HERITAGE PROVIDER NETWORK
&
AFFILIATED MEDICAL GROUPS

Provider Manual

Approval Signatures:

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Contents

Introduction / Welcome To HPN

Heritage Provider Network ("HPN") is a limited Knox-Keene licensed organization in California that provides affordable quality care to its members. Through innovative programs and services designed specifically for the managed care environment, HPN and its affiliated Medical Groups ("Medical Groups" or "Groups") have been successful in delivering the goals it set out to achieve while establishing long-standing, favorable provider relationships.

HPN's guiding philosophy and beliefs are that:

- The physician-patient relationship is the foundation for providing quality health care
- Physician and patient education must be proactive and ongoing
- Physicians will make effective decisions for their patients given the appropriate tools, information and support from their peers
- Utilization and quality management is a physician-to-physician process

Mission, Vision, and Values

Our mission is to provide and manage the highest quality healthcare to the communities we serve.

We strive to be an organization which provides excellence in every encounter. As a result, we will be recognized by:

- Our patients as their care givers of choice
- Our employees as their employer of choice
- Our provider and health plan partners as their healthcare network of choice
- OUR CUSTOMERS:
    - We will make understanding and satisfying customer needs our top priority.
    - We will treat each other as well as we treat our external customers.
- HIGHEST PERSONAL AND PROFESSIONAL STANDARDS:
    - We will recruit, reward, and retain employees and physicians of the highest caliber.
    - We will hold each other accountable to act in ways consistent with our values.

The HPN Provider Manual

HPN uses this Provider Manual to communicate important information to our contracted providers, facilities, and vendors regarding our managed care programs and your responsibilities as part of our Network. If you have any questions regarding the Manual or its contents, please contact the HPN Medical Group you work with for assistance.

Structure and Affiliated Medical Groups

HPN administers health care through its nine (9) Medical Groups:

- ADOC Medical Group (ADOC)
- Bakersfield Family Medical Center (BFMC)
- Coastal Communities Physician Network (CCPN)
- Desert Oasis Health Care (DOHC)
- High Desert Medical Group (HDMG)
- Heritage Victor Valley Medical Group (HVVMG)
- Lakeside Medical Group (LMG)
- Regal Medical Group (RMG)
- Sierra Medical Group (SMG)

HPN develops and distributes the programs, policies, and procedures for its Medical Groups. Groups may vary in the model and structure used to deliver health care to our members, but each Group maintains the infrastructure necessary to execute upon the functions which it is delegated to perform by our contracted health plans.

Our Programs

HPN and its Medical Groups partner with our contracted health plans to provide a variety of health care programs to our members.

Medicare Advantage

Medicare Advantage is another way for members to obtain Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans", are offered by Medicare-approved private companies that must follow rules set by Medicare and the Centers for Medicare and Medicaid Services (CMS). Most Medicare Advantage Plans include drug coverage (Part D) (see Services That Are Not Group Responsibility). In most cases, members need to use the health care providers who participate in the health plan's network and service area.[1]

Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low income people with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS.[2]

1 https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans
2 https://www.dhcs.ca.gov/services/medi-cal

Cal MediConnect

The Cal MediConnect demonstration tests a new model for providing Medicare-Medicaid members with a more coordinated, person-centered care experience, along with access to new services. Under this demonstration, health plans coordinate the delivery of and are accountable for covered Medicare and Medicaid services for participating members.[3]

Commercial/Exchange

Health insurance is provided and administered by non-governmental entities through California's Commercial and Exchange markets. This includes health care purchased directly or through employer-based programs.

Website / Portal

HPN's website serves as a resource to its Medical Groups and providers for overall information on HPN's programs:

https://www.heritageprovidernetwork.com

Each Group also maintains its own website with additional information for its providers, including key educational resources and access for authorization and claims submissions and communications directly with the Group. Please contact the Group for assistance with accessing your provider portal.

Medical Group	Website
ADOC Medical Group (ADOC)	https://www.adoc.us
Bakersfield Family Medical Center (BFMC)	https://www.bfmc.com
Coastal Communities Physician Network (CCPN)	https://www.ccpnhpn.com
Desert Oasis Health Care (DOHC)	https://www.mydohc.com
High Desert Medical Group (HDMG)	http://www.hdmg.net
Heritage Victor Valley Medical Group (HVVMG)	https://www.hvvmg.com
Lakeside Medical Group (LMG)	https://www.lakesidemed.com
Regal Medical Group (RMG)	https://www.regalmed.com
Sierra Medical Group (SMG)	https://www.heritagesmg.com

3 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California

Member Eligibility

A member's health plan eligibility or Medical Group/Primary Care Provider (PCP) assignment can change over time, and members may not be aware of or communicate such changes to their providers. It is therefore important for providers to verify member eligibility and coverage prior to delivering services. This includes verifying that the member has active coverage and will continue to have active coverage throughout the duration of the provision of services, that the member is affiliated with the Medical Group, and that the member is assigned to you or has a referral on file for the provision of services, as necessary. Failure to verify member eligibility may result in non-payment of claims.

To verify member eligibility, obtain a copy of the member's health plan ID card and:

- Check using the health plan electronic verification system or
- Utilize the health plan numbers provided to verify eligibility

If none of the above works, contact the Groups directly at the numbers provided for assistance.

Quality Improvement Program

HPN has developed a Quality Improvement Program (QI) that is reviewed annually and updated as needed. The goal of the program is that continuous Quality Improvement (CQI) will be achieved at all levels of the organization to assist in attaining HPN's Mission, Vision and Values. The QI Program covers both clinical and non-clinical care and services, for our Commercial, Medicare Advantage, Medicaid, and dual-eligible populations.

Purpose/Program Description

The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness and outcome of care/services delivered to our members. In addition, to provide mechanisms that continuously pursues opportunities for improvement and problem resolution.

Scope of Program

The scope of the QI Program is to monitor care and identify opportunities for improvement of care and services to both our members and practitioners, and ensure our services meet professionally recognized standards of practice. This is accomplished by assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service.

Authority For HPN Quality Improvement (QI) Activities

HPN's Governing Body is the Executive Committee. The Executive Committee is responsible for the establishment and implementation of the QI Program. The Executive Committee appoints the Chief Medical Officer/ QI Medical Director and the VP of Clinical Services to act as facilitator for all QI activities and they are the responsible entities for the oversight of the QI Program.

Quality Improvement Goals

The quality Improvement goals for the organization are:

1. Ensuring ongoing communication and collaboration between the QI Department and the other functional areas of the organization, including but not limited to: Medical Management, Member Services, Behavioral Health and Case Management.

2. Ensuring members receive the highest quality of care and services.
3. Ensuring members have full access and availability to primary care physicians and specialists.
4. Adhering to the highest standards of health care practice using evidence-based guidelines (Practice Guidelines) as the basis for clinical decision-making.
5. Monitoring, improving, and measuring member and practitioner satisfaction with all aspects of the delivery system and network.
6. Fostering a supportive environment to help practitioners and providers improve the quality and safety of their practices.
7. Assessing and meeting the cultural and linguistic needs of our members.
8. Meeting the changing standards of practice of the healthcare industry by adhering to all state and federal laws and regulations.
9. Monitoring our compliance to regulatory agency standards through annual oversight audits and survey activities
10. Adopting, implementing, and supporting ongoing adherence with accreditation agency standards.
11. Promoting the benefits of a coordinated care delivery system.
12. Promoting preventive health services and care management of members with chronic conditions.
13. Emphasizing a caring and therapeutic relationship between the patient and practitioner; and a professional and collaborative relationship between the practitioner and health plan.
14. Ensuring there is a separation between medical and financial decision making.
15. Seeking out and identifying opportunities to improve the quality of care and services provided to our members.
16. Seeking out and identifying opportunities to improve the quality of services to our Practitioners.

Quality Improvement Committee (QIC) - Authority

The QIC authority is granted by HPN's Executive Committee. The QIC is granted the authority to carry out the responsibilities and to meet the objectives stated in this program. The QIC shall have the authority to:

1. Direct the investigation of identified and suspected problems and to direct the responsible parties to implement action.
2. Request reports on QI activities and problems from HPN and the provider group's departmental heads, quality management personnel, and others as needed.
3. Direct HPN's and the provider group's medical staff, departments/committees, and/or QI Teams to complete monitoring and evaluation on specific topics as appropriate. HPN will analyze and evaluate the results of the QI activities and report them directly to the Executive Committee.
4. Determine that inappropriate care or substandard services have been provided, or services which should have been furnished have not been provided, the QIC Chairman and/or the VP Clinical Services or designee are responsible for communicating concerns identified and working with the provider to develop a corrective action plan.
5. Implement sanctions against providers. Sanction activities used by HPN may include, but are not limited to:
    a. Letter of information
    b. Letter requesting provider response
    c. Severity Level Determination
    d. Site visit with corrective action plan required
    e. 100% review of all cases
    f. Panel closed to new members
    g. Second opinion for all surgical cases
    h. Suspension
    i. Termination

Information gathered and documented for purposes of prioritizing problems and taking remedial action will be kept confidential.

Contracts

HPN has contracts with its affiliates that require:

1. Practitioners and providers cooperate with QI activities
2. Practitioners and providers maintain the confidentiality of member information and records, and shall keep member information confidential and secure;
3. Practitioners and providers allow the plan to use their performance data. This shall include allowing collection of performance measurement data, evaluation of the data, and assisting the organization to improve clinical and service measures.
4. Practitioners and providers will provide access to medical records as permitted by state and federal law.
5. Practitioners and providers will give timely notification to members affected by their termination.
6. Practitioners and providers shall not discriminate against any Beneficiary in the provision of Contracted Services whether on the basis of the beneficiary's coverage under a Benefit program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, or other unlawful basis including, without limitation, the filing by such Beneficiary of any compliant, grievance, or legal action against the provider or payer.

   Contracts with practitioners and providers include an affirmative statement indicating that practitioners may freely communicate with patients about the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Cultural Competence

HPN ensures that all the contracted provider groups have in place language assessment policies and can provide meaningful access to health services by limited English proficiency (LEP) enrollees. The medical group personnel are educated on the contracted health plans language assessment programs and how to facilitate interpreter and translation services as needed by our enrollees.

Each provider group keeps a current list of available health plan and internal resources to enhance LEP member communication and understanding. Interpreters are available to translate written material if needed, at no cost to the enrollee, and are available through the enrollees contracted health plan. Oral interpreters are scheduled at the time the doctor's appointment is scheduled.

Provider Cultural & Linguistic (C&L) Requirements:

1. Posting of the interpreter poster at provider office sites.
2. Ensuring 24-hour, 7 day a week access to interpreting services, including ASL, all points of contact, including after-hours services.
3. Discouraging the use of family and friends, particularly minors, as interpreters.
4. Documenting Member's preferred language (if other than English).
5. Documenting request and refusal of interpreting services.

Accessibility of Services

HPN and its affiliates will ensure that all primary care practitioners/providers are in compliance with DMHC Timely Access to Care Standards (Appendix A). Compliance with these standards is monitored through Member complaints and grievances, Potential Quality Improvement's (PQI's), Member Satisfaction Surveys, disenrollment, and annual access surveys. All Providers are responsible for fulfilling access to care standards outlined in this section.

Access To Care Requirements (Primary Care and Specialty Care Physicians, Behavioral Health and Ancillary Providers)

HPN has established standards and mechanisms to assure the accessibility of primary care, specialty care, behavioral health care and member services. Standards include but not limited to:

1. Preventive care appointments
2. Regular and Routine care appointments
3. Urgent care appointments
4. Emergency care
5. After-hours care
6. Telephone service

HPN's affiliates shall comply with all Federal and State accessibility guidelines. We will conduct annual access to care audits using the standards to implement and measure improvements made in performance. Our contracted behavioral healthcare practitioners conduct annual access to care audits and quarterly telephone screening and triage audits.

Assessment Against Access Standards

1. HPN will perform an annual, and as needed, analysis of data collected to measure its performance against its standards for medical care and behavioral health care access; identify any deficiencies; implement interventions to correct any deficiencies; and then measure the effectiveness of the interventions. Access & Availability survey results are reviewed by the Quality Improvement Committee and are communicated throughout the network through Joint Operating Committees (JOCs), newsletters, etc.
2. Behavioral health analysis will measure the quarterly average for screening and triaging calls answered by an unrecorded voice within 30 seconds and telephone abandonment rate within 5 percent.

Availability of Practitioners

Primary Care Physician's (PCP's) and Specialty Providers are required to make referral requests using the members' immediate contracted network. Referrals to out of immediate network, out of area providers, or non-contracted providers will require medical review by the group's medical director reviewer for medical necessity, such as, but not limited to, emergent services, services is not available within the immediate area, or immediate network provider is not accessible within the time-frame to meet access requirements. Referral requests will be directed to the immediate network provider to provide members with the easiest access to the services needed.

Assessment of the cultural, ethnic, racial, and linguistic needs of the members will be conducted and the availability of practitioners in the network adjusted, if necessary.

Tertiary Care

Tertiary care as specialized consultative care is provided by specialists working in a center that has personnel and facilities for special investigation and treatment of complicated medical conditions. Tertiary care is usually associated with teaching hospitals equipped with sophisticated diagnostic and treatment facilities, as well as sub-specialty resources, not available at general hospitals. Thus, tertiary care requests shall be generated by specialty providers in the community who document a medical need for a higher level of care in the form of a specialized diagnostic procedure or treatment and reviewed by the Medical Director for medical necessity. Tertiary care requests will be redirected to community level providers when the diagnostic procedure or treatment can be provided by community level specialists. Non-contracted tertiary care

requests will be redirected by the Medical Director to a contracted tertiary care provider that can provide equivalent cost effective services, in a more efficient manner and with more expedient access to care.

Member Satisfaction/Grievance/Appeals

Grievance Process

The Heritage Provider Network grievance process assesses the member's experience with the services provided by its affiliates and our practitioners. Each quarter member complaints and appeals are evaluated by collecting data for each of the following five (5) categories:

1. Quality of Care
2. Access
3. Customer Service
4. Billing and Financial Issues
5. Quality of Practitioner Office Site

The data is further aggregated and evaluated by the total population served. Annually, a quantitative and causal analysis is conducted of the aggregate results and trends over time, and then compared against a standard goal. Opportunities for improvement are identified and interventions put in place where appropriate.

Member Experience Surveys include Consumer Assessment Health Plan Service (CAHPS) and Patient Assessment Survey (PAS).

Medicare and Medicaid members receive the CAHPS survey. Commercial members receive the PAS survey. Surveys are conducted to monitor members' experience with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes which impact satisfaction. Surveys are conducted at least annually. We receive survey results from our contracted Health Plans or vendors. The results of the surveys are evaluated, and improvement plans are developed to address the problem areas identified.

Clinical Practice Guidelines (CPGs)

Heritage Provider Network and its affiliates are accountable for adopting and disseminating to our providers clinical practice guidelines for the provision of preventive, acute, or chronic medical services and behavioral health services to our members. The guidelines are nationally recognized Clinical Practice Guidelines (CPGs), and include professional medical associations, voluntary health organization, and National Institute of Health (NIH) Centers and Institutes. If the guidelines are not from a recognized source, they are created with the involvement of a board-certified practitioner. Selected CPGs are taken through the Quality Improvement Committee (QIC) for discussion and recommendations. Evidence based CPGs are adopted for at least two (2) medical conditions, and at least two behavioral conditions, with at least one (1) behavioral guideline addressing children and adolescent care. At least two (2) of the adopted clinical practice guidelines are the clinical basis for the Disease Management programs, examples are Diabetes, Heart Failure, Depression, and Anxiety.

The affiliates distribute these guidelines to their practitioners by posting them on their website, or through the provider web portals. If changes or revisions are made, a notice will be sent to the practitioners by blast fax.

All clinical practice guidelines are reviewed and approved through the HPN QI Committee at least every two (2) years, and ongoing if updated.

Continuity And Coordination Of Medical Care

Heritage Provider Network and its affiliates ensure that the care provided to our members is continuous and coordinated. The member may select a primary care provider (PCP), or the Medical Group may assign a PCP to the member with the primary responsibility for coordinating the member's overall healthcare.

The Medical Groups must:

1. Review all requests for continuity of care when requested by a member, member representative, or member provider.
2. For Senior members or Dual members having a Medicare benefit, the member must have seen the out of network provider within the last 6 months, or in active treatment, and the provider is willing to continue to see the member. The provider must accept the groups contracted rate for this line of business. If the provider refuses then the member will be redirected into network to a same specialty provider near the member, as stated in HPN's policy and procedures.
3. For Medi-Cal and commercial members, the member must have been seen within the last 12 months; the requested non-contracted provider is willing to see the member and accept the contracted rates for the line of business. If the provider refuses then the member will be redirected into network to a same specialty provider near the member, as stated in HPN's policy and procedures.
4. Identify members with special health care needs, including those that would benefit from Disease Management.
5. Ensure an assessment by an appropriate health care professional of ongoing needs of each member identified as having special health care needs or conditions.
6. Identify medical procedures and/or behavioral health services to address and/or monitor the need or condition.
7. Ensure adequate care coordination among providers, including other practitioners, behavioral health providers, as necessary.
8. Ensure a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care need, (e.g., a standing referral for an approved number of visits).

HPN and its affiliates identifies opportunities to improve coordination of medical care though routine medical record reviews, review of transition of care reports, potential quality of care reviews, grievance reviews and member experience surveys. Actions and interventions are developed to improve our members' experience and the coordination of their medical care in our delivery system.

Preventative Health Guidelines (PHGs)

Heritage Provider Network and its affiliates are accountable for adopting and disseminating Preventative Health Guidelines (PHGs) for perinatal care, care for children up to 24 months, care for children 2-19 years old, care for adults 20-64 years old, and care for adults 65 years and older. Heritage Provider Network adopts nationally recognized Preventative Health Guidelines (PHGs) from the U.S. Preventive Services Task Force for adults, children, and adolescents. Other guidelines may be included from professional medical associations, voluntary health organization, and National Institute of Health (NIH) Centers and Institutes. If the guidelines are not from a recognized source, they are created with the involvement of a board-certified practitioner.

HPN's Quality Improvement Committee (QIC) approves and adopts these guidelines, then the HPN affiliates disseminate these preventative health guidelines to our primary provider groups in an effort to improve health care quality and reduce unnecessary variation in care. The primary provider groups are responsible for distributing the guidelines to their practitioners by posting them on their website, or through the provider web portals. If changes or revisions to the guidelines occur, a notice will be sent to the practitioners by blast fax.

Selected PHGs are taken through the QI Committee for discussion and recommendations. The preventative health guidelines are reviewed and approved through the QI Committee at least every two (2) years, and ongoing if updated.

Clinical Measurement Activities

HPN will collaborate with its affiliates to measure and demonstrate clinical improvements. HPN will identify at least three (3) meaningful clinical issues relevant to its members for assessment and evaluation, one of which may be an issue related to preventive health. The population will be identified from the affected population and data will be collected. Performance will be assessed using a quantitative and causal analysis to determine what areas have been identified as needing improvement. Interventions will be implemented, and they will be re-measured to determine their effectiveness.

Effectiveness Of The QI Program

HPN will collaborate with its affiliates to demonstrate improvements in the quality of care and service rendered to our members. A minimum of two (2) clinical care and two (2) service improvements will be measured. These improvements will be implemented, and their effectiveness measured to determine improvement in performance.

Standards For Medical Record Documentation

Standards for medical record documentation are developed and will be maintained and distributed to the affiliates which address:

1. Confidentiality of the medical record
2. Medical record documentation standards
3. An organized medical record keeping system and standards for the availability of medical records
4. Performance goals to assess the quality of medical record keeping

If deficiencies are found, actions are taken to improve medical record keeping practices.

Grievance System

HPN has a process to ensure that grievances received within Heritage Provider Network, Inc. are processed in accordance with full-service health plan requirements and pursuant to Department of Managed Health Care (DMHC) Rule 1300.68(b).

Definitions

A Grievance is a written or oral expression of dissatisfaction regarding HPN and/or any of its providers, including quality of care concerns, and shall include a complaint.

A Complaint is the same as a grievance.

The Complainant is the same as “grievant”, and means the person who filed the grievance, including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

An Appeal is a formal request by a provider or enrollee for reconsideration of a decision to deny, modify, or delay health care services, with the goal of finding a mutually acceptable solution. This may include utilization review recommendations, benefit determinations, and administrative policies.

Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

Pended are Grievances that are not resolved within 30 days and shall be reported as "pended".

Authority

HPN is **not** delegated by any full-service Health Plan to process or resolve member grievances. HPN is also **not** delegated for Independent Medical Review. All members' grievances involving a disputed health care service are eligible for review under the Independent Medical Review System.

HPN and its contracted provider groups shall submit for resolution all grievances it receives to the full-service health plan, per the agreement and non-delegated status with the full-service plan.

Member Notification

HPN shall notify its members of the grievance system available to them via member material and websites. Notification is to include information how to file a grievance and the steps and entities involved in resolving a grievance, the telephone number and address for presenting a grievance, information regarding the DMHC's review process, the Independent Medical Review system, and the DMHC's toll-free telephone number and website address.

Process For Members To File A Grievance

Although the members are encouraged to contact the full-service health plan to file a grievance, members may contact HPN or its affiliates to receive assistance from a patient advocate in filing a grievance. HPN and its affiliates each have a toll-free number that members may access, as well as local telephone numbers within each service area where they may call to receive assistance in filing a grievance.

Assistance to the member includes addressing any cultural or linguistic needs the member may have as well as the needs of members with disabilities. Such assistance shall include translations of grievance procedures, forms, and responses as well as access to interpreters, telephone relay systems, and other devices that aid disabled individuals in communication. Grievance forms shall be readily available on the HPN website, as well as all HPN offices, including contracted provider groups offices and facilities. Members may file a grievance for at least 180 calendar days following any incident or action that is the subject of the member's dissatisfaction.

HPN and its contracted provider groups shall not discriminate against the member (including cancellation of the contract) on the grounds that the member filed a grievance.

Protocol For Processing A Grievance Received At Hpn Or Its Contracted Provider Groups

A written record shall be initiated and maintained. This file shall include the date received, the representative recording the grievance, a summary of the grievance, and its disposition. In accordance with the agreement with the full-service health plans, the grievance shall be forwarded to the full-service plan immediately for response to the grievance pursuant to Title 28 Section 1300.68 (d).

HPN shall conduct a review of all grievances received from the member directly to HPN (and subsequently submitted to the full-service health plan). Documentation of this internal investigation shall be maintained within the file. If appropriate, the file will be sent to the Quality Improvement Committee (QIC) for further review and possible corrective action plan development and implementation.

Expedited 72-Hour Review Requests

All health plan members have the right to request an expedited initial determination and/or an expedited grievance for situations that are considered "Urgent Care".

Definitions:

1. Initial determinations are those decisions made by either the full-service health plan or by the delegated provider to approve a service or deny a service prior to the service being rendered. This is the only type of 72-hour review done at the Primary Medical Group/Independent Physician Association PMG/IPA level as delegated by HPN
2. "Urgent Care" is defined as a situation where waiting for the standard decision-making process could seriously jeopardize a member's life or health or jeopardize the member's ability to regain maximum function based on a prudent layperson's judgment.

Those requests that are determined to be urgent must be processed within seventy-two (72) hours of receipt of information reasonably necessary to make the determination. This is not limited to business hours. 72-hour expedited review process will include reviews relating to an enrollee who faces imminent and serious threat to his or her health. This includes but is not limited to severe pain, the potential loss of 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 or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment requested. This regulation applies to pre-service and concurrent review of requests (such as specialist referrals or diagnostic tests), terminations of care (such as terminating physical therapy treatment or occupational therapy treatment) and reductions in care.

The member, or a representative for the member, may make a request for an expedited review determination and/or grievance orally or in writing via fax or mail. Oral requests must be documented on "Request for 72-Hour Expedited Review" form. Grievances are to be sent immediately to the full-service health plan. Any physician will be permitted to request an expedited review on behalf of the enrollee, and the health plan must accept the physician's decision that the situation meets the urgent criteria for expedited review.

Tracking And Monitoring

HPN will maintain a summary of all grievances received directly by HPN Each affiliate shall submit to HPN a summary of the grievances it receives on a quarterly basis. These summaries shall include the date received, the status of the grievance (open or closed), whether it was resolved by the full-service health plan in favor of the member or the affiliate, the category of incident, corrective actions taken, and resolution. The summary reports will be submitted to HPN's QIC for review for trends and possible corrective action plan development and implementation on a quarterly basis.

HMO Help Center Grievances

Grievances received by the Department of Managed Health Care's (DMHC's) HMO Help Center are sent to the full-service health plans for review. The full-service health plans are to notify HPN or its affiliates of the grievance and its origination with the DMHC. The affiliates are to notify HPN of the grievance and its origination with the DMHC. HPN will monitor the notification logs and review for trends. The trended information will be presented to the Quality Improvement Committee (QIC). The Quality Improvement Committee (QIC) will review and issue Corrective Action Plan (CAP) and assign follow up as indicated.

Oversight review of cases reviewed by the affiliates is done by the QIC and corrective action is taken if problems are identified.

Member's Rights And Responsibilities

Heritage Provider Network, Inc., and its affiliates along with the contracted health plans have a responsibility to reinforce and clarify to its member's information and methods for obtaining health care services. HPN's role is to ensure members are fully and clearly informed about their rights and responsibilities.
Health services are provided to members in a non-discriminatory, cultural, competent manner:

1. Public declarations are made that provision of health services is not influenced by member race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, medical condition or source of payment, including those with limited English proficiency or reading skills, and the sensory impaired.
2. When necessary, auxiliary aids and interpreter services, i.e., sign language and TTY will be utilized.
3. Member information will be in large print; recorded cassettes; and, Braille format for the visually impaired.
4. California Relay is used for members with impairment. Staff members of the affiliates are available to sign and are contacted if the need arises and will meet with that member and doctor. Members with complaints or issues can call Member Services.
5. Each office suite has posted Member's Rights and Responsibilities.
6. Practitioners are not prohibited from advocating on behalf of members. HPN's delegated provider groups allow open practitioner-patient communication regarding appropriate treatment alternatives and this is done without penalizing the practitioner for discussing medically necessary or appropriate care for patients.

The practitioners recognize that the member has final determination during action among clinically acceptable choices. Practitioners will inform members of treatment options (without regards to plan coverage) risks, benefits, and consequences of treatment or non-treatment.

Members have the right to be represented by parents, guardians, family members, or other conservators for those who are unable to fully participate in their treatment decisions.

Upon request, utilization management policies, procedures, and criteria used to authorize, modify, or deny health care services to the public, will be made available. The members are informed of this in each office with posting of the members Rights and Responsibilities statement and who to call to obtain these criteria.

Member Rights and Responsibilities include the:

1. Right to receive information about the affiliate's services, practitioners and providers, and member rights and responsibilities.
2. Right to be treated with respect and recognition of their dignity and right to privacy.
3. Right to participate with practitioners in decision-making regarding their health care.
4. Right to candid discussion of appropriate or medically necessary options for their conditions, regardless of cost or benefit coverage.
5. Right to make recommendations regarding the organization's Members Rights and Responsibility policies.
6. Right to complaints or appeals about the plan, affiliate or care provided without discrimination (including cancellation of the contract) solely on the grounds that the member filed a complaint.
7. Responsibility to provide to the extent, possible information that the medical group and its practitioners and providers need in order to care for them.
8. Responsibility to follow plans and instructions for care that they have agreed on with their practitioners.
9. Responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Practitioner Credentialing

Purpose

Heritage Provider Network, Inc. ("HPN") has developed and implemented a comprehensive Credentialing Plan for the purpose of selecting and evaluating licensed independent practitioners or groups of practitioners in a nondiscriminatory manner, who provide services within its delivery system. The Credentialing Plan has been formulated to meet the requirements of contracted Health Plans, National Committee for Quality Assurance (NCQA) California Department of Health Services (DHS), California Department of Management Care (DMHC), Medicare, Medi-Cal, and other Federal and State regulations.

Nondiscriminatory Credentialing/Recredentialing

Credentialing/Recredentialing decisions are not based on a practitioner's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures (e.g., abortions) or types of patients (e.g., Medicaid) to which the practitioner provides services. This will not preclude actions regarding practitioners who meet certain demographic or specialty needs, or to meet cultural needs of members. HPN monitors and prevents discriminatory credentialing through the following process:

1. The presence of a nondiscrimination statement on the "Statement of Confidentiality" to be signed by members, staff, and guests of the Credentialing Committee on an annual basis.
2. Periodic audits of practitioner complaints will be done to determine if there are complaints alleging discrimination.

Documents, and/or information submitted to the Credentialing Committee for approval, denial or termination do not designate a practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or payer sources.

Reporting Requirements

Any report will be filed in accordance with Division 2, Article II, Section 800 of the California Business and Professions Code by the HPN Medical Group when there are adverse decisions resulting from the peer review process. The practitioner will be advised of the report and its contents. All reports made shall be deemed confidential. Reports will be made in writing to following entities:

Medical Board of California (MBOC):
Denied Privileges: A practitioner's application is denied or rejected for medical disciplinary cause or reason.
Timeframe: An 805 report will be filed within fifteen (15) days after conclusion of all proceedings.

Termination or Revoked Privileges: A practitioner's status is terminated or revoked for medical disciplinary cause or reason, fraud, or in the case of imminent harm to the member.
Timeframe: An 805 report will be filed within fifteen (15) days after conclusion of all proceedings.

Restrictions on Privileges: Restriction on privileges are imposed, or voluntarily accepted for a cumulative total of thirty (30) days or more for any 12-month period for a medical disciplinary cause or reason.
Timeframe: An 805 report will be filed within fifteen (15) days after conclusion of all proceedings.

Resignation or Leave of Absence: The practitioner resigns or takes a leave of absence following notice of an impending investigation based on information indicating a medical disciplinary cause or reason.
Timeframe: An 805 report will be filed within fifteen (15) days after the effective date.

Summary Suspension: A summary suspension remains in effect in excess of fourteen (14) days.
Timeframe: An 805 report will be filed within fifteen (15) days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) days.

Supplement Report: A supplemental report will be made within thirty (30) days following the date the practitioner is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action.

Diversion Report: A report will be filed with the Diversion Program of the MBOC when formal investigation of a practitioner's ability to practice safely due to a disabling mental or physical condition may pose a threat to patient care.
Timeframe: A diversion report will be filed within fifteen (15) days of initiating the formal investigation. No hearing rights will be afforded prior to filing this report. A follow-up report will be filed when the investigation is completed.

805.01 Reporting Requirement
The Medical Board of California (MBOC) requires the 805.01 form to be filed when a final decision or recommendation has been made by the peer review board. The 805.01 will need to be filed for the following 4 reasons:

1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public.
2. The use of, or prescribing for or administering to himself/herself of any controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that the licentiate's ability to practice safely is impaired by that use.
3. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances without prior examination of the patient and the medical reason therefore (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied).
4. Sexual misconduct with one or more patients during a course of treatment or an examination.

These reasons do not have to go to hearing before the 805.01 form is filled out. The proposed action must be given to the practitioner within 15 days after the peer review body makes the recommendation or final decision. Another change with this law is that the practitioner can submit the reports and file electronically, but it will made public for those who request it.

National Practitioner Data Bank (NPDB)
Professional Competence or Conduct: An action based on a practitioner's professional competence or conduct that adversely affects or could affect the health or welfare of a patient and remains in effect for more than thirty (30) days.
Timeframe: A NPDB report will be filed within fifteen (15) days from the date the adverse action was imposed.

Surrender or Restriction of Authority While Under Investigation: Acceptance of the practitioner's surrender or restriction of authority to provide care to patients while under investigation for possible professional incompetence, improper professional conduct, or in return for not investigating or professional review action.
Timeframe: A NPDB report will be filed within fifteen (15) days from the date the adverse action was imposed or authority to provide care to patients is voluntarily surrendered.

Supplemental Report: If necessary, a report will be filed to revise a previously reported adverse action.

Health Plan Notification

Health Plans will be notified of final adverse actions.
Timeframe: Within fifteen (15) days of the final adverse action.

Chapter II Healthcare Delivery Organizations

Definition

A Healthcare Delivery Organization (HDO) is an organization delivering health care services in the State of California that is subject to review by the State of California Department of Health Services (DHS) and the Centers for Medicare and Medicaid (CMS).

Purpose

To ensure Healthcare Delivery Organizations meet established standards of participation.

Scope Of Authorization And Action

HDOs covered under the Credentialing Plan include, but are not limited to, the following:

- Hospitals
- Behavioral Health Organizations - Mental health and substance abuse services to inpatient, residential and ambulatory settings
- Comprehensive Outpatient Rehabilitation Facilities
- Federally Qualified Health Center (FQHC)
- Freestanding Surgical Centers
- Home Health Agencies
- Hospice
- Laboratories
- Outpatient Diabetes Self-Management Training
- Outpatient Physical and Speech Therapy Centers
- Portable X-Ray Suppliers
- Renal Dialysis Facilities
- Rural Health Clinics (RHC)
- Skilled Nursing Facilities (SNF) and Nursing Homes

HDOs not requiring credentialing under the HPN Credentialing Program are free standing facilities where practitioners practice and/or provide care exclusively for member directed to the facility. These HDOs include, but are not limited to, the following:

- Mammography Centers
- Urgent Care Centers
- Ambulatory Behavioral Healthcare Facilities
- Psychiatric and Addiction Disorder Clinics

Policy

Healthcare Delivery Organizations that fall within the Scope of Authority and Action will undergo initial HDO credentialing and re-reviewed at recredentialing every three (3) years (36 months) thereafter, to ensure that the provider continues to be in good standing with federal and state regulatory bodies and reviewed and approved by an accrediting body.

Eligibility Criteria

A qualifying HDO must meet the following eligibility criteria. If at any time it is determined that the HDO does not meet criteria, the Credentialing Department will notify the HDO of its lack of qualifications and terminate the credentialing process. The HDO may not provide care to enrollees until a final decision is rendered from the Credentialing Committee.

State Licensure (Facility/Business)
Valid, current licensure issued by State of California.

National Provider Identifier (NPI)

Valid, current NPI.

Accreditation & Onsite Quality Assessment
At the time of application, an HDO must meet this criterion by either one of the following:

- Current accreditation by an approved accrediting body or
- A current onsite quality assessment (conducted by HPN)
- A DHS or CMS site survey

Professional Malpractice Insurance
Current professional malpractice insurance with minimum coverage of:

- Hospitals: $3,000,000 per occurrence, $10,000,000 aggregate
- Others: $1,000,000 per occurrence, $3,000,000 aggregate

Liability coverage must be provided by a recognized financially viable carrier.

General Liability Insurance
Current general liability insurance with minimum coverage of $1,000,000 per occurrence and $3,000,000 aggregate is required. Liability coverage must be provided by a recognized financially viable carrier.

Sanctions
Absence of past or present sanctions by regulatory agencies, including Medicare/Medicaid sanctions.

* This requirement may be waived if evidence exists that the HDO is not currently sanctioned or prevented by a regulatory agency from participating in a federal or state sponsored program.

- Compliance with Federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid
- Compliance with State, Federal and Local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act

Credentialing Application

Acceptable Applications include Hospital Participation Application or Ancillary Facility Application.

Applicant Attestation - Verification Time Limit - 180 calendar days
The authorized signature on the acceptable applications and any relevant information may not be older than 180 calendar days at the time of the Credentialing Committee's action. If the signed attestation exceeds 180 calendar days, before review and action by the Credentialing Committee, the HDO will have the opportunity to update it. The HDO will be sent a copy of the completed application with the new attestation form requesting to update the application and attest that the information on the application is correct and complete. The HDO will not be required to complete another application. The attestation will address:

- History of sanctions, and limitations on scope of practice or loss of licensure
- History of Medicare/Medicaid sanctions or restrictions
- History of disciplinary action or loss of accreditation
- Compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid
- Compliance with state, federal and local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act
- Correctness and completeness of application

Supporting Documentation
The following items may be requested in support of the application, as applicable:

- Copy of valid, current licensure issued by the State of California
- Copy of valid, current accreditation certificate. If not accredited, copy of California Department of Health Services (DHS) or Centers for Medicare and Medicaid Services (CMS) site review
- Copy of valid, current professional and general liability insurance face sheet that includes coverage limits and expiration date
- Copy of Medicare Certification (if applicable)

Initial Credentialing Procedure

Upon receipt of an application by the Credentialing Department, the application will be reviewed for completeness. The signed attestation and any relevant information must be no more than 30 days old to allow adequate processing time. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable. An incomplete application will be returned to the applicant.

Verifications
State Licensure (Facility/Business, Primary Source Verification (PSV) not required)
Valid, current licensure issued by State of California

NPI (Verification Time Limit - 180 calendar days, Primary Source Verification (PSV))
Valid NPI of type 2 (Organization) issued by National Plan and Provider Enumeration System (NPPES) will be verified from via NPPES website.

Accreditation & Onsite Quality Assessment (Primary Source Verification (PSV) not required)
At the time of application, an HDO must meet this criterion by either one of the following:

- Current accreditation by an approved accrediting body
- A DHS or CMS site survey (the survey date may not be greater than 3 years at the time of Credentialing)
- A current onsite quality assessment (conducted by HPN)

Acceptable Regulatory and Accrediting Bodies include:

A. Hospitals/Acute Care Facilities
   - The Joint Commission
   - Healthcare Facilities Accreditation Program (HFAP) Accrediting Program approved by the American Osteopathic Association (AOA)
   - Det Norske Veritas National Integrated Accreditation for Healthcare Organization (DNV)
   - Center for Improvement in Healthcare Quality

B. Behavioral Health Organizations
   - The Joint Commission
   - Commission on Accreditation or Rehabilitation Facilities (CARF)
   - Healthcare Facilities Accreditation Program (HFAP) Accrediting Program approved by the American Osteopathic Association (AOA)
   - Council on Accreditation for Children and Family Services

C. Comprehensive Outpatient Rehabilitation Facilities
   - The Joint Commission
   - The Commission on Accreditation of Rehabilitation Facilities (CARF)

D. Free Standing Surgical Centers, including stand-alone abortion clinics and multi-specialty outpatient surgical centers
   - The Joint Commission
   - Accreditation Association for Ambulatory Health Care (AAAHC)
   - American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)

E. Home Health Agencies
   - The Joint Commission
   - Community Health Accreditation Program (CHAP)
   - Accreditation Commission for Health Care, Inc. (ACHC)
   - Accreditation Association for Ambulatory Health Care (AAAHC)

F. Hospice
   - The Joint Commission
   - Community Health Accreditation Program (CHAP)

G. Laboratories
   - Applicable Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver
   - The Joint Commission
   - Commission on Office Laboratory Accreditation (COLA)
   - College of American Pathologists, Lab Accreditation Program

H. Outpatient Diabetics Self-Management Training Providers
   - American Association of Diabetes Educators (AADE)

- Indian Health Service (IHS)

I. Portable X-Ray Supplier:
   - Federal Drug Administration (FDA) Certification

J. Skilled Nursing Facilities:
   - The Joint Commission
   - Continuing Care Association Commission (CCAC)
   - Commission on Accreditation of Rehabilitation Facilities (CARF)

K. Comprehensive Outpatient Rehabilitation Facilities
   - The Joint Commission
   - Commission on Office Laboratory Accreditation (COLA)

If a facility is not accredited, the Credentialing Committee will require an on-site HDO review be performed by the Quality Management Department. The parameters of the on-site evaluation may vary according to the type, size, and complexity of the HDO. Interviews may be conducted with, but not limited to, senior management, chiefs of major services, key personnel in nursing, quality management or utilization management.

Professional and General Liability Insurance (Primary Source Verification (PSV) not required)
The insurance is verified by a copy of the HDO's current professional and general liability insurance face sheet, which includes effective dates and amounts of coverage, as defined in the Eligibility Criteria Section.

Medicare Certification (If applicable, Primary Source Verification (PSV) not required)
Copy of Medicare Certification is required for Federally Qualified Health Centers, Outpatient Physical Therapy & Speech Pathology Providers, Outpatient Diabetics Self-Management Training Providers, Renal Dialysis Facilities, and Rural Health Clinics.

Office of Inspector General (OIG) (Verification Time Limit - 180 calendar days, Primary Source Verification (PSV)
Confirmation that the practitioner is not listed on the Office of Inspector General website.

System for Award Management (SAM) (Verification Time Limit - 180 calendar days, Primary Source Verification (PSV)
Confirmation that the practitioner is not listed on the System for Award Management (SAM) website.

Recredentialing Criteria

A formal recredentialing process is required every three (3) years with the process being completed within the month of the recredentialing date. There is no grace period beyond the 36-month allotted time period to re-verify information that may have changed over time. The three-year cycle begins with the date of the initial credentialing decision; and thereafter, three years from the recredentialing decision. HDO cannot be re-credentialed if the time is past the recredentialing date month.

Recredentialing Application

Acceptable Applications include Hospital Participation Reapplication or Ancillary Facility Reapplication.

Applicant Attestation - Verification Time Limit - 180 calendar days
The recredentialing application includes a current and signed attestation by the applicant and addresses the following:

- History of sanctions, and limitations on scope of practice or loss of licensure
- History of Medicare/Medicaid sanctions or restrictions
- History of disciplinary action or loss of accreditation
- Compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid
- Compliance with state, federal and local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act
- Correctness and completeness of application

Supporting Documentation

The following items may be requested in support of the application, as applicable:

- Copy of valid, current licensure issued by the State of California
- Copy of valid, current accreditation certificate. If not accredited, copy of DHS or CMS site review
- Copy of valid, current professional and general liability insurance face sheet that includes coverage limits and expiration date
- Copy of Medicare Certification (if applicable)

Recredentialing Procedure

A tickler file in the form of a checklist, spreadsheet, or computer-generated report alerts Credentialing staff of HDO due for recredentialing. One hundred eighty (180) days prior to expiration of the three-year (36-month) cycle, the practitioner is sent to a recredentialing application. The 36-month cycle begins with the date of the initial credentialing decision and is counted to the month, not the day.

If the application is not returned within thirty (30) days, HDO will be contacted by a Credentialing staff member to verify receipt of the application and request that the application is returned within fifteen (15) days. If the application is not returned within fifteen (15) days, Administration will be requested to assist in obtaining the recredentialing application. If the recredentialing application is not returned ninety (90) days prior to the expiration of the three-year (36-month) cycle, HDO will be notified via certified mail of intent to terminate.

Upon receipt of an application by the Credentialing Department, the recredentialing application will be reviewed for completeness. The signed attestation by the applicant should be no more than 30 days old to allow for adequate processing time. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable. An incomplete recredentialing application will be returned to the applicant.

Verification

- State Licensure (Primary Source Verification (PSV) not required)
- NPI (Verification Time Limit - 180 calendar days, Primary Source Verification (PSV)
- Accreditation & Onsite Quality Assessment (Primary Source Verification (PSV) not required)
- Professional and General Liability Insurance (Primary Source Verification (PSV) not required)
- Medicare Certification (If applicable, Primary Source Verification (PSV) not required)
- Office of Inspector General (OIG) (Verification Time Limit - 180 calendar days, Primary Source Verification (PSV)
- System for Award Management (SAM) Excluded Parties List Systems (EPLS) (Verification Time Limit - 180 calendar days, Primary Source Verification (PSV)

Performance Monitoring

Information derived from the practice experience of all HDOs is incorporated into the recredentialing process and reviewed by the Credentialing Committee. At a minimum, confidential member complaint data, information from quality improvement activities, utilization management performance data, and member satisfaction data will be used to assess professional performance, judgment and clinical competence and will be used in the recredentialing decision process.

Credentialing Committee Review And Action

Completed HDO credentialing files are presented to the Credentialing Committee for review within 180 days in which the data gathered was verified. Possible action by the Committee includes approval, denial, and recommendation for improvement, monitoring, disciplinary action, or request for further information.

A Medical Director designated by the Credentialing Committee has the authority to review and sign off on all clean files which have met HPN's credentialing or recredentialing criteria. The date the file is signed by the Medical Director is the date that will be considered the "Committee Review Date". These files do not have to be reviewed by the Credentialing Committee to be approved.

Communication Of Committee Action

The HDO is notified of the Credentialing Committee decision in writing. A copy of the letter will be kept in the HDO credentialing file. Documentation of adverse decisions will be kept in the file.

Utilization Management (UM)

UM Program Overview

HPN's UM Program provides the structure and standards that govern the utilization management functions of HPN & its Medical Groups. In addition, HPN's UM Program provides a structure to monitor the efficiency and quality of UM services offered by its Medical Groups and includes components to ensure the delivery of quality health care and the coordination of resources to manage members across all aspects of the care delivery system. The UM Program, in conjunction with HPN's policies and procedures, meet Federal, State, and accreditation requirements including those from the Department of Health Care Services ("DHCS"), CMS, Department of Managed Health Care ("DMHC"), and National Committee for Quality Assurance ("NCQA").

Access to UM Staff

Groups provide access to staff for providers seeking information about the UM process, the authorization of care and criteria, guidelines, and/or policies. Group staff are available at least 8 hours a day during normal business days for inbound calls regarding UM issues. Providers can access staff to discuss UM issues during normal business days (excludes weekends and holidays) and normal business hours (8:00 AM-5:00 PM PST). Inbound and outbound contact may include communication with providers in person, in writing by mail or fax, by telephone, or by electronic communications (e.g., sending e-mail messages or leaving voicemail messages). Providers are encouraged to utilize the Medical Group's web portals to enter authorization requests, submit records and check the status of an authorization request whenever possible. Use of electronic submission and ensuring the inclusion of all required information (i.e. medical records) reduces the time necessary to make a determination on an authorization request.

Communications received after normal business hours will be returned on the next business day.

After-hours contacts are available in the list below. This includes contacts to receive inbound notification of member admissions and to support post-stabilization care.

Medical Group	Phone Number
ADOC Medical Group (ADOC)	(866) 654-3471 or (888) 764-5732 (Toll Free 24/7)
Bakersfield Family Medical Center (BFMC)	(661) 327-4411
Coastal Communities Physician Network (CCPN)	(661) 327-4411
Desert Oasis Health Care (DOHC)	(760) 320-8814
High Desert Medical Group (HDMG)	(661) 945-5984
Heritage Victor Valley Medical Group (HVVMG)	(760) 245-4747
Lakeside Medical Group (LMG)	(818) 357-5000 or 866) 654-3471 or (888) 764-5732 (Toll Free 24/7)
Regal Medical Group (RMG)	(818) 357-5000 or 866) 654-3471 or (888) 764-5732 (Toll Free 24/7)

Sierra Medical Group (SMG)	(661) 945-9411

Member Eligibility Verification

Providers are responsible for verifying member eligibility and coverage prior to delivering services. Failure to verify member eligibility may result in non-payment of claims. Authorizations are contingent upon the member's eligibility at the time services are delivered and are not a guarantee of payment.

Refer to Member Eligibility for how to verify member eligibility.

Services Not Requiring Authorization

Routine services provided by PCPs do not require prior authorization. Other services not requiring prior authorization when referred to a contracted provider include, but are not limited to the following, subject to the applicable program and network status of the treating provider:

- Emergency (prior authorization not required for contracted or noncontracted providers)
- Urgent Care Services
- Family Planning
- Sensitive Services and confidential service treatment (including those related to Sexual Assault or Sexually Transmitted Disease) – under Medi-Cal benefits these services may be covered to noncontracted providers (contact the Medical Group or Health Plan for more information)
- Preventive Services (including immunizations)
- Basic Pre-Natal Care
- HIV Testing/Counseling
- Direct Access to Women's Health Services
- Language Assistance Program/Interpretation Services
- Health Education
- Non-Facility Based Behavioral Health (including Mental Health Counseling and Drug and Alcohol Abuse Treatment)
- Medi-Cal Carve Out Programs such as Long-Term Services and Supports ("LTSS"), In-Home Supportive Services ("IHSS"), and Community-Based Adult Services ("CBAS")
- Tobacco Cessation

Medical Groups provide direct referral alternatives for basic laboratory and radiology services provided through contracted providers or vendors, that do not require prior authorization. Standard screening mammography services are available through direct referral to Group's contracted radiology vendor. Standard screening mammography may also available to members through direct access when provided by the Group's contracted radiology vendor. Contact the Medical Group directly for information on direct referral laboratory and radiology services available in your area.

Check the member's benefits through the contracted health plan or contact the Medical Group if you are unsure if a service requires authorization.

Services That Are Not Group Responsibility

Select services are not delegated as the responsibility of the Medical Groups and are therefore "carved out" of the responsibility of the Groups. In these instances, the request for services should be directed to the appropriate entity responsible for authorizing coverage, which may be the health plan, another entity delegated by the health plan, or the fee-for-service Medicare and/or Medicaid program. Submission of such requests to the Medical Group will require re-routing to the appropriate entity for processing. Providers should check the member's benefits through the contracted health plan before submitting an authorization request or referral for the member to the Group.

Examples of services that are frequently not the responsibility of the Group include but are not limited to:

- Routine Vision Care
- Behavioral Health / Substance Abuse
- Chiropractic / Acupuncture Care
- Pharmacy Benefits

Providers should direct requests for such items to the health plan, the health plan's delegated pharmacy benefits manager (PBM), or other appropriate entity responsible for the provision of such benefits. Requests for physician-administered drugs are the responsibility of and should be directed to the Group, as noted below.

Services Requiring Authorization

Services which require authorization as part of the UM process generally include but are not limited to the following:

- Ambulatory Care
- Inpatient Services
- Skilled Nursing Facility ("SNF") Services
- Home Health Care
- Rehabilitative Services (such as physical, occupational and speech therapies)
- Physician-administered drugs
- Durable Medical Equipment ("DME") and/or Supplies

Requesting An Authorization

Requests for authorization of services can be submitted by providers to the Groups via mail, fax, phone, or direct entry via the Group's web portal. Requests for authorization must include the following information:

- Member (including name and ID)
- Requesting Provider
- Requested Provider

- Requested Facility, for facility-based services
- Place of Service Code
- Diagnosis Code(s) ICD 10 Codes
- Procedure Code(s) CPT/ HCPCS Code for requested medical services or procedures
- Clinical Information (see Submission of Clinical Information to Support Request)

If the request for authorization requires expedited/urgent (i.e., faster) processing, providers should indicate such upon submission of the request. Expedited/urgent status should not be requested for convenience, preventive care, or routine services. Expedited/urgent status should only be utilized when the routine decision time period could seriously jeopardize the life or health of the member or the member's ability to regain maximum function or would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request.

Providers are encouraged to utilize the Medical Group's web portals to enter authorization requests, submit records, and check the status of an authorization request whenever possible. Use of electronic submission and ensuring the inclusion of all required information (i.e. medical records.) reduces the time necessary to make a determination on an authorization request.

Please do not submit duplicate requests. Check the status of your request on the Group's web portal or by contacting the Medical Group's Utilization Management staff.

Submission of Clinical Information to Support Request

Providers must submit relevant supporting clinical information along with the authorization request to justify the medical necessity of the requested service(s) / item(s). This may include but is not limited to the following, as applicable for the service(s) / item(s) being requested:

- Office and hospital records
- A history of the presenting problem
- Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Operative and pathological reports
- Rehabilitation evaluations
- Information regarding the local delivery system
- Member characteristics and information
- Information from family members

Failure to submit clinical information at the time of request may result in processing delays while the Group works to obtain clinical information to substantiate the necessity of the request.

Second Opinions

Medical Groups provide or authorize a second and/or third opinion requests by an appropriately qualified health care professional when it is requested by a member, a member's authorized representative, or a participating health care professional and meets the requirements of a second or third opinion request. Some health plans do not delegate responsibility for making determinations on second and/or third opinion requests, in those cases the Group will forward the request to the member's health plan and notify the requesting provider.

If the second opinion is regarding PCP care, the member may seek a second opinion from any PCP within the Medical Group's contracted network. If the Second Opinion is regarding specialty care, the member or their physician can request the Second Opinion from any qualified provider. Depending on the member's health plan and coverage, the Medical Group may refer out-of-network requests to the health plan for determination, may approve the request if appropriate, or may redirect the member to an in-network provider.

The provider or appropriately qualified health care professional that renders a second opinion shall be required to provide the member, the PCP, and the initial provider treating the member with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. The professional rendering the second opinion is expected to refer the member back to their PCP or initial provider treating the member for follow-up and ongoing care.

Non-Contracted Providers

Referral requests should be made within the Group's contracted provider network, whenever possible. Referrals to non-contracted providers will be evaluated to determine the appropriateness of the out-of-network provision of services in accordance with the member's health plan benefits, availability of services within the Group's network, and circumstances of the member's care.

UM Criteria

Groups employ HPN's policies and procedures addressing the application of objective and evidence-based criteria in evaluating the necessity of medical, behavioral healthcare, and pharmaceutical services requiring authorization.

Criteria are applied taking into account individual circumstances and member needs (such as age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment) as well as an assessment of local delivery systems and the ability of such systems to meet members' specific needs, including but not limited to:

- Availability of inpatient, outpatient, and transitional facilities
- Availability of outpatient services in lieu of inpatient services such as ambulatory surgical centers (ASC) vs. inpatient surgery
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of skilled nursing facilities, subacute care facilities, or home care in the Group's service areas to support members after hospital discharge
- Local hospitals' ability to provide all recommended services within the estimated length of stay

The approved and adopted clinical guidelines, criteria, or medical policies are applied in accordance with HPN's approved policies and procedures on Utilization Management Review Criteria, which also defines the hierarchy under which criteria will be applied.

Criteria to be considered when making UM determinations may include but are not limited to:

- Health plan eligibility and coverage (benefit plan package)
- CMS criteria, when applicable (National Coverage Determinations ("NCDs"), Local Coverage Determinations ("LCDs") and Local Coverage Articles ("LCAs"), Medicare Benefit Policy Manuals)
- State regulations
- Health plan criteria (e.g., coverage summaries, medical policies)
- Evidence-based criteria – National/Specialty Guidelines approved by QIC/UMC for use are the latest version of:
    - AIM Specialty Health Clinical Appropriateness Guidelines
    - American College of Radiology (ACR) Appropriateness Criteria
    - InterQual
    - MCG
    - National Comprehensive Cancer Network (NCCN)
    - US Preventive Services Task Force (USPSTF) Recommendations Grade A, B & C

- Behavioral Health Guidelines:
  - American Association of Addiction Medicine guidelines
  - American Association of Community Psychiatrists - Level of Care Utilization (LOCUS)
  - American Association of Community Psychiatrists - Child and Adolescent Level of Care Utilization System (CALOCUS)
  - American Academy of Child & Adolescent Psychiatry - Child and Adolescent Service Intensity Instrument (CASII)
  - American Academy of Child and Adolescent Psychiatry - Early Childhood Service Intensity Instrument
  - World Professional Association for Transgender Health (WPATH) Standards of Care
- Other evidence-based resources

Criteria for behavioral health and non-behavioral health services are reviewed, approved, and/or updated as needed but no less than annually. Appropriate practitioners with clinical expertise in the applicable areas, including practitioners on staff and participants in the network, are involved in the development (if applicable), review, and adoption of criteria, as well as on instructions for applying criteria. Criteria are designed to comply with the applicable regulatory requirements for the given program, are reviewed against current clinical and medical evidence, and reflect new scientific evidence, as appropriate.

Providers may request and obtain copies of the behavioral health or non-behavioral health criteria, clinical review guidelines, and medical review policies utilized for decision making by contacting the Prior Authorization, Customer Service or Network Management departments of the Medical Group.

Timeliness of UM Decisions

Groups make determinations and issue notifications on requests for authorization of services in a timely manner to accommodate the urgency of the member's care and in accordance with the applicable regulatory and / or accreditation requirements for the applicable program and type of request (e.g., pre-service, concurrent, post-service).

Groups may extend / delay the timeframe for processing authorization requests, as appropriate. This may occur, as permitted by the applicable regulations / standards, when:

- The Group is not in receipt of all the information reasonably necessary and requested, where there is a reasonable likelihood that receipt of such information would lead to approval of the request;
- A consultation with an expert reviewer is needed;
- Additional examinations or tests have been asked to be performed on the member;
- The member or provider requests the extension;
- The Group determines the extension is in the member's best interest; or
- The Group determines that the extension is justified due to extraordinary, exigent, or other non-routine circumstances.

Opportunity to Discuss with a Reviewer

For denials resulting from medical necessity review, providers will be given the opportunity to discuss denial decisions with a physician or other appropriate reviewer. This opportunity may be provided:

- In the written denial notification, which includes the name and direct telephone number of the health care professional responsible for the denial or modification determination; or
- By telephone, which may include leaving a voicemail; or

in other materials sent to the treating provider, informing the provider of the opportunity to discuss a specific denial with a reviewer.

Denial Notifications

Groups provide notification of the denial of an authorization (including a modification or partial denial, where applicable) within the required timeframes. Providers can generally expect to receive the following information in their denial notification:

- A description of the service(s) being denied.
- An explanation of the reasons for the denial that is specific to the member's diagnosis, condition or situation.
- A description of the benefit provision, criteria, or guideline used as a basis for the decision.
- Notification that a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based can be obtained upon request.
- A description of rights and instructions to file an appeal of the denial.

Written communication to the provider of denial determination based on medical necessity will include the name and phone number of the health care professional responsible for the denial. Providers will receive notification of denials either in writing or electronically through the Group's web portal. Providers are expected to check the portal regularly for such notifications.

Appeal of UM Denials

Notification of the denial of a request for authorization will include the applicable rights and instructions for submitting an appeal. Groups are not delegated for processing of appeals and appeals should be submitted to the health plan or appropriate external agency, as outlined in the instructions included with the denial notice.

Non-Incentive UM Decision Making

HPN and its Groups do not encourage or reward employees or downstream entities conducting utilization management (UM) review activities for issuing denials of coverage or service. HPN also promotes appropriate utilization and discourages under-utilization or barriers to care and services.

HPN's and its Groups' compensation to providers, employees and other individuals conducting utilization review does not contain incentives, direct or indirect, to approve or deny payment for the delivery of any health care service. Utilization-related decision making is based on the individual clinical needs of the member, benefit availability, medical appropriateness of care and service, and existence of coverage. UM decisions are subject to the evidence of coverage and benefits contractually provided by the health plan to members.

Employment, compensation, termination, and promotion decisions (or any other similar matters) are not made based on likelihood that the individual would support the denial or any modification of benefits or services.

Triage & Referral For Behavioral Healthcare

Triage and Referral (T&R) functions for behavioral healthcare services are provided via direct access or direct referral by a primary care physician, specialists or medical group staff to the Group's behavioral health providers. Medical Group staff provide information about the BH practitioners but do not make judgements regarding the needed level of care or type of practitioner the member should see.

Emergency Services and Urgent Care

Emergency services and urgently needed care must be available to members 24 hours a day, 365 days a year. Members will not be required to obtain prior authorization when seeking emergency services and urgent care as a result of an emergency medical condition, as defined below for each program.

Program	Definition of Emergency Medical Condition	Source(s)
Commercial/ Exchange	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: • Placing the patient's health in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part.	CA Health & Safety Code §1317.1(b)
Medicare Advantage Medi-Cal Cal MediConnect	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part.	42 CFR §438.114 CMS Medicare Managed Care Manual Chapter 4 Section 20.2 Cal MediConnect Three Way Contract Section 1.38

Emergency service providers, acting on behalf of the Medical Group when a member seeks care due to an emergency medical condition as defined above, shall:

- Authorize the provision of emergency services.
- Screen and stabilize the member without prior approval.

Urgent or Immediate Care services are available across the HPN network. Members should be referred to contracted Urgent Care when appropriate for the member's needs and care is required outside primary care office hours.

Urgent Care centers are often open evenings and weekends and available for immediate treatment of injuries or illnesses that are not life-threatening on a walk-in basis. Urgent Care centers, often provide shorter wait times and lower out of pocket costs than emergency rooms.

HPN contracted Urgent Care and immediate care centers are right in your area. They are part of our network, so members don't have to worry about unexpected costs. Many Urgent Care centers also have on-site diagnostic equipment, including blood draw and x-ray, to ensure quick treatment and recovery.

Members or your office staff can locate our contracted urgent or immediate care centers by visiting our Medical Group web sites. Direct links to the Urgent Care center locators or listings are located below.

Medical Group	Website
ADOC Medical Group (ADOC)	https://www.adoc.us/urgent-care-finder/
Bakersfield Family Medical Center (BFMC)	https://www.bfmc.com/for-our-members/urgent-care/
Coastal Communities Physician Network (CCPN)	https://www.ccpnhpn.com/services/urgent-care/
Desert Oasis Health Care (DOHC)	https://www.mydohc.com/care-treatment/immediate/
High Desert Medical Group (HDMG)	http://hdmg.net/wordpress/urgent-care/
Heritage Victor Valley Medical Group (HVVMG)	https://www.hvvmg.com/urgent-care/
Lakeside Medical Group (LMG)	https://www.lakesidemed.com/urgent-care-finder/
Regal Medical Group (RMG)	https://www.regalmed.com/urgent-care-finder/
Sierra Medical Group (SMG)	https://www.heritagesmg.com/urgent-care

Post-Stabilization Care

HPN's Medical Groups ensure that appropriate post-stabilization care is provided to members as necessary following emergency room treatment, hospitalization, or institutional confinement. Physicians are available 24 hours a day, 365 days a year to consult with treating physicians, make medical necessity determinations, and discuss cases with the accepting physician during transfer, as required, using the contact information below.

Contact Information

Medical Group	Website	Contact Number	During Business Hours	After Business Hours
ADOC Medical Group	www.adoc.us	(714) 539-3100	Ask for Case Manger	Ask for On-Call Case Manager
Bakersfield Family Medical Center (BFMC)	www.bfmc.com	(661) 327-4411	Ask for Utilization Review Department	On-call UR Staff or Hospitalist
Coastal Communities Physicians Network (CCPN)	www.ccpnhpn.com	(661) 327-4411	Ask for Utilization Review Department	Ask for On-call UR Staff or Hospitalist
Desert Oasis Health Care (DOHC)	www.mydohc.com	(760)320- 8814	Ask for Case Management	Ask for On-call Case Manager
High Desert Medical Group (HDMG)	www.hdmg.net	(661) 945-5984	Ask for Acute Case Management	Ask for Acute Case Management On-Call Specialist
Heritage Victor Valley Medical Group (HVVMG)	www.hvmg.com	(760)245-4747	Ask for Case Management	Ask for On-call Case Manager or Medical Director
Lakeside Medical Group (LMG)	www.lakesidemed.com	(818)654-3400	Ask for Medical Management - Inpatient Department	Option #9 for On-Call Nurse and Medical Director
Regal Medical Group (RMG)	www.regalmed.com	(818)654-3400	Ask for Medical Management - Inpatient Department	Option #9 for On-Call Nurse and Medical Director
Sierra Medical Group (SMG)	www.heritagesmg.com	(661)945-9411	Ask for Case Manager	Ask for On-call Case Manager

PCP Responsibilities

PCPs are responsible for providing or overseeing comprehensive healthcare services, maintaining continuity of care, and initiating referrals for specialist care. This means providing for the majority of health care concerns including but not limited to: preventive services, acute and chronic conditions, and psychosocial issues. PCPs must provide coverage 24 hours a day, 365 days a year for the provision of care within access and availability standards/requirements.

The responsibilities of the PCP include but are not limited to the following:

- Routine office visits, related care, and after-hours care of uncomplicated medical problems.
- Periodic health evaluations which are appropriate and timely for all adults and children who are members of the PCP's practice, including sharing the findings of the history and physical examination with the member.
- Immunization/injections for child and adult members.
- Preventative care.
- Well-child care.
- Consultation time to manage the member's care.
- Provide the member with potential treatment options (without regard to plan coverage), side effects of treatment, and management of symptoms. The member has the right to choose the final course of action among clinically acceptable choices.
- Visits and examinations in the emergency room, hospital, skilled nursing facility, or extended care facility. Monitors the medical necessity of services being provided and facilitates the appropriate transfer of the member to the appropriate level of care. An attending physician may be responsible for monitoring the member's care.
- Home visits and supervision of the home healthcare regimen.
- Education of members regarding their health needs (e.g., diet, exercise, medication compliance).

- Referral of members to appropriate specialty providers or ancillary services as necessary and according to guidelines for referrals. Obtains and reviews consultation reports/summaries and determines whether additional services are needed.
- Submission of authorization requests, when necessary.
- Ensure continuity and coordination of care while preventing duplication of services.
- Document services and interactions in accordance with HPN policy
- Comply with the HPN Utilization Management and Quality Improvement Programs and HPN Provider Manual.

Specialists

Specialists are required to provide members with access to appointments within access and availability standards/requirements. Specialists coordinate care with the member's PCP and communicate the assessments, care provided, and recommendations to the member's PCP including provision of a consultation report, summary, or discharge summary within 30 days of care delivery.

Specialists may also be authorized to provide health care services within the specialist's area of expertise and training to a member that requires specialized medical care over a prolonged period of time and is life threatening, degenerative or disabling in the same manner as the member's PCP following the approval of a standing referral to the specialist and in accordance with the defined treatment plan. Standing referrals may be requested by the member's PCP in consultation with a Specialist and the Group Medical Director. Treatment plans will be developed. Requests for standing referrals requests may by submitted through the member's Medical Group, using a *Standing Referral Form* or through another standard request method when clearly identified as a Standing Referral request.

Informed Consent

Providers must ensure patients receive sufficient information to make meaningful decisions regarding their treatment. Information provided should be clear and understandable about the benefits and risks of a proposed course of treatment, alternative treatment options, and the risks of not receiving treatment. The patient should able to ask questions about recommended treatments so that they can make well-considered decisions about care. Providers are required to obtain written consent for any invasive procedure or treatment in accordance with all applicable State and Federal requirements.

In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), providers should:

- Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, informed, and voluntary decision.
- Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The provider should include information about:
    - The diagnosis (when known);
    - The nature and purpose of recommended interventions; and
    - The burdens, risks, and expected benefits of all options, including forgoing treatment.
- Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

Providers may initiate treatment without informed consent in emergency situations, which includes situations which require immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death. Inability to obtain informed consent may be caused by any of the following:

1. The patient was unconscious;
2. The medical procedure was undertaken without the consent of the patient because the physician reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or
3. A medical procedure was performed on a person legally incapable of giving consent, and the physician reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of a person authorized to give such consent for the patient.

California law requires that consent be obtained *in writing* for several specific procedures and treatments for specific types of conditions, including:

- Sterilizations,
- Hysterectomy,
- Breast cancer,
- Prostate cancer,
- Gynecological cancers,
- Psychosurgery, and
- Electroconvulsive therapy.

If you have a financial interest in the patient's treatment recommendation that might influence your judgment about treatment decisions, you are required to disclose that interest before a procedure is performed.

You are required to obtain informed consent for participation in medical research and in the area of human experimentation and research, and to comply with all State and Federal regulations governing biomedical and behavioral research.

HPN Population Health Management Program

Population Health Program

Heritage Provider Network's approach to Population Health Management is through Care Management process which provides member-centric care coordination and management for large and diverse member populations. The size and complexity of the network requires multiple programs and approaches to accommodate the needs of a population that has wide variation in age, geography, resources, benefits, and culture. The Population Health Program has a comprehensive strategy for population health management that at a minimum addressed four areas of focus:

1. Keeping members healthy
2. Managing members with emerging risk
3. Patient safety or outcomes across settings
4. Managing multiple chronic diseases

Population Health Management involves the aggregation of member data across multiple data points, and the subsequent analysis of that data into a single, actionable member record. The analysis of population health data provides clinical decision support related to quality, outcomes, cost, utilization, and other information critical to the health and well-being of the defined populations in the community. Additionally, population health management considers the distribution of such outcomes within a population.

Programs & Services

Case Management

Case Management is designed to maximize health outcomes and resource utilization for members with special and / or complex needs, including but not limited to those with chronic conditions, multiple co-morbidities, and other health risk areas. It is a collaborative process of data analysis, selection, assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive needs of the member. Case Management services vary by program but generally include an initial assessment followed by individualized planning and execution of the member's care, including collaboration across providers, securing of necessary referrals and community resources, and continued follow ups to achieve health goals.

Case Management services may be opt-in or opt-out depending on the program and the member's circumstances. Providers may identify and refer members to the Group for Case Management services by utilizing the following resources.

Medical Group	Case Management Contact Information
ADOC Medical Group (ADOC)	Call (888)787-1712
Bakersfield Family Medical Center (BFMC)	Call (661) 327-4411 or fax (661) 846-4821. For outpatient Case Management fax (661) 616-9569
Coastal Communities Physician Network (CCPN)	Call (661) 327-4411 or fax (661) 846-4821. For outpatient Case Management fax (661) 616-9569
Desert Oasis Health Care (DOHC)	Call (760) 969-6655
High Desert Medical Group (HDMG)	Call (661) 951-3034 or Fax (661)952-3690.
Heritage Victor Valley Medical Group (HVVMG)	Call (661) 945-5984 or (800) 266-4364
Lakeside Medical Group (LMG)	Call (888)787-1712
Regal Medical Group (RMG)	Call (888)787-1712

Sierra Medical Group (SMG)	Call (661) 480-2022

Care Coordination

Groups' Care Coordinators are the primary facilitators of Case Management services; however, providers must work closely with Care Coordinators to manage member care and optimize health outcomes. As part of the care coordination process, providers' responsibilities include but are not limited to the following:

- Participate in developing and updating the member's Individualized Care Plan based on health risks identified through assessments
- Participate in the member's Interdisciplinary Care Team and coordinate with other care team members for the provision of cohesive care
- Evaluate and manage the member's progress against care plan goals
- Initiate and monitor referrals to specialists and other community resources
- Perform outreach to maintain and encourage member engagement in case management
- Provide education to members on self-management of health conditions
- Participate in the member's transition of care and discharge planning processes to maintain care continuity

Disease Management

HPN's Disease Management Program focuses on a population-based process that offers coordinated healthcare interventions for defined populations to reduce healthcare costs and improve the quality of life of members with chronic conditions. These programs provide an assessment, care coordination, and member education to improve and maintain the health of those members.

Health Education

HPN's Health Education Program provides members with education services, materials, and interventions that are effective in achieving behavior changes for improved health outcomes. The program focuses on delivering high-quality, topical content that meets the diverse needs of our populations.

Transitions of Care

A transition of care occurs with a member's health status change or a change between care settings, for example home to Emergency Room, home to hospital, or facility to home whether the transition if planned or unplanned. When this occurs, transition of care procedures are implemented to mitigate potential risks associated with member transition and to reduce readmissions and unplanned admissions. To maintain continuity of member care during periods of transition, providers are expected to:

- Notify the Medical Group of any admission as quickly as possible, but not longer than one (1) day following admission
- Participate in discharge and transition planning for the member
- Collaborate with other participants on the member's care team to re-evaluate care plan strategy and care goals
- Review and provide feedback on the member's care plan with respect to the member's evolving needs post-transition
- Perform outreach following discharge to ensure member understanding and adherence to the post-discharge treatment plan

- Educate the member on health issues, medications, and follow up care

Medical Group Care Management staff will identify members who are at risk of transitions by analyzing the utilization management data on a monthly basis and focusing on those individuals. Special Needs Program members and other high risk member need to be closely monitored for transitions of care to provide a seamless delivery of care across the health continuum. Groups utilize a Transitions of Care process to obtain the documentation necessary to ensure seamless care delivery in one business day. In most instances our concurrent review process monitors and assists in this coordination through communication with the member, the member's family and the PCP. The inpatient review nurse communicates with the discharge planner and care manager when appropriate to coordinate the member's care. The member/caregiver/family is provided with available treatment options, supports, and/or alternative courses of care and are ensured access to appropriate community resources. The focus is on providing services in the least restrictive setting and providing smooth transitions between the facilities and community.

Group's Care Managers will notify the PCP of planned and unplanned admissions within one business day. Care plans will be obtained from facilities and retained in the Group's care management system for coordination upon discharge. The member's medications are reviewed and reconciled with the member or the member's family during the transitions of care.

CMS Regulations

This section will address compliance with the laws and regulations governing the delivery of health care services as a Medicare Advantage Organization (MAO) as set forth by the Centers of Medicare and Medicaid Services (CMS).

1. All regulations are required to be communicated to all delegated Physician Groups through policies, standards and manuals.
2. Delegated Physician Groups are responsible for implementing and adhering to all CMS regulations outlined in these guidelines and contract.

42 CFR § 422.64 Information about the Medicare Advantage (MA) Program

Each MA Organization must provide, on an annual basis, and in a format using standard terminology specified by CMS, the information necessary to enable CMS to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage.

42 CFR §422.80 Approval of Marketing Materials and Election Forms

An MA Organization may not distribute any marketing materials or election forms, or make such materials or forms available to individuals eligible to elect an MA plan.

1. For at least 45 days (or 10 days if using marketing materials that use, without modification, proposed model language as specified by CMS) following the date on which the MA organization submitted the material or form to CMS for review under CMS guidelines.
    a. If the MA plan is deemed by CMS to meet certain performance requirements established by CMS, the MA plan may distribute designated marketing materials 5 days following their submission to CMS.
    b. Or if CMS disapproves the distribution of the new material or form.

2. Marketing materials include any informational materials targeted to Medicare beneficiaries which:
    a. Promote the MA organization, or any MA plan offered by the Medicare Advantage (MA) organization.
    b. Inform Medicare beneficiaries that they may enroll, or remain enrolled in, a Medicare Advantage (MA) plan offered by the MA organization.
    c. Explain how benefits of enrollment in an MA or rules that apply to enrollees.

d. Explain how Medicare services are covered under an Medicare Advantage (MA) plan, including conditions that apply to such coverage.

Examples of marketing materials include, but are not limited to:

1. General audience materials, such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the internet.
2. Marketing representative's materials, such as scripts, or outlines for telemarketing or other presentations.
3. Presentation materials, such as slides and charts.
4. Promotional materials, such as brochures or leaflets, including materials for circulation by third parties (e.g., physicians or other providers).
5. Membership communication materials such as, membership rules, subscriber agreements (evidence of coverage), member handbooks, and wallet card instructions to enrollees.
6. Letters to members about contractual changes, changes in providers, premiums, benefits, plan procedures, etc.
7. Membership or claims processing activities (e.g., materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or annual notification information).

In reviewing marketing material or election forms, CMS determines if the marketing materials:

1. Provide, in a format (and, where appropriate, print size) that use standard terminology that may be, specified by CMS, the following information to Medicare beneficiaries interested in enrolling:
    a. Adequate written description of rules (including any limitations on the providers from whom services can be obtained), procedures, basic benefits and services, and fees or other charges.
    b. Adequate written explanation of supplemental benefits and services.
    c. Adequate written explanation of the grievance and appeals process, including differences between the two, and when it is appropriate to use each.
    d. Any other information necessary to enable beneficiaries to make an informed decision about enrollment.
2. Notify the general public of its enrollment period (whether time-limited or continuous) in an appropriate manner, though appropriate media, throughout its service and continuation area.
    a. Include notice that the MA organization is authorized by law to refuse to renew its contract with CMS, that CMS also may refuse to renew the contract, and that termination or non-renewal may result in termination of the beneficiary's enrollment in the plan.
    b. Are not materially inaccurate or misleading or otherwise make material misrepresentations.
    c. For markets with a significant non-English speaking population, provide materials in the language of these individuals.

42 CFR §422.100 General Requirements

An MA Organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the MA organization to provide service covered by the MA plan:

1. Ambulance services dispatched through 911 or its local equivalent.
2. Emergency and urgently needed services.
3. Maintenance and post-stabilization care services.
4. Renal dialysis services provided while the enrollee was temporarily outside the plan's service area.
5. Services for which coverage have been denied by the MA organization and to which the enrollee was found to have been entitled to have furnished, or paid for, by the MA organization.

Benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine:

1. Enrollees of MA organizations may directly access (through self-referral) screening mammography and influenza vaccines.

2. MA organizations may not impose cost-sharing for influenza vaccines and pneumococcal vaccines on their MA plan enrollees.

42 CFR §422.110 Discrimination against Beneficiaries Prohibited

Except as provided in the following paragraph of this section, an MA organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

1. Medical condition, including mental as well as physical illness.
2. Claims experience.
3. Receipt of health care.
4. Medical history.
5. Genetic information.
6. Evidence of insurability, including conditions arising out of acts of domestic violence.
7. Disability.

42 CFR §422.111 Disclosure Requirements

The MA organization must make a good faith effort to provide notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.

42 CFR §422.112 Access to Services

An MA organization that offers an MA coordinated care plan or network MA MSA plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including additional or supplemental services contracted for, by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:

1. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.
    a. MA regional plans, upon CMS pre-approval, can use methods other than written agreements to establish that access requirements are met.

2. Establish the panel of PCPs from which the enrollee may select a PCP. If an MA organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the MA organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.

3. Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits. The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs.

4. If seeking a service area expansion for an MA plan, demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served.

5. Demonstrate to CMS that its providers in an MA plan are credentialed through the process set forth.

6. Ensure that:
    a. The hours of operation of its MA plan providers are convenient to the population served under the plan and do not discriminate against Medicare enrollees.
    b. Plan services are available 24 hours a day, 7 days a week, when medically necessary.

7. Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and from diverse cultural and ethnic backgrounds.

8. Provide coverage for ambulance services, emergency and urgently needed care services, and post-stabilization care services.

9. Ensure that all its contracted provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that:
    a. The provider makes a "best-effort" attempt to conduct an initial assessment of each enrollee's health care needs, including follow up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment.
    b. Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the MA organization, taking into account professional standards.
    c. There is appropriate and confidential exchange of information among provider network components.

42 CFR §422.128 Information on Advance Directives

The MA organization must have written policies respecting the implementation of those rights concerning advance directives, including a clear and precise statement of limitation if the MA organization cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

1. Document in a prominent part of the individual's current medical record whether the individual has executed an advance directive.

42 CFR §422.202 Participation Procedures

The MA organization must establish a format mechanism to consult with the physicians who have agreed to provide services under the MA plan offered by the organization regarding the organization's medical policy, quality improvement programs, and medical management procedures and ensure that the following standards are met:

1. Practice guidelines and utilization management guidelines:
    a. Are based on reasonable medical evidence or a consensus of heath care professionals in the particular field.
    b. Consider the needs of the enrolled population.
    c. Are developed in consultation with contracting health care professionals.
    d. Are reviewed and updated periodically.

2. An MA organization that suspends or terminates an agreement under which the physician provides services to the MA plan enrollees must give the affected individual written notice of the following requirements:
    a. The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the MA organization.

b. The affected physician's right to appeal the action and the process and timing for requesting a hearing.

3. The MA organization must ensure that the majority of the hearing panel members are peers of the affected physician.

4. An MA organization that suspends or terminates a contract with a physician because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.

5. An MA organization and a contracting provider must provide at least 60 days written notice to each other before terminating the contract without cause.

42 CFR §422.208 Physician Incentive Plans: Requirement and Limitations

The requirements in this section apply to an MA organization and any of its subcontracting arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Subcontracting arrangements may include an intermediate entity, which includes but is not limited to, an individual practice association that contracts with one or more physician groups or any other organized group. Any physician incentive plan operated by an MA organization must meet the following requirements:

1. The MA organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
2. If the physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the MA organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss and conduct periodic surveys.
3. For all physician incentive plans, the MA organization provides all information requested to CMS.

42 CFR §422.504 Contract Providers

The MA organization agrees to comply with all the applicable requirements and conditions set forth in this part and in general instructions. The MA organization agrees:

1. To provide:
    a. The basic benefits and, to the extent applicable, supplemental benefits.
    b. Access to benefits as required.
    c. In a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.

2. To disclose information to beneficiaries in the manner and the form prescribed by CMS.
    a. To operate a quality improvement program and have an agreement for external quality review as required.
    b. To comply with the reporting requirements for submitting encounter data to CMS.
        I. The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful.
        II. The CEO, CFO or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the encounter date it submits are accurate, complete, and truthful.

III. If such encounter data is generated by a related entity, contractor, or subcontractor of an MA organization, such entity, contractor or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

3. To submit to CMS all information necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. The information includes, but is not limited to:
    a. The benefits covered under the MA plan.
    b. The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the MA monthly MSA premium.
    c. The service areas and continuation area, if any, of each plan and the enrollment capacity of each plan.
    d. Plan quality and performance indicators for the benefits under the plan including:
        I. Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years
        II. Information on Medicare enrollee satisfaction
        III. Information on health outcomes

4. To comply with:
    a. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84
    b. The Age Discrimination Action of 1975 as implemented by regulations at 45 CFR part 91
    c. The Rehabilitation Act of 1973
    d. The Americans With Disabilities Act
    e. Other laws applicable to recipients of Federal funds
    f. All other applicable laws and rules

42 CFR §422.562 GENERAL PROVISIONS

An MA organization, with respect to each MA plan that it offers, must establish and maintain:

1. A grievance procedure for addressing issues that do not involve organization determinations as described in §422.564.
2. A procedure for making timely organization determinations.
3. Appeal procedures that meet the requirements of this subpart for issues that involve organization determinations.

In accordance with subpart K, as HPN does not delegate the appeal or grievance function, or any of its responsibilities to another entity, HPN is ultimately responsible for ensuring that the entity or individual satisfies the relevant Appeals and Grievance requirements. All delegated entities must adhere to the HPN Appeal and Grievance policies and procedures.

42 CFR §422.752 Basis for Imposing Sanctions

For the violation listed below, CMS may impose any of the sanctions on any MA organization that has a contract in effect. The MA organization may also be subject to other applicable remedies available under law.

1. Employs or contracts with an individual or entity who is excluded from participation in Medicare under section 1128 or 1128A of the Act.

Required Submissions

The Healthcare Informatics Department at HPN Inc. contracted Medical Groups/IPAs are responsible for collecting, managing and analyzing all encounter data and paid claims for HPN members submitted by all Physician Groups, IPAs, and providers contracted with HPN Inc. contracted Medical Groups/IPAs. HPN

requests that the following types of information be submitted timely (i.e., within 45 days of date of service) by all contracted Physician Groups, IPAs, and Providers for all HPN members:

1. All paid claims on either CMS 1500 or UB92 forms.
2. All encounter data submitted on either CMS 1500 or UB92 forms. This includes all subcontracted and sub-capitated providers to a capitated entity.

Medicare Regulations

HPN Inc. requires that all data elements on the CMS 1500 or UB92 forms comply with Medicare fee-for-service submission guidelines. These submissions must be complete and timely in order to contract with CMS submission deadlines and current regulations. (42 CFR 422.257).

Accuracy and completeness of the submitted data is crucial to the contracted Physician Groups, IPAs and providers since CMS is using this information to establish payment rates under the Medicare Advantage program. In addition, CMS is requiring related entities, contractors or subcontractors of Medicare Advantage organizations to certify the accuracy, completeness and truthfulness of encounter data. CMS has instituted a program of Encounter Data Validation that includes both random and targeted medical record review of encounter data.

Common Errors

HPN is also reviewing submitted encounters to ensure the completeness and accuracy of submissions and to determine common errors. The most common errors identified are:

1. UB92
    a. ICD-10-CM coding not to the highest level of specificity.
    b. No HCPCS/CPT coding when required by Revenue Code.
2. CMS 1500
    a. “Unbundling” or fragmentation of services.
    b. ICD-10-CM coding not to the highest level of specificity.
    c. Use of outdates or invalid procedure and diagnosis codes.

Physician Groups, IPAs and providers should only use the most current ICD-10-CM, HCPCS and CPT codes.

Additional Information

Additional information on coding accuracy is available from many sources, including the CMS website at: www.CMS.gov. CMS approved computer based training modules on completion of Medicare claim forms are available at: www.medicaretraining.com.

Supplemental Information

General & Utilization Management

Initial Health Assessments (IHAS) / New Member Visits

PCPs will receive from the Group a list of new members who potentially require an initial assessment of their health care needs. PCPs are responsible for contacting new members via telephone and/or mail to assess the member's current need for an initial assessment and to schedule an appointment to complete the initial assessment, where necessary. If the member cannot be reached by telephone, the PCP must mail a new member letter. If the PCP determines that a qualifying assessment has been performed elsewhere, the appropriate records must be obtained and documented in the member's medical record. All attempts to complete an initial assessment, including instances where the member misses a scheduled appointment or refuses to complete the assessment, must be documented in the member's medical record.

For *Medicare Advantage* members:

A best effort attempt to complete the initial assessment of the member's health care needs should be performed within 90 days of the member's effective date of enrollment. The original Medicare initial preventative visit (i.e., "Welcome to Medicare" preventative visit), an Annual Wellness Visit, or a recent previous physical examination in a Commercial plan (to which the provider has access) would satisfy this requirement. Initial assessments and annual visits must include a review of the member's current opioid prescriptions and screening for potential substance use disorders.

For *Medi-Cal* and *Cal MediConnect* members:

Reasonable attempts to contact members and schedule the IHA will be performed and documented. For members under the age of 18 months, an IHA will be provided within 120 calendar days following enrollment or within periodicity timelines established by the American Academy of Pediatrics ("AAP") for ages 2 or younger (60 calendar days), whichever is less. For members 18 months and older, an IHA will be performed within 120 calendar days of enrollment. If the member changes PCPs within the first 120 days of enrollment and the IHA has not yet been completed, the IHA must be completed by the newly assigned PCP within the established timeline for new members.

The IHA may be performed by the following:

1. *The member's PCP of record*: When any person other than the member's PCP performs the IHA, the PCP must ensure that documentation of the IHA is contained in the member's primary medical record, and completed in an accurate and comprehensive manner.
2. *A perinatal care provider*: A provider who cares for the member during pregnancy may provide the IHA through the initial prenatal visit(s), and must document that the prenatal visit(s) met IHA content and timeline requirements.
3. *A PCP*: A California-licensed physician qualified to serve as a general practitioner or specific contracted physicians who are board certified or board eligible in Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Family Practice.
4. *A non-physician mid-level practitioner*, including nurse practitioners, certified nurse midwives, physician assistants, and PCPs in training.

The IHA may be performed in settings other than ambulatory care for members who are continuously enrolled for 120 days as follows:

1. *Nursing facility*: For members admitted to a nursing facility, or residing in a nursing facility when they become a member, the nursing facility PCP assessment may provide information

for the IHA. However, the member's Group PCP must either complete the IHA or ensure completion of all components of the IHA.

2. *Home visits*: The PCP may begin or perform part of the IHA at a home visit; however, all components of the IHA (including components which cannot be performed during home visits) must be completed within 120 days of the effective date of plan enrollment.
3. *Hospitalized members*: If members are hospitalized at any time during the initial 120-day period, the PCP may complete the IHA within the hospital during the 120-day period. The PCP may include the hospital admission history and physical with the post-discharge office visit for completion of the IHA requirements. Any physical findings from the hospitalization expected to be resolved will be rechecked and documented in the post-hospital discharge outpatient visit.

The IHA will consist of the following:

1. *Comprehensive history*: the history must be sufficiently comprehensive to assess and diagnose acute and chronic conditions which includes but is not limited to the following:
    a. History of present illness
    b. Past medical history
        i. Prior major illnesses and injuries
        ii. Prior operations
        iii. Prior hospitalizations
        iv. Current medications
        v. Allergies
        vi. Age-appropriate immunization status
        vii. Age-appropriate feeding and dietary status
    c. Social history
        i. Marital status and living arrangements
        ii. Current employment
        iii. Occupational history
        iv. Use of alcohol, drugs, and tobacco
        v. Level of education
        vi. Sexual history
        vii. Any other relevant social factors
    d. Review of organ systems
2. *Preventive services:*
    a. For asymptomatic healthy adults, provided based on current edition of the *Guide to Clinical Preventative Services* of the USPSTF "A" and "B" recommendations for providing preventative screening, testing, and counseling services. Status of current recommended services must be documented.
    b. For members under 21 years of age, provided based on the most recent AAP age-specific guidelines and periodicity schedule. These preventative visits must include age-specific assessments and services required by the Child Health and Disability Prevention Program ("CHDP"). When examinations occur more frequently using the AAP periodicity schedule rather than on the CHDP examination schedule, the IHA must follow the AAP periodicity schedule and the scheduled assessments and services must include all content required by the CHDP for the lower age nearest to the current age of the child.
    c. Perinatal services for pregnant members, provided based on the most current standards or guidelines of the American College of Obstetrics and Gynecology ("ACOG"). A DHCS-approved comprehensive risk assessment tool will be used for all pregnant members comparable to the ACOG standard and the Comprehensive Perinatal Services Program ("CPSP") standards. The risk assessment tool will be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.

3. *Comprehensive physical and mental status exam*: the exam must be sufficient to assess and diagnose acute and chronic conditions and should include but is not limited to:
    a. Blood pressure
    b. Height and weight
    c. Total serum cholesterol measurement for men ages 35 and over and women ages 45 and over
    d. Clinical breast examination for women over 40
    e. Mammogram for women ages 50 and over
    f. Pap smear (or arrangements made for performance) on all women determined to be sexually active
    g. Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high risk for chlamydia infection using the most current CDC guidelines
    h. Screening for tuberculosis ("TB") risk factors including a Mantoux skin test on all persons determined to be at high risk
4. *Diagnoses and plan of care.*
5. An age-specific *Individual Health Education Behavioral Assessment ("IHEBA"),* using the Staying Healthy Assessment ("SHA") tool published by the California Department of Health Care Services ("DHCS").
    a. The IHEBA requirement for members transferring from an outside group may be met if the medical record indicates than an IHEBA tool or a behavioral risk assessment has been completed within the last 12 months. The age-specific and age-appropriate behavioral risk assessment should address the following areas:
        i. Diet and weight issues
        ii. Dental care
        iii. Domestic violence
        iv. Drugs and alcohol
        v. Exercise and sun exposure
        vi. Medical care from other sources
        vii. Mental health
        viii. Pregnancy
        ix. Birth control
        x. Sexually transmitted infections ("STIs")/sexually transmitted diseases ("STDs")
        xi. Sexuality
        xii. Safety prevention
        xiii. Tobacco use and exposure

Providers should initiate the medically necessary diagnostic, treatment, and follow-up services determined to be necessary as a result of the findings of the IHA within 60 calendar days following the discovery of a problem requiring follow up.

Mammography, Screening, And Diagnostic For Breast Cancer

Providers should screen for diagnosis of, and provide treatment for, breast cancer consistent with generally accepted medical practice and scientific evidence upon referral by the member's PCP, nurse practitioner, physician assistant, certified nurse midwife, or other licensed provider, providing care to the member and operating within the scope of practice under existing law.

Medicare Advantage and Cal MediConnect members may self-refer to a contracted provider for a screening mammography.

STATE OF CALIFORNIA REQUIREMENTS *(DO NOT APPLY TO MEDICARE ADVANTAGE MEMBERS)*

Blood Lead Screening
(DOES NOT APPLY TO MEDICARE ADVANTAGE MEMBERS)

Providers will comply with current federal and state laws and industry guidelines for health care providers issued by the California Department of Public Health's Childhood Lead Poisoning Prevention Branch ("CLPPB"). Providers are expected to:

- Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance must be provided to the parent or guardian at each periodic health assessment ("PHA"), starting at 6 months of age and continuing until 72 months (i.e., 6 years) of age.
- Order all Medi-Cal children to be screened for lead poisoning.
- For all other children, evaluate the child's risk for lead poisoning by asking a parent or guardian whether the child lives in or spends a lot of time in a place built before 1978 that has peeling or chipped paint or has been recently renovated. If the parent or guardian responds affirmatively or that they don't know, the child will be screened for lead poisoning.
- Perform screenings and evaluations in accordance with the following:
  - At 12 months and at 24 months of age.
  - When the provider performing a PHA becomes aware that a child 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
  - When the provider performing a PHA becomes aware that a child 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
  - Any time a change in circumstances has, in the professional judgement of provider, put the child member at risk.
  - If requested by the parent or guardian.
- Follow the Centers for Disease Control and Prevention ("CDC") Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPBB-issued guidelines.
- Document any lead screening and tests ordered or performed in accordance with medical record content requirements.

Providers are not required to perform a blood lead screening test if either of the following applies:

- In the professional judgement of the provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
- If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

Documentation of the reason(s) for not performing a blood lead screening test must be recorded in the member's medical record. In cases where consent has been withheld, providers must obtain a signed statement of voluntary refusal which will be maintained in the member's medical record. If a signed statement of voluntary refusal cannot be obtained because the party that withheld consent refuses or declines to sign it or is unable to sign it (e.g., when services are provided via telehealth modality), providers must document the reason for not obtaining a signed statement of voluntary refusal in the member's medical record.

Breastfeeding Promotion, Education, And Counseling
(DOES NOT APPLY TO MEDICARE ADVANTAGE MEMBERS)

Providers are responsible to support women before and after childbirth by providing interventions directly or by referral to help them make an informed choice about how to feed their infants and to be successful in their choice. Interventions include promoting the benefits of breastfeeding, providing practical advice and direct support on how to breastfeed, and providing psychological support.

For Medi-Cal Members -

Providers are responsible to administer breastfeeding promotion, education, and counseling services as well as comprehensive and well-integrated services during the pre-natal and post-partum periods for pregnant and breastfeeding members.

Services provided during the pre-natal period should include:

- Nutrition and health education assessments and interventions as part of pre-natal care.
- Breastfeeding education and counseling.
- Education on the health benefits and economic advantages of breastfeeding, maternal and infant nutrition, lactation management, commonly perceived barriers to breastfeeding, and strategies to overcome barriers to breastfeeding.

Services provided during the post-partum period should include:

- Post-partum support for breastfeeding mothers through continued health education, counseling, and the provision of medically necessary interventions.
- Breastfeeding support assessment during the first newborn visit after delivery.
- Professional lactation consultation services by knowledgeable health practitioners experienced in providing lactation consultation services with appropriate referrals.
- Distribution of culturally appropriate education materials at provider sites during routine and pre-natal care visits.
- Information regarding techniques for successful initiation of breastfeeding delivered to the mother at an appropriate time after delivery.
- Information about breastfeeding contraindications for certain health risks such as galactosemia and human immunodeficiency virus ("HIV") infection.

Providers may refer the member for medically necessary equipment, such as breast pumps, breast pumps, or other specialized equipment.

Providers are not permitted to perform any marketing functions for artificial milk substitutes or formula companies, and may not routinely distribute formula samples, coupons, and materials regarding infant formula to pregnant and post-partum women.

Eligible pregnant and breastfeeding members should be referred to the Women, Infants, and Children ("WIC") Supplemental Nutrition program as appropriate. Breastfeeding promotion, education and counseling services and/or activities must be coordinated with the local WIC agency.

Cancer Screening Tests
(DOES NOT APPLY TO MEDICARE ADVANTAGE MEMBERS)

Cancer screening tests which are generally medically accepted are covered. Providers should refer to published guidelines from the United States Preventative Services Task Force ("USPSTF") and the American Cancer Society for those tests which are considered generally medically accepted.

Diabetic Equipment And Supplies

(DOES NOT APPLY TO MEDICARE ADVANTAGE MEMBERS)

Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes are covered when medically necessary. This includes:

- Blood glucose monitors and blood glucose testing strips
- Blood glucose monitors designed to assist the visually impaired
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Pen delivery systems for the administration of insulin
- Podiatric devices to prevent or treat diabetes-related complications
- Insulin syringes
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

Diabetes outpatient self-management training, education, and medical nutritional therapy are also covered and must be provided by appropriately licensed or registered health care professionals as prescribed by a participating health care professional legally authorized to prescribe the service. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.

Pediatric Asthma Treatment And Education

(DOES NOT APPLY TO MEDICARE ADVANTAGE MEMBERS)

PCPs should provide education to members related to pediatric asthma, including education to enable members to properly use asthma-related devices including inhaler spacers, nebulizers, and peak flow meters. Such education must be consistent with current professional medical practice.

Providers may request coverage from the Group for the following equipment and supplies when medically necessary for the management and treatment of pediatric asthma:

- Nebulizers, including face masks and tubing
- Peak flow meters

Coverage for inhaler spacers should be requested through the member's health plan pharmacy benefit.

Standing Referrals

(DOES NOT APPLY TO MEDICARE ADVANTAGE MEMBERS)

When a member has a condition or disease that requires specialized medical care over a prolonged period of time, and is life threatening, degenerative, or disabling, the member's PCP may request a standing referral to a specialist or a specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the member's healthcare.

If there is no specialist or specialty care center within the Group's network appropriate to provide treatment to the member, the PCP may refer the member to a specialist or specialty care center that is not employed by or under contract with the Group, as determined by the PCP in consultation with the Group Medical Director and as documented in the treatment plan.

Requests for standing referrals may be submitted to the Group using the "Standing Referral Form" or any other document clearly identifying the request as a standing referral request. If the standing referral request is granted, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the member's PCP, subject to the terms of the treatment plan.

Medi-Cal Only Requirements
(APPLY TO MEDI-CAL MEMBERS ONLY)

Alcohol Misuse Screening And Interventions In Primary Care
(APPLIES TO MEDI-CAL MEMBERS ONLY)

Consistent with United States Preventative Services Task Force ("USPSTF") recommendations and the Preventive Services Medi-Cal Provider Manual, PCPs must screen adult members 18 years of age and older for alcohol misuse no less than annually. Additional screenings will be provided when determined to be medically necessary; such need must be documented by the PCP in the member's medical record.

One of the following USPSTF-validated screening tools must be used when screening for alcohol misuse:

- The Alcohol Use Disorders Identification Test ("AUDIT")
- The abbreviated AUDIT-Consumption ("AUDIT-C")
- A single-question screening, such as asking, "How many times in the past year have you had four (4) (for women and all adults older than 65 years) or five (5) (for men) or more drinks per day?"

Brief behavioral counseling interventions to reduce alcohol misuse must be offered when, during the screening process, a member is identified as being engaged in risky or hazardous drinking. At least one but up to a maximum of three behavioral counseling interventions per year will be offered for alcohol misuse. Additional behavioral counseling interventions will be authorized when medically necessary.

Members who, upon screening and evaluation, meet the criteria for an alcohol use disorder ("AUD"), as defined by the current Diagnostic and Statistical Manual of Mental Disorders ("DSM") or whose diagnosis is uncertain, should be referred for further evaluation and treatment to the county department for alcohol and substance use disorder treatment services, or a DHCS-certified treatment program.

PCPs must maintain documentation of all related screenings, assessments, interventions, and referrals, including documentation of the medical necessity of additional screenings or interventions, in the member's medical record.

California Children's Services ("CCS") Program

The CCS Program, which is administered via a partnership between county health departments and DHCS, provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under the age of 21 with CCS-eligible medical conditions. For County Organized Health System (COHS) counties, including Orange County, the CCS program was integrated into Medi-Cal managed care effective July 1, 2019 under the WCM program. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.[4] In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitate services.

Providers must identify members potentially eligible for CCS, inform the member and/or their family of the program and application process, and refer the member to the local CCS office or to the Medical Group. Providers may also assist members or their families with the application process. Referrals to the county CCS program must be documented in the member's medical record.

[4] https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx

Child Health And Disability Prevention ("CHDP") Program
(APPLIES TO MEDI-CAL MEMBERS ONLY)

CHDP is a preventative program that delivers periodic health assessments and services to low income children and youth in California. CHDP also provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.[5]

PCPs who provide services to Medi-Cal members under the age of 21 are required to be CHDP-certified through local CHDP programs. Additionally, pediatric PCPs are required to:

- Adhere to CHDP Program requirements.
- Provide education to the member or his/her parent(s) or guardian(s) regarding the importance of preventative care services.
- Provide timely periodic health assessments for members under age 21 in accordance with the most recent recommendations of the American Academy of Pediatrics ("AAP").
- Provide immunizations according to the joint recommendations of the Advisory Committee on Immunization Practices ("ACIP") and AAP immunization schedule.
- Adhere to claims submission process set by HPN affiliated medical groups for CHDP.

Comprehensive Perinatal Services Program ("CPSP")
(APPLIES TO MEDI-CAL MEMBERS ONLY)

The CPSP integrates nutrition, psychosocial, and health education services with basic obstetrical services for a multi-disciplinary approach to the delivery of pre-natal care. The program is based on the recognition that providing these services from conception through 60 days after the month following delivery contributes significantly to improved pregnancy outcomes.

Members should be informed of the availability of CPSP services and how to access such services as soon as pregnancy is determined. Providers must document the offer and acceptance or refusal of CPSP services in the member's medical record.

The most current standards or guidelines from the American College of Obstetricians and Gynecologists ("ACOG") serve as the minimum measure of quality for perinatal services. Services must be provided in accordance with the Newborn Screening Regulations as set forth in Title 17, California Administrative Code, Section 6500 et seq. and the Hemolytic Disease of the Newborn Requirements as set forth in Title 17, California Administrative Code, Section 6510 et seq.

Perinatal care providers provide CPSP services in accordance with program requirements. All CPSP services must be documented in the member's medical record, including but not limited to:

- A brief description of the service(s) provided.
- Member refusal of any assessment, intervention, treatment, or referral offered.
- A signature of the person providing the service, including their title.
- The date the service was provided.
- The length of time (in minutes) service was provided face-to-face with the member.

The obstetric provider is responsible for personal supervision of the member's care plan to ensure that all identified risk conditions are followed up with interventions expected to ameliorate or remedy the condition or problem in a prioritized manner. This supervision is the obstetric provider's responsibility whether the support services, assessments, and interventions are accomplished in their practice or at another location.

[5] https://www.dhcs.ca.gov/services/chdp/Pages/default.aspx

Early And Periodic Screening, Diagnostic, And Treatment ("EPSDT")
(APPLIES TO MEDI-CAL MEMBERS ONLY)

EPSDT provides Medi-Cal members under the age of 21 with a comprehensive, high-quality array of preventative (such as screening), diagnostic, and treatment services without cost to the member. EPSDT services include the following, which are provided at intervals meeting reasonable standards of practice (according to the AAP Bright Futures periodicity schedule) or at other such intervals indicated as medically necessary to determine the existing of a suspected physical or mental illness or condition:

- Screening services, which at a minimum includes:
  - A comprehensive health and developmental history (including assessment of both physical and mental health development);
  - A comprehensive unclothed physical exam;
  - Appropriate immunizations according to age and health history;
  - Laboratory tests (including lead blood level assessment appropriate for age and risk factors); and
  - Health education (including anticipatory guidance) for both child and caregiver.
- Vision services, which at a minimum includes diagnosis and treatment for defects in vision, including eyeglasses.
- Dental services, which at a minimum includes relief of pain and infections, restoration of teeth, and maintenance of dental health.
- Hearing services, which at a minimum includes diagnosis and treatment for defects in hearing, including hearing aids.
- Other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Providers should render EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as possible for members under the age of 21. Appropriate diagnostic and treatment services should be initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies the need for follow-up.

All EPSDT services offered, including those administered or refused, as well as referrals for the necessary follow up diagnostic and treatment services must be documented in the member's medical record.

Expanded Mental Health Services
(APPLIES TO MEDI-CAL MEMBERS ONLY)

Services for adults with a mental health disorder, as defined by the current DSM, resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning, as well as medically necessary non-specialty mental health services for children under the age of 21, are not delegated to the Groups and are the responsibility of the health plan. This includes:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing to evaluate a mental health condition.
- Outpatient services for the purposes of monitoring medication therapy.
- Outpatient services that include laboratory work, medications (exclusions exist), supplies and supplements.
- Psychiatric consultation.
- Screening and brief intervention.

Specialty Mental Health Services ("SMHS")

The Medi-Cal SMHS program is "carved out" of the broader Medi-Cal program and operates under the authority of a waiver approved by CMS. DHCS is responsible for administering the Medi-Cal SMHS waiver program, which provides SMHS to Medi-Cal beneficiaries through county mental health plans ("MHPs").

To receive SMHS, children and youth must have a covered diagnosis and meet all of the following criteria:

- Have a condition that would not be responsive to physical health care-based treatment.
- The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening conducted by the health plan, the CHDP Program, or any qualified provider operating within the scope of his or her practice, as defined by state law regardless of whether or not that provider is a Medi-Cal provider.

Contact the member's Medical Group or Health Plan for information regarding adult criteria to receive outpatient SMHS.

Providers should refer members requiring SMHS to the county MHP for provision of such services. Group case managers can assist providers with coordination with county MHPs for the delivery of SMHS.

Tobacco Prevention And Cessation

(APPLIES TO MEDI-CAL MEMBERS ONLY)

Identification and Tracking

Providers are responsible for identifying and tracking members' tobacco use (both initially and annually), including the following:

- Completing the Individual Comprehensive Health Assessment, which includes the Individual Health Education Behavioral Assessment ("IHEBA"), for all new members. The Staying Healthy Assessment ("SHA") is DHCS' IHEBA, and each age-appropriate SHA questionnaire asks about smoking status and/or exposure to tobacco smoke.
- Assessing tobacco use status for every member annually (unless an assessment needs to be re-administered) based on the SHA's periodicity schedule. Since the IHEBA must be reviewed or re-administered on an annual basis, smoking status can be re-assessed using the SHA.
- Asking tobacco users about their current tobacco use and documenting such in their medical record at every visit.

PCPs are expected to institute a tobacco user identification system in accordance with USPSTF recommendations. This may include:

- Adding tobacco use as a vital sign in the chart or electronic health record system.
- Using International Classification of Diseases ("ICD")-10 codes in the member's medical record to record tobacco use.
- Placing a chart stamp or sticker on the chart when the member indicates he or she uses tobacco;
- A recording in the SHA or other IHEBA.
- A recording on the CHDP Program Confidential Screening/Billing Report (PM 160).
- Reviewing Nicotine Replacement Therapy ("NRT") claims.

Counseling for Members Who Use Tobacco Products

Members who wish to quit smoking will be offered counseling at no cost to the member, regardless if the member opts to use tobacco cessation medications. Providers are encouraged to use the "5 As" model (Ask, Advise, Assess, Assist, Arrange), the "5 Rs" model ("Relevance, Risks, Rewards, Roadblocks, Repetition), or other validated behavioral change model when counseling members regarding tobacco cessation. Members

are eligible to receive a minimum of at least 4 counseling sessions of at least 10 minutes, which may be conducted in person or by telephone in and individual or group counseling setting. Tobacco cessation counseling is covered without prior authorization for at least 2 separate quite attempts per year, with no mandatory breaks between quit attempts.

Members who use tobacco should be referred to the California Smokers' Helpline ("Helpline") (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use the Helpline's web- or e-referral systems.

Tobacco Cessation Medications

United States Food and Drug Administration ("FDA")-approved tobacco cessation medications are generally covered by the member's health plan pharmacy benefit. Members are not required to provide proof of counseling in order to obtain tobacco cessation medications.

Services for Pregnant Tobacco Users

Pregnant members must be offered tailored, one-on-one counseling exceeding minimal advice to quit. Providers are required to:

- Ask all pregnant members if they use tobacco or are exposed to tobacco smoke.
    - Pregnant members who smoke should be provided assistance with quitting throughout their pregnancies.
- Offer all pregnant members who use tobacco at least one face-to-face tobacco cessation counseling session per quit attempt. Face-to-face tobacco-cessation counseling services may be provided by, or under supervision, of a physician legally authorized to furnish such services under state law.
- Ensure that pregnant members are referred to a tobacco cessation quit line, such as the Helpline. These tobacco cessation counseling services are covered for 60 days after delivery, plus any additional days needed to the end the respective month
- Refer to the tobacco cessation guidelines by ACOG before prescribing tobacco cessation medications during pregnancy.

Prevention of Tobacco Use in Children and Adolescents

Medically necessary tobacco cessation services, including counseling and pharmacotherapy, are covered for children up to age 21 under the EPSDT benefit. The EPSDT benefit includes the provision of anticipatory guidance and risk-reduction counseling regarding tobacco use.

PCPs are required to provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-aged children and adolescents. Such services must be provided in accordance with the AAP Bright Futures periodicity schedule and anticipatory guidance, as periodically updated.

Clinical Practice Guidelines

Providers should review and employ the U.S. Public Health Service's *Treating Tobacco Use and Dependence* guidelines[6] ("Guidelines"), which contain effective, experimentally validated tobacco dependence treatments and practices. The 10 key recommendations from these Guidelines are:

[6] Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008. Available at: https://www.ncbi.nlm.nih.gov/books/NBK63952/

- Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.
- It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.
- Tobacco dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in the Guidelines.
- Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in the Guidelines.
- Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt:
    - Practical counseling (problem-solving/skills training)
    - Social support delivered as part of treatment
- Numerous effective medications are available for tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).
    - Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates
        - Bupropion SR
        - Nicotine gum
        - Nicotine inhaler
        - Nicotine lozenge
        - Nicotine nasal spray
        - Nicotine patch
        - Varenicline
    - Clinicians also should consider the use of certain combinations of medications identified as effective in the Guidelines.
- Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.
- Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, both clinicians and health care delivery systems should ensure patient access to quitlines and promote quitline use.
- If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivational treatments shown in the Guidelines to be effective in increasing future quit attempts.
- Tobacco dependence treatments are both clinically effective and highly cost-effective relative to interventions for other clinical disorders. Providing coverage for these treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans include the counseling and medication identified as effective in this Guideline as covered benefits.

Vaccines For Children ("VFC") Program

(APPLIES TO MEDI-CAL MEMBERS ONLY)

California's VFC Program is managed by the California Department of Public Health ("CDPH"). The Program enables providers to receive routine vaccines at no cost and therefore provide routine immunizations to eligible

children without high out-of-pocket costs. Providers should refer to the VFC Program requirements for becoming a VFC Provider. Vaccines available through the VFC Program include those recommended by ACIP.

To be eligible to receive immunizations through the VFC Program, children must be 18 years of age or younger. Providers must document the member's eligibility for VFC in their medical record. All immunizations, including those administered and refused, must be documented in the member's medical record.

Providers must enroll in the VFC Program to become a VFC Provider.

Additional Medi-Cal Programs

(APPLIES TO MEDI-CAL MEMBERS ONLY)

Medi-Cal members have access to a number of additional benefits and services through county, state, or federal agencies or offices which may provide added health care benefits or support services to the member. These programs are not typically administered through the Group or Medi-Cal Managed Care but require providers to be aware of the programs and to identify and refer eligible members to the appropriate entity for services. Group case managers are able to support providers with the referral processes for these programs. All referrals and any refusal of referrals must be documented in the member's medical record. Programs and a brief description are outlined in the table below.

Medi-Cal Program	**SHORT DESCRIPTION**
Acquired Immunodeficiency Syndrome ("AIDS") Waiver Program	The AIDS Medi-Cal Waiver Program provides comprehensive case management and direct care services to persons living with HIV as an alternative to nursing facility care or hospitalization. Case management is a participant centered, team approach consisting of a registered nurse and social work case manager. Case managers work with the participant and primary care provider(s), family, caregiver(s), and other service providers, to assess care needs in order to keep the participant in their home and community.
Assisted Living Waiver ("ALW")	The Assisted Living Waiver is designed to assist beneficiaries to remain in their community as an alternative to residing in a licensed health care facility.
Community-Based Adult Services ("CBAS") (Formerly Adult Day Health Care)	CBAS is a community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or behavioral health conditions and/or disabilities that make them at risk of needing institutional care. The CBAS Program is an alternative to institutional care for Medi-Cal members who can live at home with the aid of appropriate health, rehabilitative, personal care, and social services. The Program stresses partnership with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence.
Direct Observed Therapy ("DOT") for Treatment of Tuberculosis ("TB")	DOT is offered via local health departments ("LHDs"). Members with active TB or who are at risk of non-compliance with anti-TB drug therapy must be referred to the LHD for DOT. This includes the following individuals: • Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin). • Members whose treatment has failed or who have relapsed after completing a prior regimen; • Children and adolescents.

	• Individuals who have demonstrated noncompliance (those who failed to keep office appointments). Additionally, the following groups of members should be assessed for potential non-compliance and consideration for DOT: • Substance users; • Persons with mental illness; • The elderly; • Persons with unmet housing needs; and • Persons with language and/or cultural barriers.
Early Intervention Services	Children under 3 years of age may be eligible to receive services from the Early Start Program. These include children who have a developmental delay in either cognitive, communication, social, emotional, adaptive, physical, motor development, including vision and hearing, or a condition known to lead to developmental delay, or those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Providers should collaborate with the local Regional Center or local Early Start program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start program. PCPs will participate in the case management and care coordination process for these members 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.
Home and Community-Based Alternatives ("HCBA") Waiver	The HCBA Waiver provides care management services to persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary care team comprised of a nurse and social worker. The care management team coordinates waiver and state plan services (e.g., medical, behavioral health, In-Home Supportive Services ("IHSS"), etc.), and arranges for other available long-term services and supports available in the local community. Care management and waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.
Home and Community Based Services Waiver for the Developmentally Disabled ("HCBS-DD") Waiver	The HCBS-DD Waiver is administered by the California Department of Developmental Services ("DDS") who will authorize home and community-based services for developmentally disabled persons who are Regional Center ("RC") consumers. Twenty-one RCs throughout California purchase and coordinate services and supports for individuals with developmental disabilities. The Waiver services make it possible for consumers to live in the community instead of an Intermediate Care Facility for the developmentally disabled ("ICF-DD") or a State Developmental Center.
In-Home Supportive Services ("IHSS")	IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities. The types of services which can be authorized through IHSS include: • Housecleaning; • Meal preparation; • Laundry;

	• Grocery shopping; • Personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services); • Accompaniment to medical appointments; and • Protective supervision for the mentally impaired.
Multipurpose Senior Services Program ("MSSP")	The MSSP Waiver provides HCBS to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. The MSSP waiver allows the individuals to remain safely in their homes.
Services for Persons with Developmental Disabilities	Providers should refer members with developmental disabilities to an RC for the developmentally disabled for evaluation and for access to those non-medical services provided through the RCs, such as but not limited to, respite, out-of-home placement, and supportive living. Providers may participate with RC 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 and medically necessary outpatient mental health services, which need to be provided to the member.
Targeted Case Management ("TCM") Services	Members requiring TCM services should be referred to an RC or local governmental health program as appropriate.
Women, Infants, and Children (WIC) Supplemental Nutrition Program	WIC is a special supplemental nutrition program administered through CDPH for children up to 5 years of age or pregnant, breastfeeding, or post-partum members meeting defined income guidelines. Providers should identify and must refer eligible members for WIC services. This may occur as part of the initial health assessment or initial evaluation of newly pregnant members. As part of the referral process, providers must provide the WIC program with a current hemoglobin or hematocrit laboratory value and any other relevant values or measurements, and will ensure that such information as well as the referral are documented in the member's medical record.