FQHC services, including those in 42 United States Code (USC) 1396b(m).

1) FQHCs Availability and Reimbursement Requirement

a) If FQHC services are not available in the Contractor's Provider network or the Provider network of another Medi-Cal Managed Care Health Plan in the service area, the Contractor shall reimburse non-contracting FQHCs for services provided to the Contractor's Members at a level and amount of payment that is not less than the Contractor expense for the same scope of services furnished by a Provider that is not a FQHC or RHC, except emergency services rendered by a non-contracting FQHC or RHC.

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b) If FQHC services are not available in the Contractor's Provider network, but are available within any other Medi-Cal Managed Care Plan's Provider network in the service area, unless authorized by the Contractor, the Contractor shall not be obligated to reimburse non-contracting FQHCs for services provided to the Contractor's Members, except emergency services rendered by a non-contracting FQHC or RHC.

2) FQHC/RHC

The Contractor shall submit to California Department of Health Care Services (DHCS), within thirty (30) calendar days of a request and in the form and manner specified by DHCS, the services provided, the reimbursement level, and the amount for each of the Contractor's FQHC and RHC subcontracts. The Contractor shall certify in writing to DHCS within thirty (30) calendar days of DHCS' written request that, pursuant to W&I Code, Section 14087.325(b) and (d), FQHC and RHC subcontract terms and conditions are the same as offered to other subcontractors providing a similar scope of service and that reimbursement is not less than the level and amount of payment that the Contractor makes for the same scope of services furnished by a Provider that is not a FQHC or RHC. The Contractor is not required to pay FQHCs and RHCs the Medi-Cal per visit rate for that facility. At its discretion, DHCS reserves the right to review and audit the Contractor's FQHC and RHC reimbursement to ensure compliance with state and federal law and shall approve all FQHC and RHC subcontracts consistent with the provisions of W&I Code, Section 14087.325(h).

To the extent that IHSFs qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to subcontracts with IHSFs.

3) IHSF

The Contractor shall reimburse IHSFs for services provided to Members who are qualified to receive services from an IHSF as set forth in 42 USC 1396u-2(h)(2), Title V of the American Recovery and Reinvestment Act of 2009, Section 5006, and, insofar as they do not conflict with federal law or regulations, the reimbursement options set forth in 22 CCR 55140(a).

p. Nondiscrimination in Provider Contracts

The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of practice of their license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include individual or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision. The Contractor's Provider selection policies must not discriminate against Providers that serve high-risk populations or specialize in conditions requiring costly treatment. This section shall not be construed to require the Contractor to contract with Providers beyond the number necessary to meet the needs of the Contractor's Members; preclude

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the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with the Contractor's responsibilities to Members.

q. Excluded Providers

All Providers of covered services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All Providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and have a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in the Contractor's Provider network.

r. Provider Grievance

The Contractor shall have a formal procedure to accept, acknowledge, and resolve Provider grievances. A Provider of medical services may submit to the Contractor a grievance concerning the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to contracting, subcontracting, and non-contracting Providers.

s. Provider Termination

Pursuant to 42 CFR 438.10(f)(5), the Contractor shall make a good faith effort to give written notice of termination of a contracted Provider within fifteen (15) days after receipt or issuance of the termination notice to each Member who received their primary care from, or was seen on a regular basis by, the terminated Provider.

t. Provider Manual

The Contractor shall issue a Provider manual and updates to the Providers of Medi-Cal services. The manual and updates shall serve as a source of information to contracting and subcontracting health care Providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member grievance, appeal, and State fair hearing process. The Provider manual shall include the following Member's rights information:

1) Member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing;

2) Member's right to file grievances and appeals and their requirements and timeframes for filing;

3) Availability of assistance in filing;

4) Toll-free numbers to file oral grievances and appeals; and

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5) Member's right to request continuation of benefits during an appeal or State fair hearing.

u. Provider Network Report

The Contractor shall submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Provider network. The report can be incorporated in the current network reporting done by Contractor.

The report shall be submitted at a minimum:

1) Quarterly

2) At the time of a significant change to the network affecting Provider capacity and services, including:

   a) Change in services or benefits;

   b) Geographic service area or payments; or

   c) Enrollment of a new population.

3) The report shall identify number of Providers providing primary care services, Provider deletions and additions, and the resulting impact to:

   a) Geographic access for Members;

   b) Cultural and linguistic services including Provider and Provider staff language capability;

   c) The number of Members assigned to each Provider; and

   d) The network Providers who are not accepting new patients.

4) The Contractor shall submit the report thirty (30) calendar days following the end of the reporting quarter.

v. Subcontracts

The Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. The Contractor shall evaluate the prospective subcontractor's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 438.230(b)(3), (4) and 22 CCR 53867 and this Contract.

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1) Laws and Regulations – All subcontracts shall be in writing and in accordance with the requirements of the 42 CFR 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, California Health and Safety (H&S) Code, Section 1340 et seq., 28 CCR 1300 et seq., W&I Code, Section 14200 et seq., and other applicable federal and state laws and regulations.

2) Subcontract Requirements

   Each subcontract shall contain:

   a) Specification of the services to be provided by the subcontractor.

   b) Specification that the subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract.

   c) Specification that the subcontract or amendments entered into by the Contractor which is not a federally qualified health maintenance organization (HMO) shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed subcontract and has failed to approve or disapprove the proposed subcontract within sixty (60) calendar days of receipt. Subcontract amendments shall be submitted to DHCS for prior approval at least (30) days before the effective date of any proposal governing compensation, services or term.

   d) Specification of the term of the subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.

   e) Language comparable to 3.d. for those subcontractors at risk for non-contracting emergency services.

   f) The subcontractor's agreement to submit reports as required by Contractor.

   g) The subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination or copying:

      i. By DHCS, Department of Health and Human Services (DHHS), Department of Justice (DOJ), and Department of Managed Health Care (DMHC).

      ii. At all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California.

      iii. In a form maintained in accordance with the general standards applicable to such book or record keeping.

      iv. For a term of at least five (5) years from the close of the current fiscal year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

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v. Including all encounter data for a period of at least five (5) years.

h) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

i) The subcontractor's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the sub-subcontractor:

i. Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHCS, DHHS, DOJ and DMHC.

ii. Retain such books and records for a term of at least five (5) years from the close of the current fiscal year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

j) The subcontractor's agreement to assist the Contractor in the transfer of care pursuant to Exhibit E, Provision 49 (Phaseout Requirements), in the event of Contract termination.

k) The subcontractor's agreement to assist the Contractor in the transfer of care in the event of subcontract termination for any reason.

l) The subcontractor's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

m) The subcontractor's agreement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS.

n) The subcontractor's agreement to hold harmless both the State and Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the subcontract.

o) The subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the subcontractor's possession, in accordance with Exhibit E, Provision 25 (Records Related to Recovery for Litigation).

p) The subcontractor's agreement to provide interpreter services for Members at all provider sites.

q) The subcontractor's right to submit a grievance and the Contractor's formal process to resolve provider grievances.

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r) The subcontractor's agreement to participate and cooperate in the Contractor's quality improvement system.

s) The subcontractor's agreement to comply with all applicable requirements specified in this Contract and subsequent amendments, Federal and State laws and regulations.

t) Pursuant to H&S Code Section 1261, the subcontractor's agreement by any subcontracting or sub-subcontracting health facility, if the subcontractor is licensed pursuant to H&S Code Section 1250, to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

u) The subcontractor's agreement to provide the Contractor with the disclosure statement set forth in 22 CCR 51000.35, prior to commencing services under the subcontract.

30 calendar days

3) Departmental Approval – Federally Qualified HMOs

Except as provided in section C.1.o. regarding FQHC and RHCs, subcontracts entered into by the Contractor which is a federally qualified HMO shall be exempt from prior approval by DHCS and submitted to DHCS upon request.

4) Public Records

Subcontracts entered into by the Contractor and all information received in accordance with this subsection will be public records on file with DHCS, except as specifically exempted in statute. DHCS shall ensure the confidentiality of information and contractual provisions filed with DHCS to the extent they are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. The names of the officers and owners of the subcontractor, stockholders owning more than five (5%) percent of the stock issued by the subcontractor and major creditors holding more than five (5%) percent of the debt of the subcontractor will be attached to the subcontract at the time the subcontract is presented to DHCS.

w. Network Capacity

The Contractor shall maintain a provider network adequate to serve one hundred percent (100%) of all eligible CCS enrollees in the proposed county and provide the full scope of benefits. This includes:

1) The anticipated Medicaid enrollment,

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2) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP,

3) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services,

4) The numbers of network providers who are not accepting new Medicaid patients,

5) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

3. Provider Reimbursement

a. The Contractor shall compensate all network Providers as the Contractor and Provider negotiate and agree on compensation for services rendered.

1) The Contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition. Further, the Contractor may not deny payment for treatment obtained when a representative of the Contractor instructs the enrollee to seek emergency services.

2) The Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, the Contractor, or DHCS of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services. An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to provide stabilization.

b. The Contractor shall maintain procedures for prepayment and post payment claims review, including review of data specific to the Provider, enrollee and covered services for which payment is claimed.

c. The Contractor shall maintain sufficient claims processing/tracking/payment systems capability to comply with applicable state and federal law, regulations and contractual requirement, determine the status of received claims and calculate the estimate for incurred and unreported claims.

d. The Contractor shall reimburse for emergency services received by an enrollee from non-contracting Providers for treatment of an emergency medical condition until the enrollee's condition has stabilized sufficiently to permit discharge and/or referral and transfer in accordance with instructions from the Contractor. The attending Emergency Physician, or the Provider treating the enrollee is responsible for determining when the

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enrollee is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency services shall not be subject to prior authorization by the Contractor.

e. Disputed emergency services claims may be disputed through Contractor's Provider Dispute Resolution Process.

f. Physician Incentive Plans (PIP) - Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP) contracts must provide for compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210.

g. Prohibition – The Contractor may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a Physician or Physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

h. Disclosure to State – The disclosure to the State includes the following:

   1) The Contractor must report whether services not furnished by Physician/group are covered by an incentive plan. No further disclosure required if a PIP does not cover services not furnished by Physician/group.

   2) The Contractor must report the type of incentive arrangement, (e.g., withhold, bonus, capitation).

   3) The Contractor must report the percent of withhold or bonus (if applicable).

   4) The Contractor must report the panel size, and if patients are pooled, the approved method used.

   5) If the Physician/group is at substantial financial risk, the Contractor must report proof the Physician/group has adequate stop loss coverage, including amount and type of stop-loss.

i. Substantial Financial Risk – If the Physician/group put a substantial financial risk for services not provided by Physician/group, the Contractor must ensure adequate stop-loss protection to individual Physicians and conduct annual enrollee surveys.

j. Disclosure to Beneficiaries – The Contractor must provide information on its PIP to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a PIP).

k. Disclosure to State – Survey – If the Contractor is required to conduct beneficiary survey, survey results must be disclosed to the State and, upon request, disclosed to beneficiaries.

l. Prohibited Claims

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Except in specified circumstances, the Contractor and any of its affiliates and subcontractors shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract to a Medi-Cal Member. Collection of claim may be made under those circumstances described in 22 CCR 53866, 53220, and 53222.

The Contractor shall not hold Members liable for the Contractor's debt if the Contractor becomes insolvent. In the event the Contractor becomes insolvent, the Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

m. Contractor Risk in Providing Services

For all non-contracting Providers, reimbursement by the Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered by a non-contracting Provider pursuant to this provision shall be made in accordance with 42 USC 1396u-2(b)(2)(D), and W&I Code, Section 14091.3.

4. Specific Requirements (Medical Professionals)

a. Physician Credentialing

The Contractor will develop and maintain written policies and procedures for credentialing, re-credentialing, recertification and reappointment of Providers in its network. The Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. The Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body. In accordance with W&I Code, Section 14182.2(b)(5), the Contractor shall ensure that children enrolled in the model receive care for their CCS-eligible medical conditions from CCS-approved and/or Board Certified/Board Eligible Providers (in the case of Primary Care Providers) consistent with the CCS standards of care.

As defined in Section B.2.a-d., these Physician Providers are all CCS-approved and/or Board Certified/Board Eligible (in the case of Primary Care Providers) in the appropriate specialty or subspecialty.

1) The initial credentialing process for Physicians will include verification of all of the following information:

a) Current valid licensed to practice in the State of California by the Medical Board of California or the Board of Osteopathic Medicine;

b) Current Drug Enforcement Agency registration;

c) Graduation from medical school, completion of a residency, board certification or board eligible, as applicable;

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d) Enrollment as a Child Health and Disability Prevention (CHDP) Provider if serving as a Primary Care Physician with the intent to provide primary and preventive health care services;

e) Work history;

f) Current, adequate professional liability coverage and claims history; and

g) Information from the National Practitioner Data Bank (NPDB).

h) Enrollment as a Medi-Cal Provider and history of any sanctions imposed by Medi-Cal, Medicaid or Medicare. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in the Contractor's Provider network.

i) Sanctions or limitations on licensure from State agencies or licensing boards.

j) A signed statement by the Provider at the time of application regarding any physical or mental health problems, any history of chemical dependency/substance abuse, history of loss of license and/or felony convictions, history of loss or limitation of privileges or disciplinary actions.

k) NPI verification.

2) If the Provider has hospital clinical privileges, the initial credentialing shall include a review of the Provider's past history of curtailment or suspension of medical staff privileges.

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b. Re-Credentialing

1) The Contractor must ensure that network Physicians are credentialed every three (3) years. The process must include re-verification of all of the following:

a) Licensure;

b) Board certification;

c) Admitting privileges at a CCS-approved hospital, if so indicated at the time of the initial participation in the network;

d) Malpractice insurance;

e) Valid Drug Enforcement Agency Certificate;

f) NPDB Information;

g) Medi-Cal, Medicaid or Medicare sanctions; and sanctions or limitations on licensure from State agencies and licensing boards. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in the Contractor's Provider network; and

h) NPI verification.

2) The process must include a signed and dated application that includes an attestation as to the correctness and completeness of the information.

3) Re-credentialing must also include documentation that the Contractor has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member complaints and medical records reviews.

c. Personal Physician

1) Each enrollee shall be assigned a network Personal Physician (PP) during the enrollment process. The PP may be a PCP, a pediatric medical specialist or subspecialist appropriate to the child's CCS-eligible medical condition.

2) The PP will assume the responsibility for directly overseeing all aspects of the enrollee's health care. The latter includes primary care, preventive services, assessment, diagnosis and treatment of illness and conditions unrelated to the treatment of the CCS-eligible medical condition; determining the medical services necessary to correct, treat and/or ameliorate the enrollee's CCS-eligible medical condition, working with the family to develop the care plan; working with the assigned Care Coordinator (CC) to assure appropriate referral and arranging access to Pediatric Specialists and subspecialists and other services as needed; and

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participating in all aspects of the case management system including multidisciplinary care conferences.

d. Provider Education and Quality Assurance

The Contractor will be responsible for assuring that assigned PCPs have received the training necessary to fulfill their roles and responsibilities. Specifically, the Contractor shall have written policies and procedures pertaining as to how the Provider network will be informed/educated regarding the DP's requirements and how compliance with the stated standards will be monitored and an effective action plan implemented if the standards are not met. The Contractor must disseminate the policies and procedures to all affected providers (this may be accomplished through the provider contract and Contractor's Provider Manual) and, upon request, to enrollees and potential enrollees.

5. Access Requirements

The Contractor shall establish acceptable accessibility requirements in accordance with 28 CCR 1300.67.2 and as specified below. DHCS will review and approve requirements for reasonableness. The Contractor shall ensure that contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the Provider serves only Medi-Cal Members. The Contractor shall communicate, enforce, and monitor Providers' compliance with these requirements.

a. Appointments

The Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. The Contractor shall also include procedures for follow-up on missed appointments.

b. First Prenatal Visit

The Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

c. Waiting Times

The Contractor shall develop, implement, and maintain a procedure to monitor waiting times in Provider offices, telephone calls (to answer and return), and time to obtain various types of appointments.

d. Telephone Procedures

The Contractor shall require Providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

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e. After Hours Calls

At a minimum, the Contractor shall ensure that a Physician or an appropriate licensed professional under their supervision is available for after-hours calls.

f. Specialty Services

The Contractor shall arrange for the provision of specialty services from specialists outside the network if unavailable within the Contractor's network, when determined medically necessary.

g. Access Standards

The Contractor shall ensure the provision of acceptable accessibility standards in accordance with 28 CCR 1300.67.2.2 and as specified below. The Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

1) Appropriate Clinical Timeframes

The Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

2) Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

a) Urgent care appointment for services that do not require prior authorization – within forty-eight (48) hours of a request;

b) Urgent appointment for services that do require prior authorization – within ninety-six (96) hours of a request;

c) Non-urgent primary care appointments – within ten (10) business days of request;

d) Appointment with a specialist – within fifteen (15) business days of request;

e) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within fifteen (15) business days of request.

h. Telephone Access and Response Time

The Contractor shall implement a system which ensures toll-free telephone access to provide information regarding clinical services, to respond timely to concerns and to answer questions pertaining to Member services.

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1) Requests for Medical Advice

The Contractor will develop and maintain a specific toll-free telephone number and procedure for triaging calls from families of enrollees and providing telephone medical advice. The telephone line will be staffed on a twenty-four (24) hours, seven (7) days per week basis by a licensed RN with pediatric experience and training provided by the Contractor.

2) Services Information

The Contractor shall establish a specific toll-free Member services telephone number to assist with questions that families of enrollees may have about the DP's Providers and benefits.

i. Geographic/Physical Access

1) Travel Time

The Contractor must maintain a Provider network with specific training and expertise in care for children with CCS-eligible medical conditions, including Pediatric Specialists in, or close to, the community where enrollees live. An enrollee or the enrollee's family may elect to travel further, but should have the opportunity to receive services in their home community whenever possible.

Coordination and collaboration among the Contractor and local community resources shall be developed to ensure that existing appropriate healthcare delivery systems and supportive services are utilized and that enrollees are not unnecessarily required to change from their usual Provider.

The Contractor shall maintain a network of PPs which are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard.

2) Physical Accessibility

Primary care facilities must be physically accessible as required by federal and state laws, and shall have accessible waiting rooms, hallways, examining rooms, rest rooms and examining tables.

j. Facility Site Review

1) General Requirement

The Contractor shall conduct facility site and medical record reviews on all Personal Provider sites, in accordance with 22 CCR 53230 and 53913.

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The Contractor shall also conduct facility site physical accessibility reviews on PCP sites and all Provider sites in accordance with the W&I Code, 14182(b)(9).

2) Pre-Operational Site Reviews

Since Contractor is a current provider of CCS services, self-certification is acceptable for pre-operational site reviews. All new providers shall be reviewed prior to the provision of services.

k. Linguistic and Cultural Access

The Contractor shall ensure that communication and/or cultural barriers will not inhibit enrollees and their families from obtaining services from the health care system.

1) Linguistic Access and Communication

a) Communication Impairments

The Contractor shall establish methods for communicating effectively with enrollees and their families who have a range of communication-affecting conditions, including cognitive, vision or hearing impairments, to ensure that enrollees and their families can make informed decisions.

Standard informational and/or education materials shall be made available to enrollees and their families in alternative formats, (e.g., written, Braille, audio/video tape, etc.). Sign language interpretation for English speaking hearing impaired individuals shall also be available upon request.

b) Non-English Speaking Enrollees and Families

Interpreter services shall be made available for planned encounters with enrollees or families with limited proficiency in comprehending English to ensure that enrollees and their families are afforded full access to DP services and benefits. In addition, interpretation services shall be made available on an ad hoc basis for unplanned or emergency contacts.

These services shall include the ability to orally translate commonly used medical terminology from English to languages used by enrollees and their families and from the enrollee's or family's language to the English language.

Written materials, including commonly used forms and informational materials, shall be available in languages appropriate to the enrolled population. Sign language interpretation for non-English speaking hearing impaired individuals shall be made available upon request.

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2) Linguistic Services

The Contractor shall comply with 22, CCR, Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) enrollees receive twenty-four (24) hour oral interpreter services at all key points of contact, either through Interpreters or telephone language services.

The Contractor shall provide, at minimum, the following linguistic services at no cost to enrollees/members:

a) Oral interpreters, signers, or bilingual Providers and Provider staff at all key points of contact. These services shall be provided in all languages spoken by enrollees and not limited to those that speak the threshold concentration standards languages.

b) Fully translated written informational materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. The Contractor shall provide translated written informational materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's service area. DHCS will notify the Contractor of the threshold or concentration languages in the Contractor's service area.

c) Referrals to culturally and linguistically appropriate community service programs.

d) Telecommunications Device for the Deaf (TTY/TDD)

3) Access to Culturally Appropriate Care

The Contractor shall provide a mechanism to ensure that health care services provided through the DP are designed and delivered in a manner which is sensitive and responsive to the varying cultural needs of the enrollees and their families.

This mechanism shall, at a minimum, address:

a) Staffing that reflects the racial and ethnic makeup of the population served, and is familiar with the cultural backgrounds of enrollees.

b) Written polices stating the importance of culturally competent care and acknowledging differing cultural definitions of "family" and respecting differing views of medical care.

c) Provision for asking each family who should attend conferences, what kind of translation services are needed, what are the family's concerns and what added assistance is needed to gain access to care.

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d) Provision for working with family and Providers when the enrollee's and/or family's view of the illness and treatment differs substantially from the Physician's.

e) Protocols for defining and removing practices which are found to be barriers to care for enrollees.

l. Access for Disabled Members

All of the Contractor's facilities shall comply with the requirements of Title III of the Access for Disabled Clients Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

m. Civil Rights Act of 1964

The Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d and 45 CFR Part 80) that prohibit recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

n. Federal Nondiscrimination Requirements

The Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC 794) Nondiscrimination under federal grants and programs; 45 CFR 84 Nondiscrimination on the basis of handicap in programs or activities receiving federal financial assistance; 28 CFR 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1972 (regarding education programs and activities); 45 CFR 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

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D. Scope of Services

1. General

   The Contractor shall provide or arrange for all medically necessary covered services for enrollees in the DP. Covered services are those services set forth in 22 CCR, Chapter 3, Article 4, beginning with Section 51301, and 17 CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract.

   These services must include all medically necessary primary and preventive health care services, diagnostic assessments, treatment, rehabilitation and follow-up care in addition to the care coordination and case management that are necessary for the appropriate treatment of the CCS-eligible condition.

2. Medically Necessary Services

   "Medically necessary" services are all covered services that are reasonable and necessary to protect life, prevent significant illness or disability, and alleviate severe pain through the diagnosis or treatment of disease, illness or injury, (22 CCR 51303(a)) or are services necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by a HCP operating within the scope of their practice as long as the services are medical in nature and are not requested solely for the convenience of the beneficiary, family, Physician or another Provider of services (22 CCR 51340(e)(3)(A)).

3. Covered Services

   The Contractor shall provide the following services for CCS clients enrolled in the DP:

   a. Physician Services

      1) Pediatric Preventive Services

         a) Periodic Health Assessments

            The Contractor shall provide preventive health visits for all enrollees at the times specified by the most recent American Academy of Pediatrics periodicity schedule. As part of the periodic preventive visit, all age specific assessments and services required by the CHDP program and the age specific health education and behavioral assessment will be provided as necessary.

         b) Immunizations

            The Contractor shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP).

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Upon U.S. Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, the Contractor shall develop policies and procedures for the provision and administration of the vaccine. Such policies and procedures shall be developed within thirty (30) calendar days of the vaccine's approval date. The Contractor shall cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) program. Policies and procedures must be in accordance with Medi-Cal FFS guidelines issued prior to final ACIP recommendations.

The Contractor shall provide information to all network Providers regarding the VFC program.

c) Blood Lead Screens

The Contractor shall cover and ensure the provision of a blood lead screening test to enrollees at ages one (1) and two (2) in accordance with Title 17, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000.The Contractor shall document and appropriately follow up on blood lead screening test results.

2) Primary Care Services

The Contractor shall cover all primary care services for enrollees. These services shall include, but not be limited to, the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient hospital, home. phone and long-term care).

3) Pediatric Specialist Services

The Contractor shall cover all Pediatric Specialist and subspecialist services as required for the appropriate diagnosis and/or treatment of medical conditions.

4) Laboratory and Radiology Services

Clinical Laboratory Improvement Act (CLIA) – The Contractor shall ensure that all contracted laboratory testing sites have either a CLIA certificate or waiver of a certificate registration along with a CLIA identification number.

b. Inpatient/Outpatient Hospital Services

All medically necessary inpatient and outpatient hospital services are covered for the treatment of acute and chronic illnesses, trauma, maternity care and delivery, medical and surgical procedures and rehabilitative services.

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c. Special Care Center Services

Special Care Center (SCC) services shall be provided for those enrollees whose medical condition and/or complicating conditions require referral to and treatment by a CCS-approved SCC.

1) SCC services are coordinated multidisciplinary, multispecialty team approaches to the assessment and management of enrollees with chronic, complex medical conditions. A center's core team includes a Medical Director (a Specialist in treatment of medical conditions seen at the center), a Nurse Specialist and a Social Worker. A team frequently includes the consultation of a Dietitian as well as other appropriate Pediatric Medical and Surgical Specialists and subspecialists.

2) The services provided by the centers include:

a) Initial and periodic comprehensive outpatient evaluations by HCPs on the center team.

b) Diagnostic services when there is a need to establish the presence of a CCS-eligible condition or the status of an eligible condition.

c) Treatment services provided or requested by CCS-approved Physician team members to manage an enrollee's CCS-eligible condition.

d) Initial and periodic team conferences to coordinate decision making and health care services identified by team members as needed by the enrollee.

e) Periodic reports to the CCS program on status of enrollee and treatment recommendations.

f) Group teaching.

g) Outpatient laboratory and/or radiology services as order by the CCS-approved Physician team members.

d. Emergency Services

1) The following definitions apply to this provision:

a) **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably be expected to result in any of the following:

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i. Placing the patient's health (or in the case of pregnant enrollee, the health of the enrollee or unborn child) in serious jeopardy.

ii. Serious impairment to bodily function.

iii. Serious dysfunction of any bodily organ or part.

b) **Emergency Services** means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish those services and that are needed to evaluate or stabilize an emergency medical condition.

c) **Post-Stabilization Services** means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the enrollee's condition.

2) The Contractor is responsible for coverage and payment of all medically necessary emergency service, including those provided out-of-plan and out-of area; and medical screening stabilization provided in an emergency department, consistent with the Emergency Medical Treatment Active Labor Act.

3) The Contractor will be responsible for authorization and payment of medically necessary emergency services provided by network or non-network Providers. These services will include necessary air or ground transportation. Emergency services will be authorized and reimbursed until such time as the enrollee's condition permits transport to the nearest appropriate participating CCS-approved facility.

e. Services Provided in the Home and Community

1) Home Health Services

Intermittent services by a home health agency as prescribed by the PP and in accordance with a written treatment plan reviewed by the Physician every sixty (60) days, as per 22 CCR 51337:

a) Skilled nursing services by licensed nursing personnel

b) Physical therapy

c) Occupational therapy

d) Speech therapy

e) Home health aide

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f) Respiratory care therapy

g) Medical social services by a medical social worker

2) Shift Nursing Services

The Contractor will provide shift nursing services in the home, up to sixteen (16) hours a day, when it is documented in a treatment plan signed by the PP or treating specialist when:

a) Skilled nursing interventions are required beyond those that may be provided on an intermittent basis, including:

i. Assessment, interpretation, evaluation and monitoring of the enrollee's response to treatment on a frequent or on-going basis;

ii. Frequent need to identify and evaluate clinical changes which may result in ramifications for the enrollee's medical condition, including initiation of appropriate interventions; or,

iii. Additional parent and/or caregiver support needed to follow the care plan for managing the enrollee's medical needs in the home, including development of a training plan.

b) Perform nursing functions such as, but not limited to:

i. Respiratory treatment and/or chest physiotherapy at least three (3) times a day;

ii. Tracheostomy care requiring suctioning;

iii. Chronic/long-term ventilator management;

iv. Parenteral administration of nutritional or pharmaceutical agents by intravenous route;

v. Tube feedings through a nasogastric or gastrostomy tube, by pump for at least eight (8) hours per day, or combinations of tube feedings with oral feedings; or,

vi. Maximum assistance needed with activities of daily living, such as quadriplegic or paraplegic care.

c) Skilled nursing interventions are required to treat and/or manage the enrollee's medical conditions.

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d) There has been an initial evaluation and/or assessment by a RN documenting:

i. The language spoken in the home and the ability for the Nurse Provider to communicate in the language understood by the enrollee/family;

ii. The complexity and intensity of the enrollee's health care needs, and of the technology equipment required to meet these needs;

iii. Family/Caregiver resources and capacity to provide care;

iv. Home safety evaluation, including an emergency evacuation plan;

v. Coordination of care with other community support services which may include hospital discharge coordinator, enrollee's PCP, SCC, Medical Therapy Unit (MTU);

vi. Hospice agency, as applicable;

vii. Need for medical supplies, equipment and pharmaceuticals necessary to care out the services; or,

viii. Determination of the total number of nursing hours required, including frequency and length of services.

3) Hospice

The Contractor will provide the range of hospice services available under the Medi-Cal program in addition to medically necessary treatment services for enrollees who's PP has certified that the enrollees are within the last six (6) months of life.

4) Durable Medical Equipment

a) Rehabilitative

The Contractor will provide standard and custom durable medical equipment, specific to the needs of the enrolled population, required for mobility, community access and independence in the home environment. This equipment may include, but is not limited to, tilt wheelchairs, power chairs, walkers, commodes, positioning equipment, custom wheel chairs, custom wheel chair seating, custom motorized wheelchair bases and batteries. All repairs, replacements due to growth and/or new technology, maintenance, family training and follow up on the use of the equipment are also the responsibility of the Contractor.

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b) Medical

The Contractor will provide medical, including respiratory, equipment required for the treatment of the enrollee's medical conditions in the home. Such equipment may include, but is not limited to apnea monitors, glucometers, infusion pumps, kangaroo pumps, ventilators, suction machines, gaseous and/or liquid oxygen, specialty beds and mattresses.

The Contractor will provide emergency back-up equipment, maintenance of the equipment and family training in the use of the equipment.

5) Medical Supplies

The Contractor will provide those supplies that are necessary for treatment of medical conditions within the home and community, including those supplies that are necessary for the administration of prescribed pharmaceuticals. These supplies shall include, but are not limited to, gauze pads, syringes, infusion sets and catheters.

6) Incontinence Supplies

The Contractor will provide diapers when:

a) An enrollee is under five (5) years of age and the use of diapers is medically necessary and exceed the normal use by an enrollee of the same age; or

b) An enrollee is five (5) years of age and older and the diapers are medically necessary.

7) Prosthetics and Orthotics

The Contractor will provide prosthetics (devices utilized to replace or enhance a body part of function) and orthotics (devices to correct or prevent deformities, replace a body function and/or for positioning).These items, specific to the needs of the enrolled population, shall include, but are not limited to, dynamic splints, shoes, braces, artificial arms and legs.

The Contractor will be required to provide orthotics repairs, adjustments and/or replacements necessary for growth or new technology; usage training, as well as routine clinical check-ups by appropriate clinicians.

f. Medical Transportation

The Contractor will be responsible for the provision of emergency transportation by ground ambulance when it is needed to access medically necessary care in an emergency situation.

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The Contractor will also provide emergency transportation by air ambulance when the enrollee's condition requires rapid transport, when it is a reasonable alternative to ground transport or when air transport is less costly.

The Contractor will provide nonemergency transport by ambulance or wheelchair van and litter van when there is documentation that the enrollee's medical condition warrants the use of one of these types of transport rather than private care or public transportation. This method of transportation will also be provided when an enrollee is to be transferred from a tertiary care facility for inpatient care to a lower level facility in their community or nearer to their community.

g. Maintenance and Transportation to Access Authorized Services

The Contractor shall be responsible for reimbursing the costs of the family of an enrollee in accessing authorized health care services when it is determined there are no other available resources.

Reimbursable services shall include:

1) The cost(s) for the use of a private vehicle or public conveyance to provide the enrollee access to authorized care that is part of the treatment plan.

2) The cost(s) for lodging (such as a motel room, etc.) and food for the enrollee or family when needed to enable the enrollee to access CCS authorized medical services.

h. High Risk Infant Follow-up (HRIF) services, as provided by the HRIF Special Care Centers:

1) Comprehensive history and physical exam,

2) Developmental assessment,

3) Family psychosocial assessment,

4) Hearing assessment,

5) Ophthalmological assessment, and

6) Home assessment.

i. Pharmacy Services

1) The Contractor shall be responsible for the provision of all prescribed drugs and medically necessary services that shall include:

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a) Licensed pharmaceuticals,

b) Investigational drugs,

c) Unlabeled use of drugs,

d) Over-the-counter medications,

e) Medical foods, and

f) Enteral/parenteral nutrition.

2) Pharmaceutical services and prescription drugs shall be provided in accordance with all federal and state laws and regulations including, but not limited to the California State Board of Pharmacy Laws and Regulations, 22 CCR 56214 and 16 CCR 1707.1, 1707.2 and 1707.3. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and Provider manual.

3) At a minimum, the Contractor shall arrange for pharmaceutical services to be available during regular business hours and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the enrollee or family can reasonably be expected to have the prescription filled.

4) The Contractor shall develop and implement effective drug utilization reviews and treatment outcome systems to optimize the quality of pharmacy services.

5) The Contractor shall submit to DHCS a complete formulary. The Contractor may use the formulary as published unless DHCS notifies the Contractor of changes that must be made. A report of changes to the formulary shall be submitted to DHCS upon request and on an annual basis. The Contractor's formulary shall be comparable to the Medi-Cal FFS List of Contract Drugs, except for drugs carved out of this Contract. **Comparable** means that the Contractor's formulary must contain drugs which represent each mechanism of action sub-class within all major therapeutic categories of prescription drugs included in the Medi-Cal FFS List of Contract Drugs.

6) The Contractor shall implement and maintain a process to ensure that its formulary is reviewed and updated, no less than quarterly, by the Contractor's Pharmacy and Therapeutics committee, which includes the Contractor's Pharmacist as a voting member on the committee. This review and update must consider all drugs approved by the FDA and/or added to Medi-Cal FFS List of Contract Drugs. Deletions to the formulary must be documented and justified.

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j. Minor Consent and Sensitive Services

The Contractor shall ensure the provision of minor consent services for enrollees under the age of eighteen (18). Minor consent services shall be available within the Provider network and Members shall be informed of the availability of these services. Minor consent services are services related to:

1) Sexual assault, including rape;

2) Drug or alcohol abuse for enrollees twelve (12) years of age or older;

3) Pregnancy;

4) Family planning;

5) Sexually transmitted diseases (STDs), designated by the Director, for enrollees twelve (12) years of age or older; and

6) Outpatient mental health care for enrollees twelve (12) years of age or older who are mature enough to participate intelligently and where either;

   a) There is a danger of serious physical or mental harm to the minor or others; or

   b) The enrollees are the alleged victims of incest or child abuse.

   Minors do not need parental consent to access these services.

k. Family Planning Services

Enrollees, twelve (12) years of age and older, shall be able to access family planning services in a timely manner, through an out-of-network Provider other than the PCP if so requested with mechanisms in place for reimbursing such services.

The Contractor may only provide for pregnancy termination pursuant to 42 CFR 441.202 in the following situations:

1) If the pregnancy is the result of an act of rape or incest; or

2) In the case where an enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a Physician, place the enrollee in danger of death unless a pregnancy termination is performed.

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l. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Supplemental Services.

The Contractor shall ensure the provision of EPSDT services and EPSDT Supplemental Services for Members under twenty-one (21) years of age, including those who have special health care needs, in accordance to 22 CCR 51340 and 51340.1.

m. Organ Transplants

1) Major Organ Transplants

a) The Contractor must refer all enrollees thought to require a heart, lung, heart/lung, heart/kidney, liver, liver/kidney, liver/small bowel, small bowel or bone marrow transplant to a Medi-Cal approved organ transplant center for the comprehensive evaluation of the need for the transplant. The Contractor will be responsible for all costs associated with major organ transplants; which includes but is not limited to, evaluation, transplantation and pre- and post-transplant services.

b) The Contractor will also be responsible for:

i. Assuring that enrollees identified by a Medi-Cal approved transplant center as needing a transplant will review and determine medical eligibility for transplants based on policy and standards.

ii. Coordinating pre- and post-transplant services including discharge planning and assisting the family with necessary support services during the entire transplant process.

2) Renal and Corneal Transplants

The Contractor will be responsible for all costs and care associated with the provision of renal and corneal transplants.

a) Enrollees requiring only renal transplants will be referred to a CCS-approved renal center for an evaluation of the need for and the care of the transplant.

b) Enrollees requiring corneal transplants will have that care provided under the direction of a CCS-approved Ophthalmologist.

n. Dialysis

o. Therapies

1) Speech and Language

2) Physical and Occupational Therapy

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The Contractor shall provide physical and occupational therapy when:

a) Short-term physical and/or occupational therapy, with defined time-limited goals, is necessary to improve functional skills, eliminate the need for extension of an inpatient hospital stay and/or to prevent re-hospitalization; or

b) Long-term physical and/or occupational therapy, with time-limited goals, is necessary to maintain or prevent deterioration of functional skills.

3) The Contractor shall not be responsible for the provision of physical and occupational therapy services prescribed by a CCS Medical Therapy Conference Physician.

p. Augmentative and Alternative Communication Devices

1) The Contractor will be responsible for providing electronic or non-electronic aids, devices, or systems (in a form most appropriate for the enrollee) that correct an expressive communication disability that precludes effective communication and meaningful participation in daily activities.

2) The Contractor will be responsible for the assessment by a CCS-approved Speech/Language Pathologist, in conjunction with either an Occupational or Physical Therapist, to determine the necessity and appropriateness of a device.

3) The Contractor will also be responsible for the provision of the necessary components, including computer software programs, symbol sets, overlays, mounting devices, switches, cables, connectors and output devices, supplies, training in the use of the device and device repair and modification.

q. Audiology

1) The Contractor will be responsible for diagnostic and ongoing assessment by a CCS-approved CDC, including CCS-approved Otolaryngologists, Audiologists and Speech and Language Therapists.

2) If a candidate for amplification, then the Contractor is also responsible for:

a) Hearing aids, as recommended by a CCS-approved CDC, prescribed for an enrollee's hearing loss, including those that are beyond the scope of Medi-Cal benefits;

b) Hearing aid accessories, including cords, receivers, ear molds and batteries; and

c) Assistive listening systems including frequency modulation systems.

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3) Cochlear Implants

The Contractor will be responsible for:

a) Pre-cochlear implant evaluation at a CCS-approved Cochlear Implant Center, including audiology testing, speech pathology assessments, psychological assessments, otolaryngological evaluation and team conferences;

b) Cochlear implant surgery, when recommended by a CCS-approved Cochlear Implant Center;

c) Post-cochlear implant services, including implant orientation, implant mapping and processor programming, speech perception tests, audiological sound field tests, test assistant, interval speech and language evaluations and aural/oral rehabilitation services;

d) Cochlear implant replacement parts and batteries; and

e) Cochlear implant speech processor upgrades.

r. Medical Nutrition Therapy

The Contractor shall be responsible for medical nutrition therapy, by a CCS-approved registered dietitian, that includes nutritional assessment and the development and implementation of a therapy plan.

s. Vision Care, including Lenses

The Contractor will be responsible for eye examinations, including refraction, eyeglasses, contact lenses, low vision aids, prosthetic eyes and other eye appliances. Shatter resistant eyewear will be provided when there is absence of vision in one eye or one eye is absent.

t. Mental Health

1) The Contractor shall be responsible for:

a) Outpatient mental health services within the scope of practice and training of the PP;

b) Medically necessary psychotherapeutic drugs, including those prescribed by out-of-plan Psychiatrists;

c) Related outpatient laboratory services to treat a diagnosis of mental illness when the services are prescribed by contracting Providers or non-psychiatric, non-contracting Providers;

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d) Emergency room professional services except services provided by psychiatrists, psychologists, LCSW, marriage, family and child counselors, or other specialty mental health Providers;

e) Facility charges for emergency room visits which do not result in a psychiatric admission;

f) Emergency medical transportation services necessary to provide access to emergency mental health services;

g) All non-emergency medical transportation services, required by Members to access Medi-Cal covered mental health services, subject to a written prescription by a Medi-Cal specialty mental health Provider, except when the transportation is required to transfer the Member from one facility to another, for the purpose of reducing the local Medi-Cal mental health program's cost of providing services; and

h) Medically necessary covered services after the Contractor has been notified by a Specialty Mental Health Provider that a Member has been admitted to a psychiatric inpatient hospital, including the initial health history and physical examination required upon admission and any consultations related to medically necessary covered services. However, notwithstanding this requirement, the Contractor shall not be responsible for room and board charges for psychiatric inpatient hospital stays by members.

2) The Contractor shall develop policies and procedures defining the services that are to be provided by the PP.

3) The Contractor shall be responsible for outpatient mental health services when the services are provided by non-contracted or contracted psychiatric Providers for treatment of a diagnosis that is not covered by the local Medi-Cal county mental health plan.

4) All outpatient laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of an enrollee's mental health condition.

5) The Contractor shall develop and implement a written internal policy and procedure to ensure that enrollees who need specialty mental health services (services outside the scope of practice of PCPs) are referred to an appropriate mental health Provider and pay for those services, or, refer Members to the local mental health plan for specialty mental health services.

6) The Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made to the local Medi-Cal county mental health plan. If psychiatric services are required for a diagnosis that is not covered by the local Medi-Cal county mental health plan, the Contractor shall cover and pay for those services.

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The Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the PCP and the psychiatric service Provider(s).

u. Comprehensive Perinatal Services

1) Prenatal Care

The Contractor shall cover and ensure the provision of all medically necessary services for pregnant Members. The Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

2) Risk Assessment

The Contractor shall implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program standards per 22 CCR 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, health education, psychosocial, and risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

3) Referral to Specialists

The Contractor shall ensure that pregnant Members at high risk of a poor pregnancy outcome are provided timely referral to appropriate specialists including perinatologists and have access to genetic screening with appropriate referrals. The Contractor shall also ensure that appropriate hospitals are available and accessible to the Member within the Provider network to provide necessary high-risk pregnancy services.

v. Investigational Services

The Contractor is responsible for investigational services when there is documentation of all of the following:

1) Conventional therapy will not adequately treat the intended patient's condition;

2) Conventional therapy will not prevent progressive disability or premature death;

3) The Provider of the proposed service has a record of safety and success equivalent or superior to that of other Providers of the investigational service;

4) The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives;

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5) The service is not being performed as a part of a research study protocol; and

6) There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.

Investigational services are defined as those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but:

a) Testing is not complete;

b) The efficacy and safety of such services in human subjects are not yet established; and

c) The service is not in wide usage.

w. Out-of-State Services

The Contractor will be responsible for out-of-state care when:

1) The medically necessary care is not available within the State of California; or

2) There is an emergency out-of-state that arises from an accident, injury, or illness.

4. Payment for the following services is excluded from the responsibility of the Contractor:

a. Local Education Agency (LEA) services;

b. CCS Medical Therapy Program (MTP) services at CCS MTU;

c. Newborn hearing screening services;

d. Drug and alcohol services;

e. Specialty mental health services;

f. Experimental Services that include drugs, equipment, procedures or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans;

g. Dental services

Dental services, except when those services are provided by a CCS-approved Physician as part of the correction of a craniofacial anomaly.

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E. System Requirements

1. Medical Home

   a. The Contractor will implement a medical home model. The Contractor will ensure care coordination at two levels – one by the enrollee's designated PP and the second by the Contractor's Care Coordinators (CC).

   b. The Contractor will provide support to the medical home by providing care coordination services, chronic care management and disease management services that support the PP and the enrollee and family. Care coordination activities will include providing assistance to families needing social services and coordination with other program supports such as the MTP. Referral and active coordination with disease management programs appropriate to an enrollee's condition(s) will be provided with a "whole child" focus.

   c. Each enrollee in the DP will be assigned to a PP, who with support provided by the Contractor, will function as the enrollee's medical home. Physicians that may serve as an enrollee's PP include General Pediatricians, Family Physicians, and Internists for enrollees over fourteen (14) years of age, specialty Physicians, or qualified sub-specialty Physicians appropriate to the enrollee's condition.

   d. The medical home is responsible, working with the Contractor's CCs and the family, for the development of an individual plan of care that will serve as the basis for ensuring enhanced access to timely and appropriate services across the entire continuum of care and providing family-centered care coordination services.

   e. It is the responsibility of the medical home to stay apprised of all condition-related services and assure appropriate coordination of those services. The medical home is responsible for ensuring that the enrollee receives needed services timely and in an appropriate setting.

   f. Each enrollee in the DP will select a PP.

      1) The PP will be a PCP, a specialty Physician or subspecialty Physician, who will be responsible for ensuring enhanced access to timely and appropriate services.

      2) If an enrollee or parent/legal guardian does not select a PP, the Contractor will assign a PP based on past history, the Provider's experience with the enrollee's specific disease, disability and/or special needs, and the location of the enrollee's home, and the Provider's office.

      3) The PP will be responsible for overseeing all of an enrollee's health care needs and for ensuring care is coordinated across the continuum. The PP will work in collaboration with the Contractor's CCs to carry out these responsibilities.

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2. Care Coordination

The Contractor shall counsel Members on their right to confidentiality and the Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to 22 CCR 51009.

The Contractor will be required to provide specialized care coordination for each Member.

a. The Contractor will employ and/or subcontract with CCs to work in partnership with the PP and other agencies to ensure the Member's care is coordinated and well managed.

b. The CCs shall have experience working with enrollees with special health care needs.

c. Care coordination for enrollees with special health care needs shall include both face-to-face and telephone contacts.

d. The Contractor will utilize the initial needs assessment of the enrollee and their family's needs to determine the level and frequency of the care coordination required.

e. An initial needs assessment by the CC will be initiated within thirty (30) days of enrollment for all new enrollees to Contractor in the DP and will help inform the choice of an appropriate medical home for the enrollee and ensure continuity of care and services and a smooth transition from FFS to the DP.

f. Initial and subsequent assessments shall be performed using a standardized tool provided by DHCS. This tool shall be developed with input from participating plans and stakeholders.

g. Subsequent assessments shall be performed at recertification and/or at a frequency determined by the ranking on the initial assessment.

h. The CC will be responsible for the following key functions:

1) Assessment of an enrollee's medical, behavioral, psychosocial and functional needs;

2) Assessment of the family's functional needs;

3) Development and implementation of an individualized family-centered care plan in collaboration with the family and medical home Provider;

4) Development of an individualized family support plan;

5) Facilitation of meetings and/or team conferences with family, enrollee and relevant and appropriate Providers of services;

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6) On-going monitoring and evaluation of the care plan, including re-assessments upon a change in condition or status;

7) Coordination of care among systems and Providers;

8) Member education and advocacy, including research of and linkage to resources, services and support for the family;

9) Referral into disease and chronic care management programs, ongoing monitoring of the enrollee's status in these programs and coordination and linkage with or to other appropriate Providers or resources;

10) Making referrals and ensuring authorization of services;

11) Transition planning;

12) Coordination with the evaluation Contractor to obtain enrollee and family feedback regarding their experiences of health care; and

13) The Contractor shall inform Members that EPSDT services are available for Members under twenty-one (21) years of age.

i. The Contractor shall ensure, on an ongoing basis and that after initial implementation, enrollees in the DP shall receive an initial health assessment (IHA) by the designated PP within sixty (60) days of enrollment, if the enrollee was not previously receiving primary and preventive care services from the PP.

The IHA shall include performance of CHDP program's age appropriate assessment, including the provision of all immunizations necessary to ensure that the enrollee is up-to-date for age, and an age appropriate health education behavioral assessment.

j. While the Contractor may not be financially responsible for a range of special services, such as those provided through regional centers, HCBS waiver, behavioral health, medical therapy through the MTP, residential and institutional care services and dental services, the Contractor will be responsible for ensuring coordination of all the care the enrollee receives.

k. Out-of-Plan Case Management and Coordination of Care

1) The Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services.

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2) The Contractor shall implement protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records.

3) The Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

3. Utilization Management and Review

a. Utilization Management (UM)

The Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. The Contractor is responsible to ensure that the UM program includes:

1) Qualified staff responsible for the UM program.

2) The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.

3) The Contractor shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

4) Established criteria for approving, modifying, deferring, or denying requested services. The Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. The Contractor shall document the manner in which Providers are involved in the development and or adoption of specific criteria used by the Contractor.

5) The Contractor shall communicate to HCP the procedures and services that require prior authorization and ensure that all contracting HCPs are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

6) An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting Providers.

b. The Contractor shall ensure that all contracting HCPs are aware of the referral processes and tracking procedures.

c. Pre-Authorizations and Review Procedures

1) The Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

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a) Decisions to deny or authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

b) Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified Physician or the Contractor's Pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the plan Medical Director, in collaboration with the plan Pharmacy and Therapeutics committee or its equivalent.

c) There is a set of written criteria or guidelines for utilization review that is based on standards of clinical practice for enrollees with CCS-eligible medical conditions, and is consistently applied, regularly reviewed, and updated.

d) Reasons for decisions are clearly documented.

e) Notification to Members regarding denied, deferred or modified referrals is made. Enrollees and their families and Providers shall be advised of the appeals procedures.

f) Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

g) Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

h) Records, including any Notice of Action (NOA), shall meet the retention requirements.

i) The Contractor must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be orally or in writing.

d. Timeframes for Medical Authorization

1) Emergency care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

2) Concurrent review of authorization for treatment regimen already in place: Within twenty-four (24) hours of the decision, consistent with urgency of the Member's medical condition and in accordance with H&S Code, Section 1367.01(h)(3).

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3) Retrospective review: Within thirty (30) calendar days in accordance with H&S Code, Section 1367.01(h)(1).

4) Pharmaceuticals: Twenty-four (24) hours on all drugs that requires prior authorization in accordance with W&I Code, Section 14185(a)(1).

5) Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with H&S Code, Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Member or the Member's Provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

6) Expedited authorizations: For requests in which a Provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than three (3) working days after receipt of the request for services. The Contractor may extend the three (3) working days' time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

7) Post-stabilization: Upon receipt of an authorization request from an emergency services Provider, the Contractor shall render a decision within thirty (30) minutes or the request is deemed approved, in accordance to 28 CCR 1300.71.4.

8) Non-urgent care following an exam in the emergency room: Response to request within thirty (30) minutes or deemed approved.

9) Therapeutic enteral formula for medical conditions in infants and children: Timeframes for medical authorization of medically necessary therapeutic enteral formulas for infants and children and the equipment and supplies necessary for delivery of these special foods are set forth in Numbered Letter 22-0805, Enteral Nutrition Products as a CCS Benefit, W&I Code, Section 14103.6 and H&S Code, Section 1367.01.

10) Hospice inpatient care: Twenty-four (24) hour response.

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e. Review of Utilization Data

The Contractor shall include mechanisms to detect both under and over-utilization of health care services within the UM program. The Contractor shall include internal reporting mechanisms used to detect enrollees' utilization patterns. Reports shall be submitted to DHCS upon request.

f. Second Opinion

The Contractor shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

4. Health Education

a. The Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all enrollees in the DP.

b. The Contractor shall ensure administrative oversight of the health education system by a qualified health educator. This individual shall possess a master's degree in public or community health with specialization in health education.

c. The health education system shall:

1) Use educational strategies and methods that are appropriate for enrollees and their families and effective in achieving behavioral change for improved health.

2) Ensure that health education materials are written at the sixth (6) grade reading level and are culturally and linguistically appropriate for the enrollees and their families.

3) Provide educational interventions addressing, at a minimum, the following health categories and topics:

a) Appropriate use of health care services; including preventive and primary health care, and complementary and alternative care;

b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting; and

c) Self-care and management of health conditions specific to the enrollees in the DP.

d. The Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates an effective quality assurance/quality improvement program.

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5. Relationship with Other Agencies/Providers Serving Enrollees

   a. California Children's Services Medical Therapy Program

      The Contractor shall develop policies and procedures for coordinating with the appropriate county California Children's Services (CCS) Medical Therapy Program (MTP) to ensure the delivery of medically necessary services and equipment to enrollees receiving services through the MTP, including participation of the Contractor's CCs in the medical therapy conference.

   b. Mental Health

      The Contractor shall develop a Memorandum of Understanding (MOU) with the local mental health plan(s) (MHP) defining the respective responsibilities of the Contractor and the MHP in delivering medically necessary covered services and specialty mental health services to enrollees in the DP. The MOU shall address:

      1) Protocols and procedures for referrals between the Contractor and the MHP;

      2) Protocols for the delivery of specialty mental health services, including the MHP's provision of clinical consultation for enrollees treated by network Providers for mental illness;

      3) Protocols for the delivery of mental health services within the PP's training and experience;

      4) Protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records;

      5) Procedures for the delivery of medically necessary services, covered under the contract, to enrollees who require specialty mental health services, including:

         a) Pharmaceutical services and prescription drugs;

         b) Laboratory, radiological and radioisotope services;

         c) Emergency room facility charges and professional services;

         d) Emergency and non-emergency medical transportation;

         e) Home health services; and

         f) Medically necessary covered services to Members who are patients in psychiatric inpatient hospitals.

      6) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition.

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7) Procedures to resolve disputes between Contractor and the MHP(s).

c. Enrollees with Developmental Disabilities

1) The Contractor shall execute a MOU with the local regional center(s) in order to coordinate services for enrollees in the DP who have developmental disabilities.

2) The Contractor shall develop and implement procedures for the identification of members with developmental disabilities.

3) The Contractor shall refer Members with developmental disabilities to a regional center for the developmentally disabled for evaluation and for access to those non-medical services provided through the regional centers such as but not limited to, respite, out-of-home placement, and supportive living, as well as services that would be potentially available through the HCBS waiver program administered by the California Department of Developmental Services.

4) The Contractor's CCs shall participate with regional center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

d. Early Intervention Services

The Contractor shall develop and implement systems to identify potential enrollees who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These potential enrollees would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay.

The Contractor's CCs shall collaborate with the local regional center or local Early Start program (dependent on the potential eligible condition) in determining the medically necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. The Contractor shall provide case management and care coordination to the Member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with PCP participation.

e. Local Education Agency Services

Local Education Agency (LEA) assessment services are services specified in 22 CCR 51360(b) and provided to students who qualify based on 22 CCR 51190.1. LEA services provided pursuant to an individual education program as set forth in Education Code, Section 56340 et seq. or individual family service plan as set forth in Government Code, Section 95020, is not covered under this Contract.

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The Contractor's CCs shall ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the individual education program developed by the LEA and family, and ensure the PP's participation in the process.

f. Dental Services

1) The Contractor shall ensure that dental assessments for all Members are included as a part of the IHA. The Contractor shall ensure that Members are referred to appropriate Medi-Cal Dental Providers for ongoing dental care as well as problems identified at the time of screening.

2) The Contractor shall cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.

3) The Contractor shall cover the following when required for a dental procedure provided in an outpatient surgical facility or in an inpatient hospital stay:

a) Outpatient surgical facility charges or inpatient hospital charges;

b) Prescription drugs;

c) Laboratory services; and

d) Pre-admission physical examinations.

4) The Contractor may require prior authorization for medical services required in support of dental procedures.

g. Targeted Case Management (TCM) Services

The Contractor is responsible for determining whether a Member requires TCM services, and must refer Members who are eligible for TCM services to a regional center or local governmental health program as appropriate for the provision of TCM services.

If a Member is receiving TCM services as specified in 22 CCR 51351, the Contractor shall be responsible for coordinating the Member's health care with the TCM Provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM Provider that are covered services under the Contract.

h. Local School Districts

The Contractor shall ensure that the subcontracts with the local school districts or school sites meet the requirements and address the following:

1) The population covered;

2) Practitioners covered;

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3) Outreach;

4) Information dissemination;

5) Education responsibilities;

6) Utilization review requirements;

7) Referral procedures;

8) Medical information flows;

9) Patient information confidentiality;

10) Quality assurance interface;

11) Data reporting requirements; and

12) Grievance/complaint procedures.

6. Data Reporting

a. Management Information System (MIS) Capability

1) The Contractor's MIS shall have the capability to capture, edit, and utilize various data elements for internal management use, as well as meet the data quality and timeliness requirements of DHCS' encounter data submission.

2) The Contractor shall have and maintain a MIS that provides, at a minimum:

a) All eligibility data;

b) Information on enrollees in the DP, that includes, but is not limited to, initial and on-going needs assessments, identification of the medical home/PP and referrals for care as identified in Section D.5 (Relationship with Other Agencies/Providers Serving Enrollees);

c) Requests for authorization of services including, at a minimum, the date of request and the date of decision;

d) Provider claims status and payment data;

e) Health care services delivery encounter data;

f) Provider network information, and

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g) Financial information as specified in Exhibit E, Section 42 (Submittal of Financial Information).

3) The MIS shall have processes that support the interactions between financial, member/eligibility; Provider; encounter claims; quality management/quality improvement/utilization; and report generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.

b. Encounter Data Submittal

1) The Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of encounter data for all services which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements. Encounter data shall include data elements specified in Attachment 5.

2) The Contractor shall require subcontractors and non-contracting Providers to provide service level data to the Contractor, which allows the Contractor to meet its administrative functions and the requirements set forth in this section. The Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure service level data is complete and accurate prior to submission to DHCS.

3) The Contractor shall submit encounter data to DHCS on a monthly basis in the form and manner specified by DHCS. Encounter data shall include data elements specified in Attachment 5 (Encounter Data Elements).

a) Submit encounter data test tape produced from State supplied data.

b) Submit a detailed description of how the encounter data will flow from providers to the Contractor, and then to the State.

c) Submit P&Ps describing the process providers must follow for submitting encounter data on periodic health assessments and immunizations data using the PM-160 information only form.

d) Submit P&Ps describing the process of reporting all denials of services requested by Providers. Include a copy of the template that will be used for the report.

4) Upon written notice by DHCS that the encounter data is insufficient or inaccurate, the Contractor shall ensure that corrected data is resubmitted within fifteen (15) days of receipt of DHCS' notice. Upon the Contractor's written request, DHCS may provide a written extension for submission of corrected encounter data.

5) The Contractor shall submit encounter data on periodic health assessments and immunizations rendered to demonstration project enrollees pursuant to the requirements in Section C.,3.,a.,1).,a) using the CHDP information-only Confidential

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Screening/Billing Report (PM-160) or other reporting form or format specified by DHCS.

c. The Contractor shall submit on a monthly basis a report of all denials of services requested by Providers. The report shall include the type of service denied (e.g., inpatient hospital care, surgical procedure, prescription, or home health agency service; the reason for denial and the resolution of the denial).

d. MIS/Data Correspondence

Upon receipt of written notice by DHCS of any problems related to the submittal of data to DHCS, or any changes or clarifications related to the Contractor's MIS system, the Contractor shall submit to DHCS a Corrective Action Plan (CAP) with measurable benchmarks within thirty (30) calendar days from the date of the postmark of DHCS' written notice to the Contractor. Within thirty (30) days of DHCS' receipt of Contractor's CAP, DHCS shall approve the CAP or request revisions. Within fifteen (15) days after receipt of a request for revisions to the CAP, the Contractor shall submit a revised CAP for DHCS approval.

e. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Readiness

The Contractor shall comply with the provisions of Exhibit G, HIPAA; 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information; 22 CCR 41510.4; and all other State statutes and regulations on the privacy and security of protected health information and personal confidential information currently in effect or as they become effective.

7. Medical Records

a. The Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:

1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.

2) To ensure that medical records are protected and confidential in accordance with all federal and state law.

3) For the release of information and obtaining consent for treatment.

4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

b. The Contractor shall ensure an individual is delegated the responsibility of securing and maintaining medical records at each practice site.

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c. The Contractor shall ensure a complete medical record reflects all aspects of patient care, including ancillary services, is maintained for each Member in accordance with 22 CCR 56310 and 28 CCR 1300.67, and at a minimum includes:

1) Member identification on each page; personal/biographical data in the record.

2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

3) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

5) Allergies and adverse reactions are prominently noted in the record.

6) All informed consent documentation, including the human sterilization consent procedures required by 22 CCR 51305.1 through 51305.6, if applicable.

7) Reports of emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for hospital admissions.

8) Consultations, referrals to specialists, pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

9) Health education behavioral assessment and referrals to health education services. For patients twelve (12) years or older, a notation concerning use of cigarettes, alcohol, substance abuse, health education, counseling, and anticipatory guidance must be present.

d. Confidentiality

1) The Contractor shall maintain protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records.

2) The Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

3) The Contractor shall counsel Members on their right to confidentiality and the Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to 22 CCR 51009.

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8. Marketing

   a. The Contractor shall not conduct marketing activities without written approval of its marketing plan, or changes to its marketing plan, from DHCS. In cases where the Contractor wishes to conduct an activity not included in the marketing plan, the Contractor shall submit a request to include the activity and obtain written, prior approval from DHCS. The Contractor must submit the written request within thirty (30) calendar days prior to the marketing event, unless DHCS agrees to a shorter period. If DHCS does not approve or deny within thirty (30) calendar days from submission, the materials are deemed approved.

   b. All marketing materials, and changes in marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped and media scripts, shall be approved in writing by DHCS prior to distribution.

   c. Informed Decision

      1) If the Contractor conducts marketing, the Contractor shall develop a marketing plan as specified below. The Contractor shall implement and maintain the marketing plan only after approval from DHCS. The Contractor shall ensure that the marketing plan, all procedures and materials are accurate and do not mislead, confuse or defraud.

      2) Copies of all marketing materials the Contractor will use for both English and non-English speaking populations shall be included.

      3) Marketing materials shall not contain any statements indicating enrollments are necessary to obtain or avoid losing Medi-Cal benefits, or the Contractor is endorsed by DHCS, the Centers for Medicare and Medicaid Services, or any other state or federal government entity.

      4) The marketing plan shall be specific to the Medi-Cal program only and materials shall be distributed within the Contractor's entire service area.

      5) The Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

      6) The Contractor shall not engage in door-to-door, cold call, telephone, or other marketing for the purpose of enrolling Members or potential enrollees.

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F. Enrollment/Disenrollment

The following definitions apply to this provision:

Enrollee means a CCS-eligible recipient who is currently enrolled in a MCO, PIHP, PAHP, or primary care case manager in a given managed care program.

Potential Enrollee means a CCS-eligible client who is subject to mandatory enrollment or may voluntarily elect to enroll in the CCS demonstration managed care program.

1. Medi-Cal Managed Care Plan Model

   A Medi-Cal managed care plan that has a contract for a DP must implement policies and procedures to identify Medi-Cal beneficiaries who are potential enrollees with special health care needs that may be eligible for CCS covered services at time of enrollment into the health plan and on a regular periodic basis thereafter. When a potential enrollee has been identified as with a CCS-eligible medical condition, the health plan has the responsibility for referral to the county for confirmation to ensure identification is appropriate.

2. Enrollment Program

   a. The Contractor will accept as Members, Medi-Cal beneficiaries with a CCS-eligible condition. Enrollment is mandatory for CCS clients meeting the medical eligibility criteria and who:

      1) Do not have other health care coverage as defined in 22 CCR 53845(e); and

      2) Are not in foster care placement.

   b. CCS clients in foster care placement may voluntarily enroll in a DP if they otherwise meet the eligibility requirements of the specific model.

   c. Each enrollee will have a medical home.

   d. Enrollment – General

      Eligible beneficiaries residing within the service area of the Contractor will be identified as eligible CCS clients by the local CCS county level program and referred to the contracting health plan on a monthly basis. Eligible beneficiaries shall be accepted by the Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.

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3. Coverage

   a. At the time of implementation of the DP coverage shall begin at 12:01a.m. on the first (1) day of the calendar month for which the enrollee's name is added to the approved list of Members furnished by the local CCS program to the Contractor.

   b. On an ongoing basis, coverage shall begin at 12:01 a.m. on the first (1) day of the calendar month following determination of eligibility for the DP.

   c. The Contractor shall provide covered services to an enrollee born to a Member for the month of birth and the following month. For a child born in the month immediately preceding the mother's membership, the Contractor shall provide covered services to the enrollee during the mother's first month of enrollment. No additional capitation payment will be made to the Contractor by DHCS.

4. Assignment of Members

   Whether the contract is with a MCO, a PIHP, a PAHP, or a PCCM, if the Member fails to timely choose a PP, the Contractor shall notify the Member in writing of the PP with whom the Member will be assigned. If, at any time, a Member notifies the Contractor of a PP choice, such choice shall override the member assignment to a PP. Current eligible plan CCS Members will be disenrolled from their current health plan and shall be assigned to the new CCS DP. The PP may be a PCP, a pediatric medical specialist or subspecialist appropriate to the child's CCS-eligible medical condition.

5. Continuance of Membership

   A Member's enrollment shall continue unless this Contract expires, is terminated, or the Member is disenrolled or is no longer eligible. Upon expiration of this Contract, the Contractor shall retain its enrolled Members if prior to expiration of the Contract, the Contractor renews its Contract with DHCS.

6. Disenrollment

   a. Disenrollment of a Member is mandatory whether the contract is with a MCO, a PIHP, a PAHP, or a PCCM, when:

      1) The Member is no longer eligible for CCS.

      2) There is a change of a Member's place of residence to outside the Contractor's service area.

      3) The enrollee and the family/legal guardian's legal place of residence are outside the designated service area.

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4) The enrollee is placed in foster care, although voluntary enrollment in the DP can be maintained if the enrollee remains in the geographic service area of the DP.

5) The CCS-eligible medical condition has been corrected.

6) The enrollee is no longer financially eligible for Medi-Cal, HF or CCS-only.

7) The enrollee becomes eligible for and is enrolled in a commercial health maintenance organization (HMO) provided through parental employment that serves as the primary coverage.

b. The Contractor recommends the disenrollment when it becomes impossible for the Contractor's network Providers to adequately render services to an enrollee because of one of the following:

1) The enrollee or parent/legal guardian physically assaults one of the Contractor's staff, contracting Provider staff, other member, or threatens another individual with a weapon on the Contractor's premises.

2) The enrollee or parent/legal guardian is repeatedly verbally abusive to contracting Providers, ancillary, administrative, staff or to other DP Enrollees.

3) The enrollee or parent/legal guardian is disruptive to the Contractor operations, in general.

4) The enrollee or parent/legal guardian habitually uses Providers not affiliated with the Contractor for non-emergency services without required authorizations.

5) The enrollee has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the enrollee's plan identification card to receive services from the Contractor.

6) The enrollee needs related services to be performed at the same time; not all related services are available within the network; and the enrollee's PCP or another Provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

Other reasons include but are not limited to, poor quality of care, lack of access to services covered under this Contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

c. The Contractor may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

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d. The Contractor does not request disenrollment for reasons other than those permitted under the Contract.

e. Such disenrollment shall become effective on the first (1) day of the second (2) month following receipt by DHCS of all documentation necessary, as determined by DHCS, to process the disenrollment, provided disenrollment was requested at least thirty (30) calendar days prior to that date, for which disenrollment shall be effective the beginning of the month in which the transplant is approved.

f. Enrollment shall cease no later than midnight on the last day of the first (1) calendar month after the Member's disenrollment request and all required supporting documentation are received by DHCS. On the first (1) day after enrollment ceases, the Contractor is relieved of all obligations to provide covered services to the Member under the terms of this Contract. The Contractor agrees in turn to return to DHCS any capitation payment forwarded to the Contractor for persons no longer enrolled under this Contract.

g. An explanation of the expedited disenrollment process for Member qualifying under 22 CCR 53889(i) which includes children receiving services under the foster care or adoption assistance programs; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

7. Re-Enrollment

If the State plan so specifies, the Contractor must provide for automatic re-enrollment of an enrollee who is disenrolled solely because they lose Medicaid eligibility for a period of two (2) months or less.

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G. Rights and Responsibilities of Enrolled Children, Youth and Families

1. General

   a. The Contractor shall demonstrate a commitment to treating enrollees and their families in a manner that acknowledges their rights and responsibilities including, but not limited to:

      1) A system which acknowledges racial, ethnic, cultural, linguistic and socioeconomic diversity.

      2) Support of family and professional collaboration in all facets of care.

      3) Enrollee/family participation in the development of an individualized health plan.

      4) Education and training of the enrollee/family to increase their ability to make informed choices and to become more knowledgeable, skilled and confident in their roles.

   b. The Contractor shall be responsible for informational the enrollee/family of both their rights and responsibilities, including, but not limited to:

      1) Following through with recommendations and health care regimens which have been agreed upon by both the family and professional staff.

      2) Following appointment schedules.

      3) Providing accurate and complete information about the enrollee.

      4) Requesting clarification of issues involving the enrollee's care as needed.

      5) Accessing appropriate health care services that meet CCS standards/guidelines.

      6) Filing a grievance or requesting a fair hearing when services are denied or not appropriate.

      7) The Contractor shall provide all new Members upon request, with written Member information. The Contractor shall distribute the Member information no later than seven (7) calendar days following enrollment. The Contractor shall distribute Member information annually to each Member or family unit.

      8) The Contractor shall ensure that all written Member information is provided to Members at a sixth (6) grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions.

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a) Written Member informational materials shall be translated into the identified threshold and concentration languages.

b) Written Member informational materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.

c) The Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informational material in a specified alternative format.

9) The Contractor shall develop and provide each enrollee or potential enrollee, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the covered health care service to include:

a) Instructions on how a Member can view online, or request a copy of, the Contractor's non-propriety clinical and administrative policies and procedures including but not limited to, decisions for utilization management, enrollee education and coverage of services.

b) The Member services guide shall be submitted to DHCS for review prior to distribution to Members. The Member services guide shall meet the requirements contained in H&S Code, Section 1363, and 28 CCR 1300.63(a), as to print size, readability, and understandability of text, and shall include the following information:

i. The plan name, address, telephone number and service area covered by the health plan.

ii. A description of the full scope of covered benefits and all available services including health education, interpretive services provided by plan personnel and at service sites, and "carve out" services and an explanation of any service limitations and exclusions from coverage, or charges for services. Include information and identify services to which the Contractor has a moral objection to perform or support. Describe the arrangements for access to those services.

iii. Procedures for accessing covered services including that covered services shall be obtained through the plan's Providers unless otherwise allowed under this Contract.

A description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services shall also be provided.

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iv. Compliance with the following may be met through distribution of a Provider directory:

The name, Provider number, address and telephone number of each service location (e.g., locations of hospitals, PCP, optometrists, psychologists, pharmacies, skilled nursing facilities, urgent care facilities, FQHCs, Indian health centers). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, Provider number, address and telephone number shall appear for each Physician Provider:

The hours and days when each of these facilities is open, the services and benefits available, including which, if any, non-English languages are spoken, and the telephone number to call after normal business hours accessibility symbols approved by DHCS, and identification of Providers that are not accepting new patients.

v. Procedures for selecting or requesting a change in PCP at any time; any requirements that a Member would have to change PCP; reasons for which a request for a specific PCP may be denied; and reasons why a Provider may request a change.

vi. The purpose and value of scheduling an initial health assessment appointment.

vii. The appropriate use of health care services in a managed care system.

viii. The availability and procedures for obtaining after-hours services (twenty-four (24) hour basis) and care, including the appropriate Provider locations and telephone numbers. This shall include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services.

ix. Definition of what constitutes an emergency medical condition, emergency health care and post-stabilization services, in accordance with 42 CFR 438.114, and that prior authorization is not required to receive emergency services. Include the use of 911 for obtaining emergency services.

x. Procedures for obtaining emergency health care from specified plan providers or from non-plan Providers, including outside the Contractor's service area.

xi. Process for referral to specialists and or sub-specialty providers in sufficient detail so the Member can understand how the process works, including timeframes.

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xii. Procedures for obtaining any transportation services to service sites that are offered by the Contractor or available through the CCS program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

xiii. Procedures for filing a grievance or appeal with the Contractor, either orally or in writing, or over the phone, including procedures for appealing decisions regarding the Member's coverage, benefits, or relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the toll-free telephone number a Member can use to file a grievance or appeal, and title, address, and telephone number of the person responsible for processing and resolving grievances and responsible for providing assistance with completing the request. Information regarding the process shall include the requirements for timeframes to file a grievance or an appeal, and the timelines for the Contractor to acknowledge receipt of grievances, to resolve grievances, and to notify the Member of the resolution of grievances or appeals. Information shall be provided informational the Member that services previously authorized by the Contractor will continue while the grievance is being resolved.

xiv. The causes for which a Member shall lose entitlement to receive services under this Contract.

xv. Information on the Member's right to the CCS fair hearing process, the method for obtaining a hearing, the timeframe to request a hearing, and the rules that govern representation in a hearing. Include information on the circumstances under which an expedited CCS fair hearing is possible and information regarding assistance in completing the request, regardless of whether or not a grievance has been submitted or if the grievance has been resolved when a health care service requested by the Member or Provider has been denied, deferred or modified. Information on CCS fair hearing shall also include information on the timelines which govern a Member's right to a CCS fair hearing, pursuant to 22 CCR 42705, et seq. and as further described in CCS Numbered Letter 18-0594. Information shall include that services previously authorized by the Contractor will continue while the CCS fair hearing is being resolved

xvi. Information on the availability of, and procedures for obtaining, services at FQHCs and IHFs.

xvii. Information on the Member's right to seek family planning services from any qualified Provider of family planning services under the program, including Providers outside the Contractor's Provider network, how to access these services, and a description of the limitations on the services that Members may seek outside the plan. The Contractor may use the following statement:

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Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the U.S. Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan name (Contractor)] shall pay that doctor or clinic for the family planning services you get.

xviii. Procedures for providing female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist.

xix. DHCS' Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

xx. Information on how to access State resources for investigation and resolution of Member complaints, including the California Department of Managed Health Care (DMHC), HMO Consumer Service toll-free telephone number (1-800-400-0815).

xxi. Information concerning the provision and availability of services covered under the CCS program from Providers outside California's Provider network and how to access these services.

xxii. An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR 53889(i) which includes children receiving services under the foster care or adoption assistance programs; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

xxiii. Information on how minor consent services may be obtained through the Contractor's Provider network, an explanation of those services, and information on how they can also be obtained out of the Contractor's Provider network.

xxiv. An explanation of an American Indian Member's right to not enroll in a Medi-Cal managed care plan, to be able to access Indian Health Service facilities, and to disenroll from the Contractor's plan at any time, without cause.

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xxv. A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to H&S Code, Section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage (Member services guide), health plan newsletter or any other direct communication with Members.

xxvi. A statement as to whether the Contractor uses Provider financial bonuses or other incentives with its contracting Providers of health care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's Provider or the Provider's medical group or independent practice association.

xxvii. A notice as to whether the Contractor uses a drug formulary. The notice shall:

a. Be in the language that is easily understood and in a format that is easy to understand;

b. Include an explanation of what a formulary is, how the plan decides which prescription drugs are included in or excluded from the formulary, and how often the formulary is updated;

c. Indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information; and

d. Indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by their prescribing Provider for a particular medical condition.

xxviii. Policies and procedures regarding a Member's right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of State law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but not later than ninety (90) calendar days after the effective date of change.

xxix. Instructions on how a Member can view online, or request a copy of, the Contractor's non-propriety clinical and administrative policies and procedures.

xxx. Any other information determined by DHCS to be essential for the proper receipt of covered services.

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xxxi. The Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR 422.128 and 438.6(i), and Probate Code, Sections 4673 to 4678 and Sections 4800 to 4806, and all applicable regulations. The Contractor must inform Members that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

c) The Contractor must disseminate guidelines to all affected providers and, upon request, to enrollees and potential enrollees

2. Grievances

The following definitions apply to this provision:

Grievance means an expression of dissatisfaction about any matter other than an action (as identified within the definition of Member Appeal).

The Contractor shall implement and maintain a grievance system in accordance with 28 CCR 1300.68 (except Section 1300.68[g]), and 1300.68.01, 22 CCR 53858, and 42 CFR 438.420(a)-(c). The Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within thirty (30) calendar days from the date the Contractor receives the grievance. The Contractor shall notify the Member of the grievance resolution in a written Member notice.

a. The Contractor shall establish and maintain written procedures for the submittal, processing and resolution of all enrollee/family grievances and complaints and shall:

1) Operate according to its written procedures, which shall be approved in writing by DHCS prior to use, as shall any amendments.

2) Be described in information sent to each family within seven (7) days of the date of enrollment into the plan and annually thereafter. The description shall include:

a) An explanation of the Contractor's system for processing and resolving grievances.

b) A statement that grievance forms are available in the office of each PCP or in the Member services office.

c) A statement that grievances may be filed in writing or verbally directly with the Contractor or within any office of the Contractor's Providers.

d) The local or toll-free telephone number a family may call to obtain information about the grievance procedure, request grievance forms and register a verbal grievance.

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e) A written statement explaining the family's right to request a fair hearing.

3) The Contractor shall make local or toll-free telephone service available to families during normal business hours for requesting grievance forms, filing verbal grievances and requesting information.

4) The Contractor shall provide upon request a grievance form, either directly or by mail, if mailing is requested, to any family requesting the form.

5) The Contractor shall provide assistance to any family requesting assistance in completing the grievance form.

b. Grievance System Oversight

The Contractor shall implement and maintain procedures as described below to monitor the Member's grievance system and the expedited review of grievances required in 28 CCR 1300.68 and 1300.68.01 and 22 CCR 53858.

1) Procedure to ensure timely acknowledgement, resolution, and feedback to complainant. Provide oral notice of the resolution of an expedited review.

2) Procedure to ensure a Member is given reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and a toll-free number with TTY/TDD and interpreter capability.

3) Procedure for systematic aggregation and analysis of the grievance data and use for quality improvement.

4) Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, the Contractor shall ensure that any grievance involving the appeal of a denial based on lack of medical necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease.

5) Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's Medical Director.

6) Procedure to ensure that requirements of 42 CFR 438.420(a) through (c) are met regarding services to Members during the grievance process.

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7) Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance and is a health care professional with clinical expertise in treating a Member's condition or disease if any of the following apply:

   a) A denial based on lack of medical necessity;

   b) A grievance regarding denial of expedited resolutions of an appeal; or

   c) Any grievance or appeal involving clinical issues.

8) Procedures to ensure that Members are given a reasonable opportunity to present, in writing or in person before the individual(s) resolving the grievance, evidence, facts and law in support of their grievance. In the case of a grievance subject to expedited review, the Contractor shall inform the Member of the limited time available to present evidence. The Contractor shall also comply with 42 CFR 438.406(b)(3) concerning a Member's request to review records in connection with a grievance.

c. Grievance Log and Quarterly Grievance Report

The Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in 22 CCR 53858(e).

1) The Contractor shall submit quarterly grievance reports in the form that is set forth in 28 CCR 1300.68(f). The grievance report should include an explanation for each grievance that was not resolved within thirty (30) calendar days of receipt of the grievance.

2) In addition to the types or nature of grievances listed in 28 CCR 1300.68(f)(2)(D), the report shall also include, but not be limited to, untimely assignments to a PCP, issues related to cultural sensitivity and linguistic access, difficulty with accessing specialists, and grievances related to out-of-network requests.

3) For the Medi-Cal and CCS categories of the report, provide the following additional information:

   a) The total number of grievances received;

   b) The average time it took to resolve grievances, which includes providing written notification to the Member; and

   c) A listing of the zip codes, ethnicity, gender, and primary language of Members who filed grievances.

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4) The Contractor shall submit reports resulting from its quarterly review and analysis of all recorded grievances as required by 22 CCR 53858(e)(4).

5) The Contractor shall submit the quarterly grievance reports for the following quarters: April – June, July – September, October – December, January – March. The reports are due thirty (30) calendar days from the date of the end of the reporting quarter.

6) Recording in a grievance log of each grievance received by the Contractor, either verbally or in writing. The log shall include the following:

   a) Date and time the grievance is filed with the Contractor or Provider;

   b) Name of the enrollee and family filing the grievance;

   c) Name of Provider or staff person receiving the grievance;

   d) A description of complaint or problem;

   e) A description of the action taken by the Contractor or Provider to investigate and resolve the grievance;

   f) The proposed resolution by the Contractor or Provider;

   g) Name of Provider or staff person responsible for resolving the grievance;

   h) Date of notification of family regarding the proposed resolution; and

   i) An annotation if family filed for a CCS fair hearing, date of such filing, the date of the adjudication of the fair hearing and a synopsis of the determination resulting from the adjudication.

7) Immediate submittal of all medical quality of care issues to the Medical Director for action.

8) Submittal, at least quarterly, of all family grievances to the Quality Improvement Committee for review and appropriate action, for grievances related to access to care, quality of care and/or denial of services.

9) Review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care and denial of services, and the initiation of action to remedy any problems identified in such reviews.

10) Mailing of a written notice of the proposed resolution to the family that includes information about the family's right to request a fair hearing.

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11) System for addressing any cultural or linguistic requirements related to the processing of Member grievances.

12) A procedure for expedite review and disposition of grievances in the event of a serious or imminent health threat to a child, in accordance with H&S Code, Section 1368 and 1368.02.

13) Grievance forms shall be available in the offices of each of the PCPs, or in the Member services department of the Contractor.

14) The Contractor shall adhere to the following requirements and time frames in processing grievances:

a) Grievances shall be resolved within thirty (30) days of the enrollee's family submittal of a written or verbal grievance.

b) In the event resolution is not reached within thirty (30) days, the enrollee's family shall be notified in writing within thirty (30) days by the Contractor of the status of the grievance and shall be provided with an estimated completed date for resolution of the grievance.

c) Such notice shall include a statement that the enrollee's family may exercise its right to request a fair hearing.

i. The Contractor shall maintain in its files copies of all grievances, the responses to them and the date the grievance was filed.

ii. The Contractor shall report to DHCS, in summary form, on a quarterly basis all grievances filed by families of enrollees pursuant to this provision and the manner in which each grievance is resolved.

iii. Submission of a grievance shall not be construed as a waiver of the enrollee's family's right to request a fair hearing.

3. Notice of Action

The Contractor shall establish and maintain written procedures to provide each enrollee's family with a notice of any action taken by the Contractor to deny a request by a Provider for authorization of any medical services for the enrollee. The written Notice of Action (NOA) issued pursuant to this subsection shall be mailed within ten (10) days of the decision.

a. **Action** is defined as:

1) Denial or limited authorization of a requested service, including the type or level of service;

2) Reduction, suspension, or termination of a previously authorized service;

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3) Denial, in whole or in part, of payment for a service;

4) Failure to provide services in a timely manner, as defined by the State;

5) Failure of an MCO or PIHP to act within the timeframes; or

6) For a rural area resident with only one MCO or PIHP, the denial of a Medicaid enrollee's request to obtain services outside the network:

   a) From any other provider (in terms of training, experience, and specialization) not available within the network.

   b) From a provider not part of the network that is the main source of a service to the recipient – provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within sixty (60) days.

   c) Because the only plan or provider available does not provide the service because of moral or religious objections.

   d) Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.

   e) The State determines that other circumstances warrant out-of-network treatment.

b. A NOA is a formal letter informational a Member that a medical service has been denied, deferred, or modified. A NOA must include all of the following:

   1) The action that the MCO or its contractor has taken or intends to take;

   2) The reason for the action;

   3) A citation of the specific contract provision, statute or regulation that supports the action;

   4) The method by which such a hearing shall be obtained;

   5) The family's right to be self-represented or be represented by an authorized third party such as legal counsel, relative, friend or any other person;

   6) The Member's or Provider's right to file an appeal;

   7) The Member's right to request a State fair hearing;

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8) Procedures for exercising the Member's rights to appeal or grievance;

9) Circumstances under which an expedited review is available and how to request it;

10) The Member's right to have benefits continue pending the resolution of the appeal;

11) How to request benefits be continued; and

12) The circumstances under which the enrollee may be required to pay the costs of these services.

c. If a Member receives a NOA, the Member has three (3) options:

1) Members have ninety (90) days from the date on the NOA to file an appeal of the NOA with their plan. Members may request a CCS fair hearing regarding the NOA from DHCS, Office of Administrative Hearings within ninety (90) days of the NOA.

2) Members may request an independent medical review (IMR) regarding the NOA from DMHC. An IMR may not be requested if a State fair hearing has already been requested for that NOA.

3) Members may file an appeal with their plan regarding a NOA and request a State fair hearing regarding that NOA at the same time.

d. During the appeal the Member must have a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Member must be given the opportunity before and during the appeals process to examine their case file, including medical records and any other documents and records considered during the appeals process.

e. The Member must be notified that the State must reach its decision for a CCS fair hearing within ninety (90) days of the date of the request. For an expedited fair hearing, the State must reach its decision within three (3) working days of receipt of the expedited fair hearing request.

f. The Member can also file a grievance that is not about a NOA. The Member must file a grievance within one hundred eighty (180) days from the date the incident or action occurred which caused the Member to be dissatisfied.

The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the appeal is pending and the Contractor reverses a decision to deny, limit, or delay services.

The Contractor must pay for disputed services if the Member received the disputed services while the appeal was pending.

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Pursuant to 42 CFR 438.424, if the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor or the State must pay for those services, in accordance with State policy and regulations.

4. Member Appeal Process

The following definition applies to this provision:

Appeal means a request for review of an action.

The Contractor shall implement and maintain an appeal process as described below to resolve Member appeals.

a. The Member, or a Provider acting on behalf of the Member and with the Member's written consent, may file an appeal.

b. The Contractor must provide a Member notice, as expeditiously as the Member's health condition requires, within forty-five (45) days from the day the Contractor receives the appeal. A Member notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the Member's favor, the Contractor, at a minimum must include:

1) Member's right to request a CCS fair hearing;

2) How to request a CCS fair hearing;

3) Right to continue to receive benefits pending a CCS fair hearing; and

4) How to request the continuation of benefits.

c. The Contractor may extend the timeframe to resolve an appeal by up to fourteen (14) calendar days if the Contractor shows that there is a need for additional information and how the delay is in the Member's interest.

d. The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the appeal is pending and the Contractor reverses a decision to deny, limit, or delay services.

e. The Contractor must pay for disputed services if the Member received the disputed services while the appeal was pending.

5. Responsibilities in Expedited Appeals

The Contractor shall implement and maintain procedures as described below to resolve expedited appeals. When the Contractor determines or the Provider indicates that taking the

time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

a. Member or Provider may file an expedited appeal either orally or in writing and no additional Member follow-up is required.

b. The Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing.

c. The Contractor must provide a Member notice, as quickly as the Member's health condition requires, within three (3) working days from the day the Contractor receives the appeal.

d. The Contractor may extend the timeframe to resolve an appeal by up to fourteen (14) days if the Contractor shows that there is a need for additional information and how the delay is in the Member's interest.

e. The Contractor must make a reasonable effort to provide oral notice of expedited appeal decision.

6. Rights to a Fair Hearing

a. The Contractor is responsible for ensuring written procedures are in place to inform the enrollee's family of its right to a fair hearing conducted by the State in the event that a complaint/grievance is not resolved to their satisfaction. The Contractor shall inform each enrollee's family in writing of their right within seven (7) days of the date of the enrollment in the DP and annually thereafter.

b. Written notification shall be sent to the enrollee's family within seven (7) calendar days of the decision by the Contractor if there is a denial, deferral or modification of a request for a health care service requiring prior authorization.

7. Responsibilities in Expedited CCS Fair Hearings

Within two (2) working days of being notified by DHCS that a Member has filed a request for fair hearing which meets the criteria for expedited resolution. The Contractor shall deliver directly to the designated/appropriate DHCS, Office of Administrative Hearings administrative law judge all information and documents which either support, or which the Contractor considered in connection with, the action which is the subject of the expedited CCS fair hearing. This includes, but is not limited to, copies of the relevant treatment authorization request and NOA, plus any pertinent grievance resolution notice. If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to DHCS along with copies of the original NOA and grievance resolution notice. One or more plan representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited fair hearing, shall be available by phone during the scheduled CCS fair hearing. During the fair hearing process, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the hearing is pending and

the Contractor reverses a decision to deny, limit, or delay services. The Contractor must pay for disputed services if the Member received the disputed services while the hearing was pending.

8. Parties to an Appeal or CCS Fair Hearing

   The parties to an appeal or the CCS fair hearing include the Contractor as well as the Member and their representative or the representative of a deceased enrollee's estate

9. Denial, Deferral, or Modification of Prior Authorization Requests

   a. The Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with 22 CCR 51014.1 and 53894 by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in 22 CCR 51014.1, 51014.2, 53894, and H&S Code, Section 1367.01.

   b. The Contractor shall ensure that at least ten (10) days of advanced notice is given to a Member when a NOA results in a termination, suspension, or reduction of previously authorized covered services. The Contractor shall shorten the advanced notice to five (5) days if fraud probable recipient fraud has been verified.

   c. The Contractor shall provide expedited advanced notice to a Member when the Contractor or PCP indicates that the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The Contractor shall ensure an expedited authorization decision and provide an expedited notice as the Member's health condition requires and no later than three (3) working days after receipt of the request for services. Upon approval from DHCS, the Contractor may extend the three (3) working day expedited period to fourteen (14) calendar days if the enrollee requests an extension, or if the Contractor justifies a need for additional information and that the extension is in the Member's interest.

   d. The Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informational the Member of all the following:

      1) The Member's right to, and method of obtaining, a CCS fair hearing to contest the denial, deferral, or modification action and the decision the Contractor has made.

      2) The Member's right to represent themselves at the CCS fair hearing or to be represented by legal counsel, friend or other spokesperson.

      3) The name and address of the Contractor and California Department of Social Services toll-free telephone number for obtaining information on legal service organizations for representation.

   e. The Contractor shall provide required notification to beneficiaries and their authorized representatives in accordance with the timeframes set forth in 22 CCR 51014.1 and

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53894. Such notice shall be deposited with the United States Postal Service (USPS) in time for pick-up no later than the third (3) working day after the decision is made not to exceed fourteen (14) calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified, the Contractor shall notify the Member in writing of the deferral of the decision no later than fourteen (14) calendar days from the receipt of the original request. If the final decision is to deny or modify the request, the Contractor shall provide written notification of the decision to Members no later than twenty-eight (28) calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the timeframes, the decision is considered denied and notice of the denial must be sent to the Member on the date the timeframe expires.

10. Timeframes for Notice of Action: Termination, Suspension or Reduction of Services

a. The Contractor shall ensure that at least ten (10) days of advanced notice is given to a Member when a NOA results in a termination, suspension, or reduction of previously authorized covered services. The Contractor shall shorten the advanced notice to five (5) days if fraud probable recipient fraud has been verified.

b. The Contractor shall not be required to provide advanced notice of termination, suspension, reduction of services, or reduction of previously authorized covered services when the following conditions apply:

1) Death of a Member;

2) Member provides a written statement requesting service termination or giving information requiring termination or reduction of services;

3) Member admission into an institution that makes the Member ineligible for further services;

4) Member's address is unknown and mail directed to the Member has no forwarding address;

5) Member has been accepted for services by another local jurisdiction;

6) Member's PCP prescribes a change in the level of medical care;

7) An adverse determination made with regard to the pre-admission screening requirements for nursing facility admissions on or after January 1, 1989; or

8) Safety or health of individuals in a facility would be endangered. Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Member's urgent medical needs, or Member has not resided in the nursing facility for a minimum of thirty (30) days.

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11. Timeframes for Notice of Action: Standard Service Authorization Denial

    The Contractor shall provide required notification to beneficiaries and their authorized representatives in accordance with the timeframes set forth in 22 CCR 51014.1 and 53894. Such notice shall be deposited with the USPS in time for pick-up no later than the third (3rd) working day after the decision is made, not to exceed fourteen (14) calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified, the Contractor shall notify the Member in writing of the deferral of the decision no later than fourteen (14) calendar days from the receipt of the original request. If the final decision is to deny or modify the request, the Contractor shall provide written notification of the decision to Members no later than twenty-eight (28) calendar days from the receipt of the original request.

    If the decision regarding a prior authorization request is not made within the timeframes, the decision is considered denied and notice of the denial must be sent to the Member on the date the timeframe expires.

12. Timeframes for Notice of Action: Expedited Service Authorization Denial

    The Contractor shall provide expedited advanced notice to a Member when the Contractor or PCP indicates that the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The Contractor shall ensure an expedited authorization decision and provide an expedited notice as the Member's health condition requires and no later than three (3) working days after receipt of the request for services. Upon approval from DHCS, the Contractor may extend the three (3) working day expedited period to fourteen (14) calendar days if the enrollee requests an extension, or if the Contractor justifies a need for additional information and that the extension is in the Member's interest. If the Contractor denies a request for expedited resolution of an appeal, the Contractor must give the enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days.

13. Appeal and CCS Fair Hearing Process: Continuation of Benefits

    a. The Contractor must continue the Member's benefits if:

        1) The appeal is filed timely, meaning on or before the later of the following:

            a) Within 10 days of the Contractor mailing the NOA.

            b) The intended effective date of the Contractor's proposed action.

        2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

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3) The services were ordered by an authorized provider;

4) The authorization period has not expired; and

5) The Member requests extension of benefits.

b. The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the appeal is pending and the Contractor reverses a decision to deny, limit, or delay services.

c. The Contractor must pay for disputed services, in accordance with State policy and regulations, if the Contractor reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending.

14. Appeal and State Fair Hearing Process: Duration of Continued or Reinstated Benefits

a. If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

1) The Member withdraws the appeal;

2) The Member does not request a fair hearing within ten (10) days from when the Contractor mails an adverse decision;

3) A State Fair Hearing decision adverse to the Member is made; or

4) The authorization expires or authorization service limits are met.

15. Out-of-Network Providers

If the Contractor's network is unable to provide necessary medical services covered under this Contract to a particular Member, the Contractor must adequately and timely cover these services out-of-network for the Member, for as long as the Contractor's network is unable to provide them. Out-of-network Providers must coordinate with the Contractor with respect to payment. The Contractor must ensure that cost to the Member is no greater than it would be if the services were furnished within the Contractor's network.

The Contractor shall provide for the completion of covered services by a terminated or out-of-network Provider at the request of a Member in accordance with the continuity of care requirements in H&S Code, Section 1373.96.

If a Member fails to timely choose a PCP, the Contractor shall notify the Member in writing of the PCP with whom the Member will be assigned. If, at any time, a Member notifies the Contractor of a PCP choice, such choice shall override the Member assignment to a PCP.

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16. Changes in Availability or Location of Covered Services

    The Contractor shall obtain written DHCS approval prior to making any substantial change in the availability or location of services to be provided under this Contract, except in the case of natural disaster or emergency circumstance, in which case notice will be given to DHCS as soon as possible. The Contractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to DHCS at least sixty (60) days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. The Contractor's proposal shall allow for timely notice to Members to allow them to change Providers if desired.

17. Prohibited Punitive Action against the Provider

    The Contractor must ensure that punitive action is not taken against the Provider who either requests an expedited resolution or supports a Member's appeal. Further, the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient: for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information the Member needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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H. Quality Monitoring and Improvement Measures

1. The DP will be required to participate in State-led collaborative Quality Improvement Projects (QIP) during the course of the Contract.

2. Development of the focus of each of the QIPs will be done collaboratively with representatives from the DP, including administrators, network Physicians and families.

3. The Contractor will be required to submit data related to the QIP in a format as determined by DHCS.

4. Quality Assessment and Performance Improvement Program

   The Contractor shall develop an annual quality improvement report for submission to DHCS on an annual basis. The annual report shall include:

   a. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to:

      1) The collection of aggregate data on utilization;

      2) The review of quality of services rendered;

      3) The results of the external accountability set measure; and

      4) Outcomes/findings from QIPs, consumer satisfaction surveys and collaborative initiatives.

   b. Copies of all final reports of non-governmental accrediting agencies (e.g., Joint Commission on Accreditation of Healthcare Organizations, National Committee for Quality Assurance) relevant to the Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

   c. An assessment of subcontractor's performance of delegated quality improvement activities.

5. Performance Measurement

   QIP performance measurements will be developed collaboratively with representatives from the DP, including administrators, network Physicians and families.

6. The Contractor is required to conduct or participate in QIPs approved by DHCS.

   a. One QIP must be an internal quality improvement project or

   b. One QIP must be a DHCS facilitated statewide collaborative.

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I. Administrative Responsibilities

1. Legal Capacity

   a. The Contractor shall be a legal entity under California statute, have the legal capacity to enter into a Contract with DHCS, and be appropriately licensed by the State of California.

   b. The Contractor shall have a legally constituted governing body, an appropriate administrative structure and a qualified administrative team that will enable it to carry out the functions for which it is contractually liable.

   c. The Contractor shall possess appropriate financial capability and experience to undertake the provision of health care services as identified Exhibit E, Section 35 (Financial Statements).

2. Governing Body

   The Contractor shall have an accountable governing body that shall be committed to supplying any necessary resources to assure full performance under the Contract.

3. Advisory Board

   The Contractor shall establish a Demonstration Project Advisory Board (DPAB) with a minimum of nine (9) representatives included CCS-approved health care professionals, advocacy groups, and parents of potential enrollees with a CCS-eligible medical condition who potentially would be enrolled in the DP as well as an enrollee with a CCS-eligible medical condition who might be enrolled in the DP.

   The purpose of the DPAB is to provide advice on the development, implementation and ongoing activities of the DP. Family representatives must equal at least one-liability (1/3) of the total membership of the DPAB and shall also function as members of a family subcommittee to encourage active and ongoing participation of parents and other family members in the development and implementation of a family-centered health care delivery system. To the extent possible, selection of family representatives to DPAB should reflect the cultural, educational and socio-economic background of the families proposed to be served through the DP.

   a. Written Plan

      The Contractor must develop and maintain a written plan, approved by DHCS, which provides a detailed description of the responsibilities and operation of DPAB, including the family subcommittee. At a minimum, the plan must include the following:

      1) The intended composition of DPAB, the number of members and the criteria and process for selection.

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2) The roles, responsibilities and authority of DPAB, particularly in relation to the administrative body of the DP.

3) The mechanisms for linking DPAB with the family subcommittee and families of children enrolled in the plan for purposes of identifying issues for discussion and/or action, disseminating information, and eliciting feedback related to consumer experiences.

b. Roles and Responsibilities

The Contractor must allow for ongoing input on and evaluation of policies, procedures and the operation of the DP by the DPAB in relation to the following:

1) Access to care, including information on the number and nature of requests for services; criteria and processes for authorization or denial of services and appeal mechanisms, procedures and outcomes.

2) Care delivery, including utilization patterns, system efficiency and quality of care, including incorporation of family-centered philosophy into Provider/staff training.

3) Evaluation of care, including policies and protocols of the QIP, mechanisms for soliciting family feedback.

c. Family Subcommittee

The subcommittee, consisting of a minimum of seven (7) members, will serve as a vehicle for communication and collaboration between the members of the DPAB and the parents and other family members of children enrolled in the DP. The purpose of the subcommittee shall be to encourage and facilitate the active participation of families of children enrolled in the DP in a family-centered system of health care.

4. Administrative Team

The administrative team shall include, at a minimum:

a. Administrator

There shall be a full-time Administrator with experience in health care management who will assume the overall responsibility for the day-to-day management of the DP, including staff, personnel performance and fiscal oversight.

b. Medical Director

1) The DP shall appoint a Medical Director who must be a CCS-approved Pediatrician, Pediatric Specialist or Pediatric Subspecialist. The Medical Director shall:

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a) Ensure that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.

b) Develop medical policies and procedures for the delivery of health care that are consistent with CCS program standards.

c) Develop policies and procedures for the credentialing of network individual Providers and facilities.

d) Ensure that medical policies and procedures are implemented and followed.

e) Develop and implement a system to resolve medically related grievances from Providers and/or clients and families.

f) Develop, implement and provide on-going management of the QIP.

g) Develop, implement and provide on-going management of the utilization review system.

h) Ensure compliance with all State and local reporting statutes and regulations on communicable disease and child abuse and neglect.

i) Develop and implement training of DP staff in:

i. CCS program Provider standards;

ii. DP's medical policies and procedures, including care coordination and case management activities;

iii. DP's policies and procedures on implementation of the medical home; and

iv. Family-centered care and the role of the enrollees and families in decision making.

2) Develop and implement training of DP network Providers in:

a) CCS program Provider standards;

b) DP medical policies and procedures, including care coordination and case management activities;

c) Medical home assignments and responsibilities; and

d) Family-centered care and the role of the enrollees and families in decision making.

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3) Provide oversight and review of all medical care provided.

4) Participate in the monitoring, investigating and hearing of grievances.

5) Provide lead responsibility for the DP's participation in quality improvement activities, including participation with other DP Medical Directors in designing and implementing collaborative projects.

6) Review all denial of services.

7) Review all deaths of enrollees.

c. Director of Care Coordination

1) The Contractor shall have a full time Director of Care Coordination, who meets the following qualifications:

a) Current licensure as an RN in California;

b) Bachelor of Science degree in nursing and a Master's degree in nursing or health related field; a combination of items c) and d) below may be substituted in lieu of a Master's Degree;

c) Minimum of three (3) years of management experience; and

d) Relevant experience with children and youth with special health care needs, as well as experience with care coordination, utilization review, insurance authorization, regulatory compliance, and quality monitoring.

2) The responsibilities of the Director of Care Coordination shall include:

a) Supervision of the CC;

b) Development and implementation of the policies and procedures for the CCs;

c) Participation in utilization review activities; and

d) Serving as a quality improvement team member.

d. Parent Liaison

The DP will employ or contract with a parent of an enrollee with a chronic CCS-eligible medical condition. The parent will provide consultation to the DP's administration and CCs as well as work with the DPAB and its family subcommittee.

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e. Social Worker

The Contractor will employ or contract with a social worker to provide consultation to the DP's Provider network and the CCs.

The social worker shall:

1) Possess a Master's degree in social work;

2) Be a LCSW; and

3) Have at least two (2) years of experience providing social work services to children and youth with special health care needs.

f. Nutritionist

1) The Contractor will employ or contract with a Nutritionist to provide consultation to the Provider network and to the CCs.

2) The Nutritionist shall:

a) Possess a Master's degree in nutrition, dietetics, institutional management, public health nutrition or other nutrition field; a combination of items b) and c) below may be substituted in lieu of a Master's Degree;

b) Possess a valid Certificate of Registration with the Commission of Dietetic Registration of the American Dietetic Association; and

c) Have at least two (2) years of full-time or equivalent clinical nutrition experience providing nutrition assessment and counseling for enrollees with special health care needs.

5. Care Coordinators

The Contractor shall employ or contract with either licensed RNs or medical social workers to perform the functions of care coordination.

6. Administrative Structure

The DP shall have as part of its administrative structure the capability to carry out the duties and responsibilities required under the Contract which shall include at a minimum:

a. Submit a complete organizational chart;

b. A management information system that can capture and report data sufficient to provide specified reports on a timely basis in order to enable ongoing monitoring and evaluation by DHCS;

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c. The maintenance of financial records and books of accounts maintained on an accrual basis, in accordance with generally accepted accounting principles which fully disclose the disposition of all DP funds, including payment for services to contracted Providers;

d. Membership and enrollment reporting systems as specified by DHCS; and

e. A medical record system maintained in a consistent, PHI and organized manner, with designated persons, qualified by training or experience, responsible for the system.

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J. Evaluation of Demonstration Projects

DHCS may utilize an "intervention and comparison group" design or other appropriate evaluation method to determine or assess the effects of the DPs as they relate to key research questions. An independent evaluation team selected by the Department will work with DHCS officials and Pediatric Specialists and subspecialists representing the Contractor to create a comparison group of patients with similar diagnoses, co-morbidities and annual baseline expenditures who are age- and gender- matched to those patients who are enrolled at the intervention sites. The Contractor will cooperate with the independent evaluation team and Department representatives as necessary to ensure successful implementation of the evaluation methodology.

1. Evaluation Questions

   Key questions to be answered and some of the measures to be reported may include:

   a. Did the implementation of the new model demonstrate evidence of improved care coordination, including satisfaction with communication among health care Providers, satisfaction with accessing specialist care, and satisfaction with coordinating care provided by other agencies and organizations?

   b. Did the quality of care for children included in the program improve over the course of the demonstration, including condition-specific measures and adherence to standards and/or guidelines, age-appropriate wellness visits and readmission rates?

   c. Did the model reduce the rate of growth in spending?

   d. Did the model change the distribution of the mix of services utilized by patients targeted in the demonstration, including immunization rates, emergency room visits, inpatient hospital days and use of community-based services?

   e. Did the model improve the value or cost-effectiveness of care provided to enrollees in the demonstration?

   f. Did enrollee, family and Provider satisfaction improve over the course of the demonstration, including satisfaction by family with its participation in the decision-making process and by Providers with use of the system of care?

2. Evaluation Requirements for Contractors

   The Contractor shall ensure that all reporting requirements which provide information on specific enrollees in the DP are fully complied with. This will ensure that encounter/claims information is available for all services which enrollees will receive.

   The Contractor will assist the evaluators in accessing family members of some of the enrollees for the purposes of completing surveys and/or in-depth studies.

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Some or all of the enrollees in a DP, their families and some or all of the Providers that may be part of a DP's network will be asked to participate in one or more surveys related to the DP. Such surveys may include but not limited to experiences with access, availability, satisfaction and quality of care received in the DP. These surveys could potentially compare these experiences to the experiences encountered prior to the development of the DPs. The Contractor will participate in one or more surveys on a variety of subjects related to the DP.

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K. Implementation Plan and Deliverables

The implementation plan and deliverables section describes DHCS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the implementation period before beginning operations. Deliverables are those policies and procedures necessary for the conduct of business including but not limited to those listed in the summary readiness review submissions below.

Once the Contract is awarded, the Contractor has fifteen (15) calendar days after they sign the Contract to submit a Workplan that describes in detail how and when the Contractor will submit and complete the deliverables to DHCS as specified in the Readiness Review. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plans in the event of implementation delays.

The implementation period begins with the effective date of the Contract and extends to the beginning of the operations period (approximately six (6) months after the effective date of the Contract). The operations period is the period of time beginning with the effective date of the first (1) month of operations and continues on through the last month of capitation and services to Members.

The Readiness Review will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. DHCS will review and approve each of the deliverables, milestones, and timeframes. However, the Contractor shall not delay the submission of deliverables required in the Readiness Review while waiting for DHCS approval of previously submitted deliverables required by the Readiness Review. Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved Readiness Review. In the event the Contractor fails to submit all deliverables in accordance with the milestones and timeframes in the approved Readiness Review, DHCS may impose sanctions or any other remedy available under this Contract, or applicable law.

In the event that this section omits a deliverable required by the Contract, the Contractor will be responsible to assure that all Contract requirements are met. Upon successful completion of the implementation plan and deliverables section requirements, DHCS will authorize, in writing, that the Contractor may begin the operations period.

Summary of Readiness Review Submissions

DHCS will conduct a comprehensive readiness review prior to the operations phase to ensure that the Contractor is prepared to meet all program requirements. The first step of the readiness review will be a meeting between the Contractor and DHCS to review timeline and discuss all necessary submissions to document readiness for the program implementation. As a follow-up to the meeting, DHCS will provide the Contractor with a letter further outlining pre-implementation requirements. Requirements will be documented through the use of the Readiness Review. Prior to program implementation, DHCS may also conduct a site visit to confirm that all necessary components are in place.

2015

UTILIZATION MANAGEMENT PROGRAM

2015
Utilization and Resource Management Program

SIGNATURE PAGE

Signature of Chief Medical Officer

_____ _____

Dr. Margaret Beed Date

Program Scope

The purpose of this Utilization Management Program document is to define and describe the Health Plan of San Mateo (HPSM)'s multidisciplinary, comprehensive approach to managing resource allocation through systematic monitoring of medical necessity and quality while maximizing the cost effectiveness of the care and service provided to members.

HPSM's Utilization Management (UM) Program) has been designed to meet the needs of beneficiaries across the continuum of care. This includes pre-service review and authorization, concurrent and retrospective review of inpatient care including acute care, rehabilitation and skilled nursing), pharmaceuticals, DME, and ambulatory services. The UM Program is designed to promote the provision of medically appropriate care; to monitor, evaluate, and manage resource allocation; and to monitor cost effectiveness and quality of the healthcare delivered to our members through a multidisciplinary, comprehensive approach and process. The Utilization Management Program supports the HPSM mission: to improve the health of our members through high quality and preventive care.

Utilization and resource management functions are performed by HPSM's Health Services Department. The Health Service Department provides UM services to meet the needs of its members, and UM functions are integrated into the care coordination and care management functions related to members determined to be at risk for adverse health outcomes.
This Utilization Management Program is developed in compliance with the California Department of Health Services, the Center for Medicare and Medicaid Services (CMS) regulations for Medi-Cal and Knox-Keene regulations 1300.70, and SB 59. In addition, this program applies to all lines of business within HPSM.

ORGANIZATION

Background

The Health Plan of San Mateo (HPSM) was created in 1987 by a coalition of local elected officials, hospitals, physicians, and community advocates to serve the needs of Medi-Cal eligible beneficiaries. As a County Organized Health System (COHS), HPSM is authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in San Mateo County. Based within the community it serves, HPSM is sensitive to, and its operation reflects, the unique health care environment and needs of San Mateo County's Medi-Cal beneficiaries. In 2006, HPSM began a Dual Eligible Special Needs Plan (D SNP), CareAdvantage, which allowed HPSM to offer the Medicare and Medi-Cal benefits under one umbrella to all dually eligible individuals with the goal of providing members with access to high quality services delivered in a cost-effective and compassionate manner. Beginning April 2014, HPSM began its Cal MediConnect (CCI) Medicare-Medicaid Plan to further serve dually eligible members.

Consistent with its mission, HPSM operates three additional product lines in response to community needs. These include Healthy Families, Healthy Kids and HealthWorx. The first two lines of business serve low income children while the latter serves In-Home Supportive Services (IHSS) workers and eligible San Mateo county temporary employees. By taking on these additional groups and a state-licensed Medicare program under a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS), HPSM has expanded and reaffirmed its commitment to providing health care to San Mateo County's most vulnerable residents.

Effective February, 2010, HPSM expanded its service contract with the Department of Health Care Services (DHCS), to include Long Term Care (LTC). This expansion includes facility charges in LTC facilities, sub-acute and intermediate care facilities (ICFs). In July 2012, Community-Based Adult Services (CBAS) was added to HPSM's DHCS' contract. In 2013, beneficiaries in the Healthy Families Program have been transitioned to Medi-Cal, as part of phased transition throughout the State of California.

In 2015, HPSM serves approximately 130,000 members under the following lines of business: Medi-Cal, Care Advantage (D SNP), CareAdvantage Cal MediConnect (MMP), Healthy Kids and HealthWorx. All HPSM Dual eligible members of CA CMC, D-SNP and Medi-Cal Seniors and Person's with disabilities (SPDs) will be eligible for CCI Medi-Cal services.

HPSM's Delivery System

HPSM is able to fulfill its mission in San Mateo County because of its successful partnership with its outstanding healthcare delivery partners. Medical services are delivered to our members through our directly-contracted provider network. HPSM's network includes over 650 primary care physicians and over 2,400 specialists. In addition, HPSM's network includes 8 hospitals and medical centers located in San Mateo County and in neighboring San Francisco. While HPSM does not contract directly with its pharmacy network, HPSM's delegates this responsibility to its contracted pharmacy benefits manager, Argus. All pharmacy and medical service authorizations under HPSM's scope of service for each line of business are performed by HPSM licensed clinical staff.

Scope of Services

HPSM provides a comprehensive scope of acute and preventive care services for its members through its Medi-Cal, Healthy Kids, HealthWorx, Care Advantage (D SNP), and CareAdvantage Cal MediConnect (MMP) lines of business. Certain services are not covered by HPSM or may be provided by a different agency:

- Mental Health services (Mild to Moderate mental health services and Behavioral Health Treatment (BHT) for autism) are administered by the San Mateo County Behavioral Health and Recovery Services for all lines of business.

- Delta Dental contracts with HPSM to provide services for Healthy Kids and CareAdvantage members.

- California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS authorizes care and in San Mateo County, HPSM pays for the specific medical services and equipment provided by CCS-approved specialists. The CCS program is funded with State, County, and Federal tax monies, along with some fees paid by parents or guardians.

- Health Plan of San Mateo works with community programs to ensure that members with special health care needs, high risk or complex medical and developmental conditions receive additional services that enhance their medical benefits. These partnerships are established through special programs and specific Memorandums of Understanding (MOUs) with certain community agencies including the San Mateo County Health Services Agency (HSA), California Children's Services (CCS), and the Golden Gate Regional Center (GGRC).

AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

Individuals

A. While the San Mateo Health Commission (Commission) has ultimate accountability and responsibility, the Commission holds the Chief Executive Officer (CEO) and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The CEO and CMO ensure separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced.

B. The Chief Medical Officer oversees the Health Services Department and Quality Improvement Program. The Chief Medical Officer is the CEO's designee for the implementation of both the QI and the UM program. In conjunction with the Deputy Chief Medical Officer, the Chief Medical Officer is responsible for ensuring that the Utilization Management program is properly developed, implemented and coordinated.

C. The Deputy Chief Medical Officer reports to the Chief Medical Officer and is responsible for the management of the Health Services Department. The Senior Health Services Clinical Manager reports to the Chief Medical Officer, and is responsible for the planning, organizing, and development of materials and systems to support the utilization management and transitions of care functions within the Health Services Department. The Senior Health Services Clinical Manager works closely with the Health Services and Care Coordination Staff to assure members receive high quality, medically necessary care in a way that balances individual need and cost effectiveness in the short and long term. Care Coordination staff focuses on coordination of care and utilization needs of high risk members of the Plan. These members are identified through health risk assessments and provider and community referrals as well by utilization data and trends.

D. The Senior Health Services Clinical Manager, reporting to the Chief Medical Officer, is responsible for the day to day supervision of utilization staff including RNs and LVNs responsible for utilization determinations. The Senior Health Services Clinical Manager also supervises clerical and support staff in the Health Services Department.

E. The Deputy Chief Medical Officer/Clinical and Administrative Director of Behavioral Health reports to the Chief Medical Officer. Serving as the behavioral health subject matter expert, the Deputy Chief Medical Officer/Clinical and Administrative Director of Behavioral Health oversees and monitors the behavioral health services delivered to HPSM members, ensuring coordination, appropriateness, and quality.

F. The Pharmacy Services Manager reports to the Chief Medical Officer and is responsible for the oversight of pharmacy benefits operations activities, including Medi-Cal and Medicare Part D programs, formulary management, cost containment and reimbursement strategies, program administrative leadership, supervision of pharmacy staff, program development and policy enhancement.

G. The Director of Provider Network Development and Services is responsible for provider network development, contracting, and provider relations management for contracted and non-contracted providers. The Provider Services Department is responsible for assuring that providers are able to efficiently deliver services to members and receive prompt reimbursement for services performed. The Provider Services Representatives perform provider education and assist providers in problem resolution.

H. The Director of Compliance and Regulatory Affairs is responsible for contract requirements and coordination of external quality review requirements as well as compliance to HIPAA and functions relating to fraud investigations, referrals, and prevention. As part of this function, the Director ensures that HPSM meets the requirements set forth by the Department of Health Services (DHS), Department of Health Services Managed Medi-Cal Division (DHS/MMCD), Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS). The compliance staff works in collaboration with the HPSM QM Department and other functional areas, such as Utilization Management and Grievance and Appeals, to evaluate the results of performance audits and to determine the appropriate course of action to achieve desired results. In addition, the Director oversees the development and amendment of HPSM policies and procedures to ensure adherence to state and federal requirements and functions as HPSM's Privacy Officer.

Committee Organization and Reporting Structure

The structure of the Utilization Management Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of the HPSM healthcare delivery. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect the multiple disciplines within the organization.

The HPSM Organization Chart and the Commission Structure outline HPSM's governing body, HPSM senior management, as well as committee reporting structure and lines of authority. Job descriptions and committee policies/ procedures define associated responsibilities and accountability.

PURPOSE OF THE UTILIZATION MANAGEMENT PROGRAM

Utilization Management Program Goals

The Utilization Management Program shall endeavor to promote the delivery of high quality care in the most cost-effective manner for HPSM's members, and thus contributes to the achievement of the HPSM mission. The Utilization Program goals and objectives are:

- Improve the quality of care delivered to members by ensuring they receive the appropriate level and mix of medical services in the most appropriate setting - The right service at the right time at the right place for the right reason.
- Facilitate communication and develop positive relationships between members and contracted providers by providing timely appropriate utilization review processing.
- Identify members with special needs and ensure that appropriate care is delivered to them through collaboration with county partners. This will reduce overall healthcare expenditures by developing and implementing effective preventive care and health promotion programs.
- Identify actual and/or potential quality issues during utilization review activities and refer to the Chief Medical Officer.
- Ensure compliance with regulatory agencies.

The Utilization Management Program will ensure that:

- HPSM's UM review staff utilize nationally recognized standard criteria and informational resources to determine the medical necessity of healthcare services to be provided (e.g., Medi-Cal Manual of Criteria issued by the State of California, Milliman Care Guidelines, Medicare Coverage Determination Manuals, and the California Code of Regulations, Title 22).

- HPSM's UM review staff, including physicians, licensed nurses, and unlicensed trained employees, carries out the responsibilities designated for their level of expertise within their respective scope of practice, and as defined in their Job Descriptions.

- HPSM's UM Program collaborates with the HPSM Quality Management program to ensure ongoing monitoring and evaluation of quality of care and service, and continuous quality improvement. At least annually, the UM Program description, policies, and procedures are reviewed by members of the HPSM Senior Management. The UM Program is revised if necessary.

Evaluation of the UM program

An evaluation of the Utilization Management Program is conducted at least annually. This includes an evaluation of program structure, scope, processes, information sources used to determine benefit coverage and medical necessity and involvement of senior level physician and behavioral health practitioner. In addition the evaluation includes a thorough review of reports and analysis of performance measures and standards, complaints, activity reports, denials and appeals, consistency audits, and subscriber and provider satisfaction surveys. This UM program evaluation is a component of the Annual Evaluation of the Quality Program. Members and Providers are surveyed at least annually regarding their level of satisfaction with HPSM Utilization Management processes. Where opportunities for improvement are identified during the evaluation process, the organization takes action to improve performance.

Program Structure

The Health Services Department is responsible for all UM processing for members in all programs. Leadership is provided by the Chief Medical Officer. The Deputy Chief Medical Officer reports to the Chief Medical Officer. Under the direction of the Deputy Chief Medical Officer, the Senior Health Services Clinical Manager is responsible for the direct supervision of the staff performs UM functions within the department. The Senior Health Services Clinical Manager supervises the Care Coordination Nurse Case Managers and Care Coordination Technicians and is responsible for the day-to-day management of the Care Coordination unit, including the UM functions performed by this unit.

The Senior Health Services Clinical Manager directly supervises the UM Nursing review staff and Authorization Assistants.

The Pharmacy Services Manager, who also reports to the Chief Medical Officer, supervises the pharmacy staff and day to day operations of pharmacy benefit management and utilization. The UM staff work collaboratively with contracted healthcare providers in the community, in an effort to assure the delivery of appropriate, cost effective, quality evidence-based healthcare. The UM Program necessitates the cooperative participation of all HPSM contracted healthcare providers, including physicians, allied healthcare professionals, hospitals, outpatient facilities as well as members to ensure timely and effective delivery of healthcare services.

➢ HPSM Utilization Management Committee

The Utilization Management Committee promotes the optimal utilization of healthcare services while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee monitors the utilization of healthcare services by HPSM members in all programs to ensure appropriate ness and timeliness of clinical decision making, identify areas of improvement including under or over utilization that may adversely impact member care. The UM Committee meets at least Quarterly.

Roles and Responsibilities

- Provides coordination of UM functions.
- Provides oversight for appropriateness and clinical criteria used to monitor care.
- Monitors data and reports and identifies opportunities for improvement of internal processes and systems.
- Measures and documents effectiveness of actions taken.
- Reviews and evaluates data to identify under or over utilization patterns.
- Reviews care management issues related to continuity and coordination of care.

METHODS OF REVIEW AND AUTHORIZATION

Authorization Decisions

HPSM UM staff evaluates and processes authorization requests to ensure timely and medically appropriate healthcare and health services are rendered in an efficient and cost effective manner. Standard Medicare and Medi-Cal definitions of medically necessary services are applied as follows:

a) For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR §1395v;

b) For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as under Title 22 California Code of Regulations (CCR) Section 51303.

If there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), HPSM will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards. For other lines of business, i.e. Healthy Kids, HealthWorx, the Medi-Cal standard is the norm.

Authorization determinations made by licensed review nurses or pharmacist reviewers are based on medical necessity and appropriateness and reflect the application of HPSM's approved review criteria and guidelines. Physician review and determination is required for all denial decisions for requested medical and pharmacy services. Reviewing physicians will consult with referring provider when appropriate.

The HPSM Chief Medical Officer is responsible for providing clinical expertise to the HPSM Health Services staff and exercising sound professional judgment during review determinations regarding healthcare and health services. The HPSM CMO has the authority, accountability and responsibility for denial determinations referred by the HPSM Health Services staff.

Services Excluded from Prior Authorization

Prior Authorization is not required for the following when provided by a qualified, licensed healthcare provider:

a. Emergency and post-stabilization services, including emergency behavioral health care;

b. Urgent care;

c. Crisis stabilization, including mental health ;

d. Urgent support for home and community service-based recipients;

e. Family planning service

f. Preventive services;

g. Basic prenatal care;

h. Communicable disease services, including STI and HIV testing;

i. Out-of-area renal dialysis services;

SELF-REFERRALS

Prior Authorization or referrals for specialty services are not required by HPSM if provided by network providers and the referral is made through member’s primary care physician.

There are some services, which can be accessed without a referral from the PCP. Obstetrical and gynecological (OB/GYN) services may be self-referred when obtained through HPSM’s provider network. OB/GYN services include an annual well-woman gynecological visit, primary and preventive gynecology care, including a PAP smear and referrals for diagnostic testing related to maternity and gynecological care, and medically necessary follow-up care.

Family planning services also do not require referral: family planning services include health education and counseling necessary to make an informed choice about contraceptive methods.

SPECIALTY CARE AND OUT OF NETWORK REFERRALS

The primary care practitioner (PCP) is responsible for initiating, coordinating and documenting referrals to specialists. Members may request a second opinion from providers within the contracted network. If there is not a second provider with the same specialty in the network, members may request a second opinion from a provider out of network at no charge to the member.

Emergency Services Authorization

HPSM members have access to emergency services. Emergency services do not require prior authorization. In accordance with current law and Prudent Layperson definition, members presenting to an emergency room facility will be triaged by the emergency room staff.

Each primary care provider/PCP shall provide 24-hour, seven days per week physician access. After regular business hours, the PCP or on-call physician has the authority to direct care as needed to emergency and urgent services and redirect members to the appropriate level of care.

A "Prudent Layperson" is considered to be a person who is without medical training and who draws on his/her practical experience when making a decision regarding whether emergency medical treatment is needed. A Prudent Layperson is considered to have acted reasonably if other similarly situated laypersons would have believed that emergency medical treatment was necessary.

Emergency services are subject to retrospective review for medical necessity and to determine if the condition meets the Prudent Layperson definition of emergency.

Prospective Review/Prior Authorization

Prior Authorization is required for the following services.

CareAdvantage (D SNP and MMP)

a) Home Health

b) Durable Medical Equipment

c) Non-emergency ambulance transportation

d) Skilled Nursing Facility stays

e) Elective Acute Inpatient admissions

Medi-Cal, Healthy Kids, HealthWorx

- Inpatient admissions
- LTC admissions
- Selected outpatient surgeries (except where otherwise specified, i.e., minor office procedures)
- Selected advanced imaging tests
- Home Healthcare
- General inpatient hospice care, continuous care, respite care
- Selected Durable Medical Equipment
- New medical technology (considered investigational or experimental – includes drugs, treatment, procedures, equipment, etc.)
- Medications not on the HPSM Approved Drug List and/or exceeding the HPSM monthly medication limit
- Community Based Adult Services (CBAS)
- Long Term Services and Supports services under CCI program

HPSM routinely analyzes past utilization patterns to determine whether it would be in the member's best interest to remove any of the listed services from the prior authorization requirement or add additional requirements. HPSM can make adjustments to this list by amending it as appropriate. Authorization requirements for medical services are listed on the HPSM website at www.hpsm.org. Providers can also review the approved HPSM drug formulary at this website.

Authorization Process

Prospective review is a process performed by the UM staff to evaluate requests for specified services or procedures that require authorization. Providers send requests for prior authorization of medical services to the HPSM Health Services Department by mail, fax and/or telephone, based on the urgency of the requested service. Providers are required to supply the following information for the requested service:

- Member demographic information (name, date of birth, etc.);
- Provider demographic information (Referring and Referred to);
- Requested service/ procedure, including specific CPT/HCPCS Codes;
- Member diagnosis (ICD-9 Code and description);
- Clinical indications necessitating service request;
- Pertinent medical history and treatment; and
- Location where service will be performed.

Pertinent data and information are required by the UM staff to enable thorough assessment for medical necessity and to assign appropriate diagnosis and procedure codes to the authorization. The UM staff use various sources to obtain all necessary clinical information.

These sources may include, but may not be limited to, providers and their staff, hospital utilization review/discharge planning staff, specialists and ancillary providers, member medical records and referral/ authorization history.

Prior authorization (PA) requests for pharmacy services are sent to HPSM's contracted pharmacy benefit manager, Argus, and must include:

- Member demographic information (name, date of birth, etc.);
- Prescriber demographic information;
- Provider demographic information;
- Requested medication, including specific NDC codes;
- Member diagnosis (ICD-9 Code and description);
- Clinical indications necessitating medication; and
- Pertinent medical history and treatment.

Prior authorizations for pharmacy requests that do not meet criteria established by HPSM are forwarded to HPSM staff pharmacist reviewers for evaluation. All denials are reviewed by the Chief Medical Officer.

Eligibility

Authorization is based on member eligibility at the time of service and is verified by the UM staff at the time of the request. UM staff verifies eligibility for all other product lines by looking the member up in the HPSM Claims and Authorization Management system, HEALTHsuite.

Benefits

HPSM administers healthcare benefits for its members, as defined by contracts with the Department of Health Services (DHCS) for Medi-Cal, and Centers for Medicare and Medicaid Services (CMS) for Medicare. HPSM Medi-Cal Benefit Guidelines are utilized by HPSM to support UM decisions. CMS posts benefit information on its web site regarding Medicare benefits, applicable to CareAdvantage (D SNP and MMP). Benefits for those eligible for CCI are defined in contracts with DHCS and CMS. All other product lines have specific benefit packages described in each individual program's Evidence of Coverage. Benefit coverage for requested service is verified by the UM staff during the authorization process.

Exclusions

Based on the specific contract requirements, some services are explicitly excluded from coverage. Per contract requirements, specific services may not be covered benefits, unless clinical indicators support medical necessity as determined by the Chief Medical Officer, in which case the medically needed services may be provided. Every attempt is made by the UM staff to identify additional community programs to provide wrap around services to enhance the HPSM benefit packages.

UM PROCESS AND THE AUTHORIZATION OF CARE

HPSM has standardized authorization processes in place. These processes are reviewed continuously, with changes adopted as appropriate following guidance from Operating Instruction letters (OILS), the Medi-Cal Provider manuals and bulletins and CMS updates.

Pre-Admission Review of Elective Procedures (Acute, Skilled, Rehabilitation, Long Term Care)

The HPSM UM nurse receives requests for authorization of certain elective procedures prior to admission to ensure admission to a healthcare facility is appropriate and medically necessary.

The UM nurse will authorize the procedure and inpatient designation or number of acute inpatient days as appropriate by line of business." Inpatient status" approval will be used when payment is rendered by global payments, such as Diagnostic Related Group (DRG), for example, CareAdvantage inpatient authorizations and, specific Medi-Cal authorizations (obstetric). Approval of individual "acute inpatient days" is used for Care Advantage Skilled Nursing stays, and Medi-Cal, Healthy Kids and HealthWorx acute inpatient stays as payment is rendered on a per diem basis.

Should the UM nurse question the medical necessity of services to be rendered, or appropriateness of the level of care for service based on review criteria and guidelines, the HPSM Chief Medical Officer will be consulted for case review. The HPSM Chief Medical Officer or designee will contact the Attending Physician to discuss the case, if necessary.

Should the HPSM Chief Medical Officer or designee determine that proposed services are not medically necessary or indicated, a denial determination might be made by the HPSM Chief Medical Officer or designee. Denial notification and communication will be made in accordance with HPSM UM timeliness standards and denial notification requirements.

Concurrent/Continued Stay Review (Acute, Rehabilitation, Long Term Care)

Concurrent/Continued Stay Review is a process coordinated by the on-site UM nurse or Care Coordination Nurse case manager. This review occurs during a member's course of hospitalization, which may include acute hospital, acute rehabilitation, or skilled nursing inpatient stay, to assess the medical necessity and appropriateness of continued confinement at the requested level of care. Concurrent/Continued Stay Review may also involve the telephonic or on-site medical record review that occurs after admission.
Additional objectives of Concurrent/Continued Stay Review are:

- To ensure that services are provided in a timely and efficient manner
- To ensure that established standards of quality care are met
- To implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate
- To implement effective discharge planning
- Identification of cases appropriate for referral to Care Coordination

The Concurrent Review procedure shall be followed throughout the member's hospitalization, utilizing HPSM's approved criteria and guidelines.

Telephonic or facsimile reviews are coordinated by the UM staff daily or on cyclic intervals based on individual case requirements.

In the event a scheduled review date falls on a weekend or holiday, the UM staff will coordinate a Concurrent Review on the work day prior to the scheduled review date, or not later than the first work day after the holiday or weekend. UM staff will work with the contracted network facilities to schedule concurrent review schedules that best meets the needs of both HPSM and the provider.

Should the UM staff be unable to justify the need for continued patient stay and/or ancillary services, the case is referred to the HPSM Chief Medical Officer or designee to evaluate and consult with the Attending Physician as appropriate. If the HPSM Chief Medical Officer or designee makes a determination that the case does not meet criteria for continued stay based on the medical necessity or appropriateness, a notice of denial letter may be issued immediately by fax and via overnight Certified Mail to the Attending Physician, hospital and the member. These processes are done to comply with California Senate Bill (SB) 59 and all applicable Medi-Cal and CMS regulations).

Discharge Planning Review

Discharge planning begins as early as possible during an inpatient admission and is designed to identify and initiate cost effective quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the Attending Physician, hospital discharge planner, HPSM UM staff, ancillary providers and community resources to coordinate care and services.

Objectives of the UM participation in Discharge Planning Review:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Communication to the Attending Physician, hospital discharge planner, and member, when appropriate, to provide information regarding access to covered benefits in order to meet the member’s needs when transferring to a lower level of care.
- Coordination of care between member, PCP, Attending Physician, specialists, hospital UM/Discharge Planning staff, and HPSM’s UM staff and/or Health Services Clinical Manager.
- Concurrence with plan of care developed for CA CMC, D-SNP and CCI recipients through Individual Care Plan and Interdisciplinary Care Team process.

The UM staff obtains medical record information and identifies the need for discharge to lower level of care based on discharge review criteria/guidelines. If the Attending Physician orders discharge to lower level of care, the UM staff assists the hospital UR/Discharge Planner to

coordinate post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the HPSM Medical Director as previously noted in the Concurrent Review Process.

Second Opinion Consultations

The second opinion authorization process for care from the assigned PCP is within the contracted provider's scope and practice and is a delegated function. The second opinion request regarding care from the PCP can be with any provider within the HPSM network or outside of the network with prior authorization. Specialist second opinions can be with any specialist within the HPSM managed care network in accordance with State guidelines. Second opinions may be sought to establish diagnoses, address concerns with ongoing care, and to evaluate the need for treatments/procedures. Requests for authorization of a second opinion must be reviewed and the decision determined in accordance with HPSM UM Timeliness Standards.

Retrospective Review

A retrospective review is performed by the HPSM licensed staff on any service that has not received required prior authorization to determine:

- Medical necessity and appropriateness of authorized services
- Services were rendered at the appropriate level of care and in a timely manner
- Existence of potential quality of care issues
- Need for care coordination referral or disease management

Should a retrospective review of the medical records indicate that medical necessity or appropriateness of services did not exist; a physician denies the authorization for services. Should a potential or actual quality of care issue be identified, the case will be evaluated per policy and procedure.

Timeliness Standards

There are established timeliness standards for UM requests determined to be either routine (non-urgent) pre- service, or urgent pre-service. Standards are also outlined for concurrent and retrospective (post service) review. HPSM timeliness standards for determination and notification comply with State and Federal rules, including 42 CFR §438.210(d), §422.568, 42 CFR §422.570, and 42 CFR §422.572. CA H&SC 1367.01 (h) (2) and SB 59. These standards apply to all lines of business including, the Medicare-Medicaid Plan.

UTILIZATION MANAGEMENT TIMELINESS STANDARDS

Type of Request	Decision	Initial Notification (Notification May Be mail or Electronic)	Written/Electronic Notification of Denial, Deferral and Modification to Practitioner and Member
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision but no later than 14 calendar days after receipt. HPSM may extend the timeframe by up to 14 calendar days if the member requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the member.	Practitioner: Within 24 hours of the decision	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision
Post-Service / Retrospective Review- All necessary information received at time of request.	Within 30 calendar days from receipt of request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request
Urgent Authorization (Pre-Service) Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or	Within 1 working day of receipt of the request	Practitioner: Within 24 hours of making the decision	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service

Type of Request	Decision	Initial Notification (Notification May Be mail or Electronic)	Written/Electronic Notification of Denial, Deferral and Modification to Practitioner and Member
regain maximum function. • All necessary information received at time of initial request			
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. CA H&SC 1367.01	Within 5 working days or less, consistent with urgency of Member's medical condition **NOTE:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Type of Request	Decision	Initial Notification (Notification May Be mail or Electronic)	Written/Electronic Notification of Denial, Deferral and Modification to Practitioner and Member
(h)(3)	to exceed 24 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination		
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services)	Within 24 hours of receipt of the request	Practitioner: Within 24 hours of receipt of the request (for approvals and denials) Member: Within 24 hours of receipt of the request (for approval decisions)	Member & Practitioner: Within 24 hours of receipt of the request **Note:** If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification

PHARMACYTIMELINESS STANDARDS

LOB	Turnaround Time		Written/Electronic Notification Requirements included within timeframes; except CA/CMC
CA	Expedited = 24 hrs Standard = 72 hrs		Expedited requests where Pharmacy notify member verbally and follow up with written notification within 72 hrs
CMC	Expedited = 24 hrs Standard = 72 hrs		Expedited requests where Pharmacy notify member verbally and follow up with written notification within 72 hrs
MC	24 hrs		
H-LINES	24 hrs		
ACE	72 hrs		

MEMBER NOTIFICATION

Members are notified in writing of HPSM's initial determination to modify, deny, or extend a pre-service request as outlined above. All notices must include the specific reason for the denial and this information must be communicated to the member in a format that can be understood. The following strategies may be employed to enhance understanding of notification; 1) specific language requirements 2) accommodation of disabilities, such as need for large print or type 3) Health Plan of San Mateo's contact information in order to obtain assistance from Member Services or Health Services Staff.

LONG TERM CARE, LONG TERM CARE SERVICES and SUPPORTS AUTHORIZATION PROCESS

Preadmission Screening Preadmission Screening and Resident Review (PAS/PASARR)

Each HPSM Medi-Cal recipient applying for Nursing Facility (NF) admission is subject to PAS/PASARR Level I screening or evaluation either prior to admission or on the first day for which HPSM Medi-Cal reimbursement is requested. The admitting NF is responsible for performing the evaluations. The admitting NF is also responsible for making a referral for Level II evaluation when appropriate. Welfare and Institutions Code Section 9390.5 has required Preadmission Screening for every Medi-Cal recipient applying for admission to a Nursing Facility to determine if the recipient's condition requires institutionalization in a NF or whether he/she could remain in the community with support services. The NF will utilize PAS/PASARR Level I Screening Document (DHS 6170), Long Term Care Treatment Authorization Request (Form 20-1), Minimum Data Set (MDS) Full Assessment Form or Minimum Data Set (MDS) Quarterly Assessment Form, and PAS/PASARR Monthly Statistical Report. The NF will comply with applicable regulations in the Code of Federal Regulations, the Medi-Cal Long Term Care Provider Manual, the Welfare and Institutions Code and Title 22.

TAR Process and Criteria for Admission to, Continued Stay in, and/or Discharge from a SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N, and Sub-acute Adult/Pediatric Facility

HPSM's UM staff processes all requests for admission to, continued stays in, or discharge from any LTC facility in accordance with the California Department of Health Services (DHS) standard clinical criteria for levels of services. Each level of care TAR processing procedure will be in compliance with applicable regulatory requirements.

Community Based Adult Services TAR (CBAS)

HPSM"s UM staff performs evaluations of eligibility for CBAS as outlined in DHCS requirements. Authorization of services is based on need. Authorized services are consistent with those developed as part of the care planning process of LTSS services for those eligible for CCI.

CalMediConnect CCI services:

Services provided through CCI, including In Home Support Services (IHSS, MultiService Senior Program (MSSP) programs are authorized and managed based on the terms and conditions of the MOU with Aging and Adult Services. Authorization of all CCI services is consistent with assessment and care planning process for CCI eligible members.

On Site TAR Review, Long Term Care

HPSM's UM staff may perform on-site review for DP-NFs, Intermediate Care Facilities and sub-acute sites. On-site review may also be done at free standing NFs, when indicated; e.g., patterns of high service utilization, frequent acute hospitalization of members, large numbers of member complaints/concerns. TAR requirements will be in compliance with Title 22 California Code of Regulations and DHS Manual of Criteria for Medi-Cal Authorization.

Prescription Medication Prior Authorization Process

HPSM has a process in place to ensure that procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and to make medical necessity exceptions to the HPSM formulary (HPSM Approved Drug List).

The HPSM Pharmacy Staff and the Pharmacy Review Committee are responsible for development of HPSM Approved Drug List, which is based on sound clinical evidence and reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the HPSM Approved Drug List are communicated to both members and providers.

If the following situations exist, HPSM will consider the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate, and the drug is medically necessary
- Member has failed treatment or experienced adverse effects on formulary drugs
- Member's treatment has been stable on a non-formulary drug and change to formulary drug is medically inappropriate

To request a prior authorization (PA) for outpatient medication not on the HPSM Approved Drug List, the physician or physician agent must provide documentation to support the request for coverage. Documentation is provided on a HPSM Medication Request Form (MRF), which is submitted to HPSM's pharmacy unit for review. The initial review is based on PA guidelines approved and established by HPSM. Denied PA requests are reviewed and signed off by the Chief Medical Officer.

The pharmacy review staff profiles drug utilization by member to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members on eight (8) or more medications are reviewed by a clinical pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

Monitoring for Over and Under Utilization

In an effort to review appropriateness of care provided to members, HPSM tracks and trends various data elements to determine over- and/or under- utilization patterns. The industry benchmark rates are used as guidelines for comparison. The Utilization Management Committee regularly reviews a number of utilization data sets. These data sets include but are not limited to:

- Acute bed days per thousand,
- Admits per thousand,
- ER visits,
- Average length of acute stay,
- 30 day re-admission rate
- PCP visit rates
- Pharmaceutical utilization including but not limited to:
    - Generic utilization
    - Brand name utilization
    - Narcotic utilization
    - Top prescribing physicians

HPSM enacts actions to improve performance as a result of these clinical data analysis, and feedback is provided to both entities and individual practitioners so that corrective actions can be taken. HPSM continues to monitor for compliance with corrective action plans and improvements in the care delivery process.

REVIEW CRITERIA, GUIDELINES, AND STANDARDS

Standards, criteria and guidelines are the foundation of an effective Utilization Management Program. They offer the licensed UM staff explicit and objective decision support tools, which are utilized to assist during evaluation of individual cases to determine the following:

- If services are medically necessary
- If services are rendered at the appropriate level of care
- Quality of care meets professionally recognized industry standards
- Consistency of UM decisions

The following standards, criteria, and guidelines are utilized by the UM staff and Chief Medical Officer as resources during the decision making process:

- Medical necessity review criteria and guidelines
- Length of stay criteria and guidelines
- Clinical Practice Guidelines
- Policies and Procedures

Decision Support Tools

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment and application of individual case information and local geographical practice patterns. Licensed nursing review staff applies professional judgment during all phases of decision-making regarding HPSM members.

Decision Support Tools are intended for use by nursing review staff as references, resources, screening criteria and guidelines with respect to the decisions regarding medical necessity of healthcare services, and not as a substitute for important professional judgment.

The HPSM Chief Medical Officer or physician designee evaluates cases that do not meet review criteria/guidelines and is responsible for authorization/denial determinations. For those authorization requests that do not fall within guidelines listed above, the Chief Medical Officer or physician designee is responsible for rendering a determination based on current standards and community practice guidelines as found in peer reviewed medical literature. Any decision to defer, modify or deny a service that is less then requested must be made by the Chief Medical Officer based on peer reviewed literature, community standards of practice or consultation with referring or treating physician. HPSM's UM staff clearly documents the review criteria/guidelines utilized to assist with authorization decisions. In the event that a provider should question a medical necessity/ appropriateness determination made, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

The following approved department Decision Support Tools have been implemented and are evaluated and updated at least annually:

Criteria and Guidelines

Approved HPSM Guidelines shall be used for all medical necessity determinations. HPSM uses the following criteria sets: Medi-Cal Manual of Criteria, published by the State of California, American Academy of Pediatric Guidelines (AAP), Milliman Care Guidelines, Medicare Coverage manual and the HPSM Medical Policy and Medi-Cal Benefits Guidelines (Medi-Cal Provider manuals- Allied Health, Inpatient/Outpatient, Medical, Vision, Pharmacy).

Medi-Cal Manual

The State of California publishes *Medi-Cal Manual of Criteria,* which is the basis for Medi-Cal benefit interpretation and used as an UM guideline.

Medicare Coverage Manual

http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/index.html

Milliman Care Guidelines Criteria

Milliman Care Guidelines are developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry.

Milliman criteria enable health plans and providers to capture data about the intervention requested and the rationale for each request. The criteria also provide a clinical reference for managing the dialogue between provider and reviewer, provider and payer, and provider and patient. Milliman criteria support an explicit, clinical rationale for care decisions.

Milliman guidelines update cycles are done at a minimum on an annual basis. Milliman states that update reviews include: development of new procedures, new technology, requests from clients, criteria incorporating high frequency, high risk, high visibility and high variation, literature review and analysis, new clinical practice. (Milliman, 2007)

New Technology Assessment

When authorization requests deal with treatments that do not fit the standard of care guidelines or are for modalities that are considered experimental or investigational, the authorization is reviewed against recommendations and policies determined by the appropriate program benefit. Cases in which investigational treatment is proposed are evaluated on a case by case basis according to policy.

If no existing guidelines are developed to handle a new or emerging technology medical necessity request, the Chief Medical Officer involved in the review follows a standard review process. They have access to online medical literature search tools and have a panel of subspecialty expert consultants from the Peer Review Committee/Physician Advisory Group to assist in the review of these requests and make decisions regarding coverage and medical appropriateness.

Monitoring for Consistent Review Criteria Application

The Chief Medical Officer or Designee is responsible for ensuring that there is ongoing monitoring of consistency of Medical Director clinical UM decision making. Health Services

Clinical Manager and Senior Clinical Manager perform ongoing monitoring of UM nurse reviewer application of criteria/guidelines to:

- Measure the reviewers' comprehension of the review criteria and guideline application process
- Ensure accurate and consistent application of the criteria among staff reviewers, and ensure criteria and guidelines are utilized per policy/procedure
- Ensure a peer review process for inter-rater reliability

The Health Services staff is responsible for identification of potential or actual quality of care issues, and cases of over- or under-utilization of healthcare services for HPSM members during all components of review and authorization.

UTILIZATION MANAGEMENT APPEALS PROCESS

An organization determination is any decision made by or on behalf of HPSM regarding the payment or provision of a service a Member believes he or she is entitled to receive. An organizational determination is made in response to a Treatment Authorization Request or a request for Prior Authorization submitted by a provider and may include approval, denial, deferral, or modification of the request. HPSM has a comprehensive review system to address matters when members or providers (on behalf of members for services yet to be provided) wish to exercise their rights to appeal an organizational determination that denied, deferred or modified a request for services.

The administration of HPSM's reconsideration of an organization determination and appeals process is the responsibility of the Grievance and Appeals staff under the direct supervision of the Director of Compliance and Regulatory Affairs. All investigation efforts are geared to protect the enrollee's privacy and confidentiality and to achieve rapid resolution.

CONFIDENTIALITY

Due to the nature of routine UM operations, HPSM has implemented policies and procedures to protect and ensure confidential and privileged medical record information. Upon employment, all HPSM employees, including contracted professionals who have access to confidential or member information sign a written statement delineating responsibility for maintaining confidentiality.

Both the HPSM UM staff voice mails for utilization review information and the computer network system are controlled by a secured password system, accessible only by the individual employee.

The facsimile machines used for utilization review purposes are located within the department to assure monitoring of confidential medical record information by HPSM UM staff. HPSM has implemented Health Information Portability and Accessibility Policies and Procedures to guide the organization in HIPAA compliance. All records and proceedings of the UM Committee

related to member or provider specific information are confidential and are subject to applicable law regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58.

STAFF ORIENTATION/TRAINING/EDUCATION

HPSM seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program as applicable to specific job description:

- HPSM New Employee Orientation
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Utilization Management Program, policies/procedures, etc.
- Care Coordination Model of Care, policies and procedures, etc.
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeal Process
- Orientation to specific programs of each delegated entity.
- Services provided through CCI Medi-Cal program

HPSM encourages and supports continuing education and training for employees, which increases competency in present jobs and/or prepares employee for career advancement within the HPSM. Each year, a specific budget is set for continuing education employees.

Licensed nursing staff is monitored for appropriate application of Review Criteria/ Guidelines, processing referrals/ service authorizations, and inter-rater reliability. Training opportunities are addressed immediately as they are identified through regular administration of proficiency. Training, including seminars and workshops, are provided to all UM staff regularly during regularly scheduled meetings and on an ad hoc basis as need arises.