Benefits and Services for Kaiser Permanente's Medi-Cal Managed Care Members
Contracted Provider Quick Reference Guide

Beginning in January 2024, Kaiser Permanente and Medi-Cal are entering a new era. The Medi-Cal Direct Contract, which goes into effect on January 1, 2024, is part of the state's long-term plan to transform and improve the quality of the Medi-Cal program. The new Contract creates a single, direct contract between the Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, Inc. to provide coverage and care for Medi-Cal enrollees in 32 California counties. It reduces complexity and confusion for Medi-Cal enrollees and will result in less fragmented care.

- For general questions about Medi-Cal, please email KP's Medi-Cal Strategy and State Programs team at Medi-Cal-State-Program@kp.org
- To speak with a consultant regarding Medi-Cal benefits, please contact KP's Member Service Contract Center at 1-855-839-7613

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Executive Summary and Medi-Cal Program Overview

The following information has been compiled to provide you with an orientation to Kaiser Permanente's (KP) participation in California's Medicaid Program, known as Medi-Cal.

The Medi-Cal program is a public health insurance program that provides health care services in California for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and people with specific diseases. Medi-Cal is financed by both the state of California and the federal government. KP's participation in Medi-Cal is fundamental to our mission to provide high-quality, affordable health care services and to improve the health of our Members and the communities we serve.

Across California, KP serves over 1 million Medi-Cal enrollees, out of a total of 15.9 million[1] Medi-Cal enrollees in the state. Approximately 40 percent of KP's Medi-Cal enrollees are in the Northern California region. Kaiser Permanente's Medi-Cal Health Plans in California are the highest rated in the state for quality care, according to a December 2022 report from DHCS.

As of January 1, 2024, Kaiser Foundation Health Plan, Inc. contracts directly with the DHCS under a new direct contract to provide Medi-Cal services to enrollees in all the geographic regions where KP has a commercial footprint. This area comprises 32 counties in the state.

Operational instructions in this Medi-Cal Provider Manual Supplement specifically relate to Medi-Cal Managed Care (MMC) Members. Capitalized terms used in this Medi-Cal Provider Manual Supplement may be defined within this Supplement or if not defined herein, will have the meanings given to them in your Agreement.

Provider Communications

To keep up-to-date on the most recent news, announcements, and other important communications, please visit https://kp.org.

Physician-specific communications can be accessed via the Southern California Community Provider Portal: Community Providers | Kaiser Permanente

➔ Member-Practitioner Communication

A basic value of KP is that MMC Members are treated with sensitivity, dignity, and respect. We are committed to providing culturally competent medical care and culturally appropriate services to improve the health and satisfaction of our increasingly diverse membership. KP collects MMC Member demographic information such as race, ethnicity, language preference and religion, to further assist our efforts to reduce health disparities and provide quality, culturally competent care. We believe that quality health care includes a full and open discussion with each patient regarding all aspects of medical care and treatment alternatives, without regard to benefit coverage limitations, while maintaining confidentiality consistent with KP policies. KP allows open Provider patient communication regarding appropriate treatment alternatives and does not penalize Providers for discussing medically necessary or appropriate care. KP does not reward Providers or other individuals for issuing denials of coverage. There are no financial rewards or incentives that exist which could encourage decisions that would specifically result in over or underutilization, denials of service, or create barriers to care and service. All Providers and health professionals should be especially diligent in identifying potential over or underutilization of care or service, to maintain and improve the health of our MMC Members

Access & Availability Standards

KP's appointment access guidelines meet or exceed the minimum requirements of the California Department of Managed Health Care Services (DMHC) established Timely Access Regulations.[2]

Provider Type / Care Type	Timely Access Standard
Urgent Care	
Urgent Care (no prior authorization required)	Within 48 hours of request
Urgent Care (prior auth. required)	Within 96 hours of request
Non-Urgent Care	
Primary Care (Adult and Pediatric PCP) Incl. Obstetrics/Gynecology (OB/GYN) (Primary Care)	Within 10 business days of request
Specialty Care (Adult and Pediatric) Incl. OB/GYN (Specialty Care) and Psychiatry	Within 15 business days of request
Non-Physician Mental Health Services (Adult and Pediatric)	Within 10 business days of request
Ancillary Services	Within 15 business days of request
Pharmacy	Dispensing of at least a 72-hour supply of covered outpatient drug in an emergency situation
Telephone triage and screening services	Answer within 30 minutes, 24/7
Telephone customer service inquiries	Answer within 10 minutes

KP must provide geographic coverage for 100% of its service area, even accounting for potential enrollees at the farthest points in any zip code.[3]

Provider / Care Type	Access Standards May Vary by County Category			
	Rural	**Small**	**Medium**	**Dense**
Primary Care (Adult and Pediatric PCP) Incl. OB/GYN (Primary Care)	10 miles and 30 minutes from any Member or anticipated Member's residence			
Specialty Care (Adult and Pediatric) Incl. OB/GYN (Specialty Care) and Psychiatry	60 miles and 90 minutes from any Member or anticipated Member's residence	45 miles and 75 minutes from the any M or anticipated Member's residence	30 miles and 60 minutes from any Member or anticipated Member's residence	15 miles or 30 minutes from any Member or anticipated Member's residence
Non-Physician Mental Health (Adult and Pediatric)	60 miles and 90 minutes from any Member or anticipated Member's residence	45 miles and 75 minutes from any Member or anticipated Member's residence	30 miles and 60 minutes from any Member or anticipated Member's residence	15 miles and 30 minutes from any Member or anticipated Member's residence
Hospital	15 miles and 30 minutes from any Member or anticipated any Member's residence			
Pharmacy	10 miles and 30 minutes from the member's residence			

Acupuncture

All MMC Members are covered for acupuncture when medically indicated to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.[4] Members can contact KP's contracted provider American Specialty Health (ASH) directly at 1-800-678-9133 (8:00 a.m. to 5:00 p.m. PST) or they can go on the website: www.ashlink.com for more information.

Alternative Birthing Centers, Certified Nurse Midwives, and Licensed Midwives, Doula Services and Abortion Services (Family Planning Services/Providers)

KP provides our MMC Members with access to Comprehensive Perinatal Services Program-certified freestanding Alternative Birthing Centers, as well as services provided by Certified Nurse Midwives (CNN), Licensed Midwives, and Doula services, if requested by the MMC Member[5]. Alternative Birthing Centers (ABC) must be Comprehensive Perinatal Services Program (CPSP) certified to provide obstetrical and delivery services. If a MMC Member is interested in receiving pregnancy care at a CPSP birthing center, please refer them to OB/GYN for a pregnancy risk assessment. If the MMC Member meets the low pregnancy risk criteria, a referral for prenatal, delivery, and postpartum services may be issued if a CPSP birthing center is located within the MMC Member's County.

KP also provides our MMC Members with access to abortion services, as well as the medical services and supplies incidental or preliminary to an abortion.[6] KP and its Network Providers and Subcontractors are prohibited from requiring medical justification, or imposing any Utilization Management or Utilization Review requirements, including Prior Authorization and annual or lifetime limits, on the coverage of outpatient abortion services. Providers can contact KP's Medi-Cal Member Services at 1-855-839-7613 for assistance.

Annual Cognitive Health Assessment

For MMC Members who are age 65 and older, and who do not have Medicare coverage, KP will cover an Annual Cognitive Health Assessment. Providers must complete the DHCS Dementia Care Aware at https://www.dementiacareaware.org/. Training must be completed prior to conducting the assessment, which should be administered as part of a visit. The following tools can be used General Practitioner assessment of Cognition (GPCOG), Mini-Cog, Eight-item Informant, Short Informant Questionnaire. Use CPT code 1494F for billing.[7]

Cancer Biomarker Testing

KP covers medically necessary biomarker testing for MMC Members with: Advanced or metastatic stage 3 or 4 cancer, and cancer progression or recurrence in the MMC Member with advanced or metastatic stage 3 or 4 cancer. For additional information, providers can contact KP's Member Services Call Center at 1-855-839-7613 for assistance.[8]

Care Coordination

KP coordinates services for its MMC Members, including referrals to community resources and other agencies, when appropriate. These services include, but are not limited to:

➔ Behavioral Health

KP provides timely access to Non-Specialty Mental Health Services (NSMHS) for MMC Members-in-outpatient mental health settings for adults and children MMC Members with mild to moderate levels of mental health

impairment.[9] MMC Members may be managed by Primary Care Physicians (PCP) within their scope of practice, or KP Behavioral Health, as appropriate. MMC Members are referred by KP Behavioral Health to the local County Mental Health Plan (MHP) for Specialty Mental Health Services (SMHS), including inpatient and outpatient services for MMC Members with severe mental health conditions, wraparound, and other Short-Doyle mental health services; and to the County MHP programs for substance use disorder treatment services. KP Behavioral Health assesses MMC Members' level of treatment need and refers to County MHP programs based on clinical necessity. KP ensures MMC Members access to medically necessary SMHS when County MHP services are delayed or not available.[10] The referral process to County MHP services may vary by County. For additional information, contact KP's Behavioral Health Department for assistance at 1-833-579-4848 Monday through Friday, from 8:00 a.m. to 5:30 p.m. PST.

➔ Substance Misuse: Screening - Assessment, Brief Interventions and Referral to Treatment (SABIRT)

PCPs are responsible for screening MMC Members ages 11 and older for tobacco, alcohol and drug use using validated screening tools. KP provides SABIRT services for MMC Members 11 years of age and older, including pregnant women. When, during the screening process, a MMC Member is identified as engaging in risky or unhealthy drinking or drug use, KP provides brief behavioral counseling interventions to reduce unhealthy substance use.[11]

These services may be provided by Providers within their scope of practice. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable Alcohol Use Disorder (AUD) or Substance Use Disorder (SUD). Brief interventions may be delivered by face-to-face sessions, written self-help materials, computer-or Web-based programs, or telephone counseling.

KP ensures that MMC Members who, upon screening and evaluation, meet the criteria for an AUD or SUD, or whose diagnosis is uncertain, are appropriately referred to the County department responsible for substance use treatment or KP Addiction Medicine services for Medication Assisted Treatment.

KP makes a good faith effort to confirm whether MMC Members receive referred treatments and document when and where MMC Members receive treatment and any next steps following treatment for coordination of care. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Dyadic and Family Therapy Services

KP provides access to prevention and early intervention Behavioral Health services for KP MMC Members (children and youth (ages 0-20)) and their parents/caregivers, integrated with pediatric well-child visits or adult primary care visits. Covered Dyadic Services are provided by a multi-disciplinary team including pediatrics, primary care, medical social work, and other specialty services. Dyadic Care is provided within pediatric primary care settings when possible. The Dyadic Behavioral Health (DBH) visit should occur on the same day as the well-child visit whenever feasible. When not possible, KP schedules the DBH visit as close as possible to the well-child visit. Treatment, referrals and coordinated linkage to services are also a covered Dyadic Services benefit. The Dyadic Services benefit also covers up to five (5) family therapy sessions without a diagnosis. Additional family therapy sessions are covered when the MMC Member or their parents/caregivers have risk factors for mental health disorders or related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death; foster care placement; food insecurity; housing instability; exposure to domestic violence or trauma; maltreatment; severe/persistent bullying; and discrimination.[12] For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Eating Disorders

KP is responsible for coordinating care and providing medically necessary services for MMC Members who are diagnosed with eating disorders (EDO) and are currently receiving SMHS from a County MHP. For EDO services provided by Partial Hospitalization Programs (PHP) and Residential Treatment Centers (RTC), KP is responsible for the medically necessary physical health components and the MHP is responsible for the medically necessary SMH services components. KP is responsible for care coordination for step-up/down and transitions of care and following up to ensure medically necessary services were rendered. In coordination with the County MHP, KP may assist with higher level of care placement, such as EDO Intensive Outpatient (IOP), Partial Hospitalization (PHP) or Residential Treatment Center (RTC).[13] For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ No Wrong Door

KP ensures that MMC Members receive timely mental health services without delay regardless of the delivery system where they seek care, and that MMC Members may maintain treatment relationships with trusted providers without interruption in certain situations. KP maintains robust care coordination responsibilities for all MMC Members, including those with Specialty Mental Health (SMH) needs that have been referred to and are receiving care with the County Mental Health Plan (MHP). KP coordinates MMC Members' SMHS and NSMHS. Continuity of care considerations apply. If a MMC Member needs SMHS and the service is not available through the County MHP or the Member experiences delayed access to medically necessary care with the MHP, KP coordinates with the MHP to ensure access to care.[14] For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services

KP uses DHCS required Screening Tools (Youth and Adult) for MMC Members new to mental health services, and a Transition of Care tool (TOC) for MMC Members currently being seen by a KP network mental health provider. DHCS Screening and Transition of Care Tools are unique to the Medi-Cal program and are administered by Medi-Cal Health Plans (MCP) and County MHPs. The Adult Screening Tool for Medi-Cal Mental Health Services and Youth Screening Tool for Medi-Cal Mental Health Services determine where MMC Members who are new to Behavioral Health receive services, either through KP or the County MHP. The DHCS Screening Tools do not replace KP protocols and policies for Crisis, Emergency or Urgent Care. The Transition of Care Tool for Medi-Cal Mental Health Services is used when a MMC Member who is receiving KP mental health services experiences a change in their service needs and their services need to be transitioned to the County MHP or County services need to be added to their existing mental health treatment. This form includes relevant clinical information for coordinating care to and from the County MHP. When a MMC Member requires a transition of their mental health care to the County MHP, KP continues providing care until the Member is linked to clinically appropriate care with the County.[15] For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Behavioral Health Treatment (BHT) Services for Members Under the Age of 21

Behavioral Health Treatment (BHT), including Applied Behavioral Analysis (ABA) therapy are covered for MMC Members under 21 years of age. The MMC Member must have a recommendation from a licensed physician, surgeon, or psychologist that evidenced-based BHT services are medically necessary. In addition, the MMC Member must be medically stable and not in need of 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.[16] For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Blood Lead Screening

In accordance with state and federal requirements, KP requires contracted PCP to screen children enrolled in Medi-Cal for elevated Blood Lead Levels (BLL) as part of required prevention services offered through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. See "Early and Periodic Screening, Diagnosis, and Treatment" section for additional details on EPSDT.[17]

➔ California Children's Services

California Children's Services (CCS) is financially responsible for any services that are determined to be CCS-eligible. Any CCS eligible services should be billed to CCS before billing KP. If CCS determines there is no eligibility, include a copy of the CCS Notice of Action (NOA) when you bill us, or the claim will be denied. For tips on billing CCS, please refer to the DHCS Medi-Cal Provider website at: http://www.medi-cal.ca.gov.

Whole Child Model (WCM) is carved out of CCS and not part of the above process. For specific details on CCS medical eligibility please visit: https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx.

➔ Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are defined as "children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally." A CSHCN identified MMC Member receives a comprehensive assessment of health and related needs, including needed referrals for additional supports and services as applicable.[18] Please direct any MMC Member requests for the above listed services, to their PCP. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Coordination with Local Education Agency Services

KP collaborates with Local Education Agencies (LEAs) in the development of Individual Education Plans (IEPs) or Individual Family Service Plans for its MMC Members.[19] Please direct any MMC Member requests for the above listed services to their PCP. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Developmental Disabilities

KP refers MMC Members with developmental disabilities to a Regional Center for evaluation.[20] The Association of Regional Center Agencies (ARCA) represents the community-based network of regional centers which provides lifelong services for individuals with developmental disabilities in California. Children with both a developmental disability and other medical conditions being served by regional centers, may be eligible for California Children's Services (CCS). The vast majority of these children rely primarily on CCS and Medi-Cal funding for primary, specialty, and subspecialty medical and medical equipment services. Please direct any MMC Member requests for the above listed services to their PCP. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Early Intervention Services/Early Start Program

KP identifies children who may be eligible for a referral to a local Early Start program to address developmental delays. KP covers/provides all medically necessary speech, occupational, and physical therapy services for MMC Members with a developmental delay regardless of age.[21] The Early Start program provides a wide range of services for infants and children three years or under, who have developmental delays in cognitive, physical (motor, vision, and hearing), communication, social/emotional and adaptive functions. Please direct any MMC

Member requests for the above listed services to their PCP. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ HIV/AIDS

KP is responsible for the identification and referral of MMC Members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program.[22] For more information on Medi-Cal waiver programs please visit: https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx

➔ Dental

While dental services are covered through DHCS Medi-Cal Dental Program, PCPs ensure Members under 21 years of age receive dental screenings/oral health assessments. Annual dental referrals to the Medi-Cal Dental Program should begin with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. KP provides dental screenings during the Initial Health Appointment (IHA) and during periodic assessments for MMC Members under the age of 21. MMC Members are referred to appropriate Medi-Cal dental Providers. For the provision of covered medical services not provided by dentists or dental anesthetists, please refer the MMC Member to their PCP for further assistance.[23]

➔ Women, Infants, and Children Supplemental Nutrition Program

The Women, Infants, and Children Supplemental Nutrition Program (WIC) is a nutrition/food program that helps pregnant, breastfeeding, or postpartum MMC Members, and MMC Members less than five (5) years of age to eat well and stay healthy. KP is responsible for the referral of MMC Members to WIC, if need is identified during the evaluation of a pregnant, breastfeeding, or postpartum MMC Member. The MMC Member will need the completed WIC referral form to take with them to the WIC agency. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.[24]

➔ Major Organ Transplant Services

Major organ transplants are the responsibility of Medi-Cal MCP for all adult MMC Members (21+ years of age) all pediatric MMC Members (under 21) participating in the Whole Child Model program, and all pediatric Members not eligible for CCS enrolled in a plan.[25] Eligible pediatric MMC Members must be referred to DHCS-approved transplant Special Care Center (SCC) and will require a CCS Service Authorization Request (SAR). KP is required to cover transplant and transplant-related services for its MMC Members who are enrolled with KP for Medi-Cal services. KP contracts with DHCS approved Centers of Excellence (COEs) for its transplant network. A COE is a transplant center that has received DHCS designation to confirm that the transplant unit within the hospital meets DHCS criteria for a transplant program. Providers or their clinic staff should contact the Transplant HUB at 888-551-2740 for additional details or care coordination needs.

➔ Non-Duplication of Services

Providers must coordinate with the MMC Member and KP to ensure that the services they are receiving are appropriate and non-duplicative. These services may be delivered from external entities outside of KP such as local government agencies, local health departments, County mental health programs, and community-based partners. These services may also be provided internally through KP. If a MMC Member is enrolled in another care/case management program or may be receiving duplicative services through another program, Providers should notify KP's Member Services Call Center at 1-855-839-7613 for assistance.

Chiropractic Benefits

Medi-Cal beneficiaries may have coverage for chiropractic services regardless of which Medi-Cal contract they are enrolled in.[26] They include the following groups:

- MMC Member under age 21
- Pregnant MMC Member through the postpartum period
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility

KP MMC Members under 21 years of age, pregnant MMC Members, and MMC Members residing in a skilled nursing facility, intermediate care facility, or subacute care facility are able to contact KP's contacted Provider, American Specialty Health (ASH) directly at 1-800-678-9133 (8:00 a.m. to 5:00 p.m. PST) to request a list of Providers near them, or view website: www.ashlink.com for more information

Covered Chiropractic services are limited to manual manipulation of the spine for up to two visits per calendar month. ASH shall manage medical necessity beyond the two visits per calendar month requirement. Please note that coverage does not include chiropractic appliances.

Note: Chiropractic services are covered for MMC Members of all ages when received at County hospital outpatient departments, County outpatient clinics, at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) that are in KP's network. FQHCs or RHCs may require a referral. Not all County facilities, FQHCs or RHCs offer outpatient chiropractic services. MMC Members requesting chiropractic services at any of the above-mentioned facilities are encouraged to contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

Claims and Encounter Data Submission

Periodic reporting of encounter data is a requirement for MCP Providers. Contracted providers must ensure the complete, accurate, reasonable, and timely submission of claims and encounter data to KP. KP encourages the electronic submission of claims and encounter data. If you have questions about electronic submission, please contact the Southern California KP EDI Helpline at 1-866-285-0361, or visit KP's Community Portal, Claims at: https://healthy.kaiserpermanente.org/southern-california/community-providers/claims.

Clinical Practice Guidelines

KP's Clinical Practice Guidelines (CPGs) are clinical references used to educate and support clinical decisions by practitioners at the point of care in the provision of acute, chronic, and behavioral health services. The use of CPGs by practitioners is discretionary. However, CPGs can assist providers in providing patients with evidence-based care that is consistent with professionally recognized standards of care.

The development of KP's CPGs is determined and prioritized according to established criteria which include number of patients affected by a particular condition/need, quality of care concerns and excessive clinical practice variation, regulatory issues, payor interests, cost, operational needs, leadership mandates and prerogatives.

Physicians and other practitioners are involved in the identification of KP's CPG topics, as well as the development, review, and endorsement of all CPGs. The CPG team includes a core, multi-disciplinary group of physicians representing medical specialties most affected by the CPG topic, as well as health educators, pharmacists, or other medical Providers.

The KP CPGs are sponsored and approved by one or more Clinical Chiefs groups, as well as by the KP Guidelines Medical Director. Established guidelines are routinely reviewed and updated at least every two years or earlier when new evidence emerges. CPGs are available by contacting KP Member Services Call Center (MSCC) at 1-855-839-7613 or contacting the KP referring physician.

Additionally, the California Department of Health Care Services (DHCS) requires managed care plans, including Kaiser Foundation Health Plan, to inform contracted providers of additional guidelines published by the US Preventive Services Task Force (USPSTF). The current list of USPSTF's preventive services "A" and "B" recommendations are available online at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics.

Confidentiality and Protection of Privacy

All Providers with whom KP contracts are subject to state and federal confidentiality requirements. KP has developed and distributed to MMC Members a Notice of Privacy Practices describing MMC Members' privacy rights and KP's obligation to protect MMC Members' health information.

MMC Members have the right to privacy. KP will not release Protected Health Information (PHI) without written authorization, except as required or permitted by law. If the MMC Member/patient is unable to provide authorization, the MMC Member's legally authorized representative may provide authorization for the release of information on the MMC Member's behalf. MMC Member-identifiable PHI is shared with employers only with the MMC Member's permission or as otherwise required or permitted by law.

MMC Members have a right to access their own PHI, as provided by law. MMC Members also have the right to authorize, in accordance with applicable law, the release of their own PHI to others.

KP may collect, use, and share personal information (including race, ethnicity, language preference, and religion) for treatment, health operations, and for other routine purposes, as permitted by law, such as for use in research and reducing health care disparities. Any breach of patient information must be reported immediately to KP's Compliance Hotline at 1-888-774-9100.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is a method for determining the order in which benefits are paid and the amounts which are payable when a member is covered under more than one health benefit plan. It is intended to prevent duplication of benefits when an individual is covered by multiple health benefit plans providing benefits or services for medical or other care and treatment. Medi-Cal is always the payer of last resort. Please visit KP's Community Portal, Coordination of Benefits and Medi-Cal Cost Avoidance at: https://healthy.kaiserpermanente.org/southern-california/community-providers/medi-cal. For questions contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

Continuity of Care (COC)

The law requires KP to inform our Providers about the Continuity of Care (COC) provisions within the law. MMC Members new to KP may be eligible to receive COC from their prior Out-of-Network (OON) Provider. The MMC Member may request COC for up to 12 months after the enrollment date with KP, if a pre-existing relationship exists with that OON Provider, regardless of the MMC Member having a condition listed in HSC section 1373.96. Continuity of Care protections extend to PCP, Specialists, and select ancillary Providers, including physical therapy; occupational therapy; 7 42 CFR section 438.62. 8. A pre-existing relationship means the Member has seen an OON Primary Care Provider; Specialist; or select ancillary Provider including physical therapy, occupational therapy, respiratory therapy, Behavioral Health Treatment (BHT), and speech therapy Provider for a nonemergency visit, at least once during the 12 months prior to the date of their initial enrollment in KP,

unless otherwise pursuant to DHCS.[27] These protections are subject to the COC requirements. COC protections do not extend to all other ancillary Providers such as radiology; laboratory; dialysis centers; Non-Emergency Medical Transportation (NEMT); Non-Medical Transportation (NMT); other ancillary services; and non-enrolled Medi-Cal Providers. For Members requesting additional information on COC policy, refer new MMC Members, an advocate, or their current Provider to KP's Member Services Call Center at 1-855-839-7613.

Cultural Competency/Sensitivity and Seniors & Persons with Disabilities (SPD) Training

KP ensures that all medically necessary covered services are available and accessible to all MMC Members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or group defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.[28]

California and Federal laws require that KP provides Limited English Proficient MMC Members with 24/7 access to qualified language assistance services. Onsite and telephone or video interpreters are available. It can be located by visiting the KP Community Provider Portal at: https://healthy.kaiserpermanente.org/southern-california/get-care/interpreter-services.

KP is committed to providing equal access to our facilities and services for people with disabilities. This includes full compliance with the Americans with Disabilities Act (ADA), federal, state, and regulatory requirements in making all facilities, services, and programs accessible in a timely and effective manner.

DHCS requires that KP, as a Medi-Cal MCP, provide cultural competency, sensitivity, or diversity training for its contracted Providers at key points of contact for KP MMC Members, such as reception staff and direct caregivers. This training helps reinforce KP's commitment to effectively deliver health care services in a culturally competent manner that meets the social, cultural, and linguistic needs of our MMC Members. To obtain an electronic copy of this training to disseminate to staff, please visit the KP Community Provider Portal, at: https://healthy.kaiserpermanente.org/southern-california/community-providers/medi-cal.

Data Exchange

KP and its Subcontractors and Network Providers are obligated to support the secure exchange of and access to health and social services information in compliance with applicable laws, regulations, and policies.[29]

Durable Medical Equipment Coverage

Medi-Cal coverage for Durable Medical Equipment (DME) may cover some items not usually covered by other insurance or Medicare. Examples include incontinence supplies, shower chairs, and some types of wheelchairs. Prior Authorization is required for DME. For further information on ordering DME, please contact KP's Member Services Call Center at 1-(855) 839-7613.

For members with Dual coverage, their primary coverage may cover above items; Medi-Cal is secondary coverage. For assistance with Medi-Cal DME benefits, please contact KP's Member Service Contact Center.

Early Periodic Screening, Diagnosis, and Treatment Programs (EPSDT)

Under the EPSDT Program, KP provides and covers all Medically Necessary EPSDT services, defined as any service that meets the standards set forth in Title 42 of the USC section 1396(r)(5), unless otherwise carved out of the KP contract with DHCS, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be Medically Necessary to correct or ameliorate defects

and physical and mental illnesses or conditions. Such services include comprehensive screening including Blood Lead Screening, vision, dental, and hearing services at intervals that meet reasonable standards of medical/dental practice and as medically necessary as well as other necessary health care, behavioral health, diagnostic services, treatment, and services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services for individuals under the age of 21 who are enrolled in Medi-Cal. Starting January 1, 2024, KP is required to ensure all Network Providers complete a DHCS supplied, EPSDT-specific training no less than every two (2) years. Please see KP's Community Provider Portal, Managed Medi-Cal Program section, for training requirements at https://healthy.kaiserpermanente.org/southern-california/community-providers/provider-info [30] Please direct any Member requests for the above listed services to their PCP. For additional information, Providers can contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

Electronic Visit Verification (EVV)

EVV is a federally mandated telephone and computer-based application program that electronically verifies in-home service visits. The program aids in reducing fraud, waste, and abuse. All Medi-Cal Personal Care Services (PCS) and Home Health Care Services (HHCS) Providers must capture and transmit the following six mandatory data components:

1) The type of service performed.
2) The individual receiving the service.
3) The date of the service.
4) The location of service delivery.
5) The individual providing the service; and
6) The time the service begins and ends.

KP will monitor our Providers to ensure compliance with these requirements in accordance with the established guidelines per EVV requirements.[31]

- Monitor Providers for compliance with the EVV requirements and CalEVV Information Notice(s), and alert DHCS to any compliance issues.
- Supply Providers with technical assistance and training on EVV compliance.
- Require Providers to comply with an approved corrective action plan.
- Deny payment if the Provider is not complying with EVV requirements and arrange for the Members to receive services from a Provider who does comply.

When a Provider is identified as non-compliant with these requirements, KP must not authorize the Provider to perform services and/or withhold the payment. If a non-compliant Provider is the employee of a subcontractor, the specific Provider will not be able to provide Medi-Cal PCS and HHCS services.

Ethical/Religious Objections

Practitioners are not required to perform, or otherwise support, referrals and/or coordination of covered services to which the practitioner has a religious or ethical objection. KP shall evaluate these situations to arrange, coordinate, and ensure the timely provision of services through other means.

Facility Site Review

All PCP sites participating in the Medi-Cal Managed Care Program and the Medicare-Medicaid Plans are required by *California Code of Regulations* (*22 CCR § 56230*) and California Department of Health Care Services (DHCS) to complete Facility Site Reviews[32]:

Initial site review: Consists of an initial Facility Site Review (FSR) and an initial Medical Record Review (MRR) before joining KP's provider network. The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations. The MRR is conducted within 90 -180 days of MMC Member assignment. Each site must also have a Physical Accessibility Review Survey (PARS) to assess the physical adequacy of provider sites that provide services to Seniors and Persons with Disabilities (SPDs). PARS are also required of high-volume specialty and ancillary providers, and Community Based Adult Services (CBAS).

Subsequent site review: Conducted every three years at minimum, consisting of FSR, MRR and the Physical Accessibility Review Survey (PARS).

Ongoing Monitoring: Occurs between regularly scheduled 3-year site review audits. Monitoring methods may include site reviews, information gathered for quality improvement, as well as Provider and program-specific reports from external sources (e.g., public health). At a minimum, an evaluation all Critical Elements (CEs).

At Kaiser Permanente, DHCS-Certified Nurse Reviewers conduct the FSR and MMR and score them with standardized DHCS guidelines and audit tools. Corrective Action Plans are required for those providers who do not meet the minimum required score.

Fraud, Waste, and Abuse

Providers and their staff must be trained on Fraud, Waste, and Abuse, to comply with requirements of California's Medi-Cal regulator, the Department of Health Care Services (DHCS). For more information on Fraud, Waste, and Abuse, please refer to KP's Principle of Responsibilities at https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/scal/ever/principles-of-responsibility-en.pdf. To report a concern related to fraud, waste, or abuse, call the Compliance Hotline at 1-888-774-9100.

Health Education

KP is required to maintain a robust health education system for MMC Members, including educational workshops, telephonic wellness coaching, consultation, support groups, and print as well as online health information.[33] Through this system, MMC Members are provided information, tools, and resources to improve health, support behavior change/lifestyle management, and better manage disease. MMC Members may access health education services in-person at a local Health Education department, on kp.org or via phone. For additional information, Providers can contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

Initial Health Appointment (IHA)

The Initial Health Appointment (IHA) is an assessment required to be completed within 120 days of Medi-Cal Managed Care Plan enrollment for new MMC Members and must include a history of the MMC Member's physical and be documented in the MMC Member's medical record. These assessments can be completed during subsequent health visits. The components of the IHA include history of the MMC Member's physical and mental health, identifications of risks, assessment of need for preventative screen or services, health education, diagnosis, and plan for treatment. The IHA must be completed for all MMC Members, be performed by a Provider within the primary care setting and provided in a way that is culturally and linguistically appropriate for

the MMC Member. Exceptions to the IHA are if the MMC Member's PCP determines that the medical record contains complete information that was updated within the past 12-months, the MMC Member was not continuously enrolled in the plan and/or disenrolled within 120 days, a MMC Member refuses IHA completion or the MMC Member missed a scheduled appointment, and there are documented attempts to reschedule the appointment.[34]

Interoperability and Patient Access

"Interoperability" refers to an application programming interface (API) technology that allows one software application to programmatically access the services provided by another software application.

KP maintains a secure **Patient Access API** and a **Provider Directory API** that connects to mobile applications, Provider electronic health records, and the practice management system. Both the Patient Access API and the Provider Directory API are available to Members. Members have the right to share their information with a third-party web or mobile application of their choice.

Language Assistance/Interpreter Services

KP Language Assistance Program (LAP) guidelines for all KP MMC Members who are limited English proficient (LEP), including MMC Members who require sign language services. High quality and timely language assistance that is free of charge and available 24 hours/day, 7 days/week or during all hours of business must be provided to all KP MMC Members.

Further information on KP's Language Assistance Program is available at https://healthy.kaiserpermanente.org/southern-california/get-care/interpreter-services

Managed Long-Term Services and Supports (MLTSS)

MLTSS encompasses several services, including Community Based Adult Services (CBAS), Long Term Care (LTC), Multi-purpose Senior Support Programs (MSSP), and In-Home Supportive Services (IHSS). Eligibility for these programs often requires an assessment and pre-authorization.

In Southern California, depending on the service and County, MLTSS are coordinated and/or paid for through Kaiser Foundation Health Plan (KFHP), the County, or the state. Regional Complex Care Management Department at (866) 551-9619 (TTY users call 711) for assistance. Department staff are available Monday through Friday from 8:00 a.m. to 5:30 p.m. For Special Needs Plan (SNP) members, please contact the local Special Needs Plan Team. See below:

Kaiser Permanente Southern California Region			
Medical Center SNP Program Main Telephone Numbers			
Medical Center	**SNP Main Tel #**	**Medical Center**	**SNP Main Tel #**
Antelope Valley	(866) 324-0010	**Riverside**	(951) 358-2664
Baldwin Park	(877) 347-5176 (626) 851-7046	**San Bernardino County**	(909) 609-3736
Downey	(562) 622-3820 (888) 215-4350	**San Diego**	(866) 300-0019
Kern	(661) 398-3855 (877) 524-7373	**South Bay**	(424) 251-7516
Los Angeles	(323) 783-3230	**West Los Angeles**	(323) 900-7500
Orange County	(714) 734-4590	**Woodland Hills**	(818) 592-2427
Panorama City	(866) 331-8042 (818) 375-2940		

➔ Community-Based Adult Services

The Community Based Adult Services program (CBAS) is intended to help MMC Members maintain the highest possible level of functioning in a community environment as opposed to placement in a nursing facility. This facility-based service provides Adult Day Health Care services to MMC Members who meet medical necessity criteria for LTC services. MMC Members may attend one to five days per week, and transportation to and from home is provided. For assistance contact KP's Regional Complex Care Management Department at (866) 551-9619 (TTY users call 711).

➔ Long Term Care

For MMC Members, institutional Long-Term Care (LTC) includes admission to skilled nursing facilities (SNF) (both freestanding and hospital-based SNFs), subacute facilities, pediatric subacute facilities, and intermediate care facilities for developmentally disabled. MMC Members meet medical necessity criteria for LTC services.[35]

➔ Multi-purpose Senior Support Programs

Multipurpose Senior Services Program (MSSP) waiver provides Home and Community-Based Services (HCBS) for MMC Members who are 65 years or older and disabled, as an alternative to nursing facility placement. Examples include respite care, additional personal care services, and meals. Coordination for MSSP is by the Managed Care Plan, payment is by the County. The MMC Member must meet eligibility requirements: meet Nursing Facility level of care, aged 65 years and older, shall only be enrolled in one HCBS waiver at any time, must reside in a County with an MSSP site. PCPs may advise MMC Members in need of MSSP to contact their local MSSP office for assistance or KP's Regional Complex Care Management Department at (866) 551-9619 (TTY users call 711).

➔ In Home Support Services

In Home Support Services (IHSS) are for MMC Members who need assistance with Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) to live safely in their homes. Examples of IHSS include meal prep and clean up, laundry services, bathing and grooming assistance, grocery shopping, running errands, escort to medical appointments, household and yard cleaning, and protective supervision. Coordination for IHSS is by the MCP; payment is by the County. PCPs may advise MMC Members in need of IHSS to contact their local IHSS office for assistance, or KP's Regional Complex Care Management Department at (866) 551-9619 (TTY users call 711).

Mandatory Managed Care Enrollment (MMCE)

Dually eligible Medicare and Medi-Cal beneficiaries and institutional long-term care populations will transition from fee for service Medi-Cal to mandatory managed care enrollment effective January 1, 2024. There are some exemptions to mandatory managed care enrollment that could impact a small number of Members.[36]

If there is a need to verify benefits and eligibility, please refer to the Online Affiliate tool by visiting the KP Community Provider Portal at: https://healthy.kaiserpermanente.org/southern-california/community-providers/online-provider-tools. Select Online Provider Tools to view Eligibility.

Medical Decisions

KP must ensure that medical decisions, including those by Providers and rendering Providers, are not unduly influenced by fiscal and administrative management.[37] KP does not reward Providers or other individuals for issuing denials of coverage. Additionally, financial incentives for Utilization Management (UM) decision makers do not encourage decisions that result in underutilization.

Member/Provider Complaints, Grievances & Appeals

A grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, any aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the health plan to make an authorization decision. An initial determination is a type of grievance which also includes a request for referral, provision of or reimbursement for services or supplies, or other financial resolution, regardless of how that dissatisfaction is submitted to KFHP.

MMC Members, or an authorized representative acting on behalf of a MMC Member, may submit a Grievance or an Initial Determination in person, by phone 1-855-839-7613, by email or online through the KP website (kp.org), by facsimile 1-855-414-2317, or in writing to KP (Attn: Kaiser Permanente Civil Rights Coordinator, Member Relations Grievance Operations, PO Box 939001, San Diego, CA 92193) for investigation and resolution. KP does not limit the timeframe during which the MMC Member is eligible to submit a grievance or an initial determination. Standard grievances are processed within 30 calendar days. Initial determinations are processed within 14 to 30 calendar days, depending on the type of request. Expedited grievances and initial determinations are processed within 72 hours. The MMC Member will be notified of the applicable timeframe within 5 calendar days for standard cases or 24 hours for expedited cases. A notice of resolution is provided, in the MMC Member's preferred language, to the MMC Member within 30 calendar days from the date the MMC Member makes an oral or written standard Grievance or Appeal, or 72 hours for an expedited Grievance or Appeal.

An appeal is defined as a review of an initial adverse decision/Notice of Action. MMC Members, or an authorized representative acting on behalf of a MMC Member, may submit an appeal in person, by phone 1-855-839-7613, by email or online through KFHP website (kp.org), by facsimile 1-855-414-2317, or in writing to KP (Member Case Resolution Center, PO Box 939001, San Diego, CA 92193, for standard appeals; Expedited Review Unit, PO Box 1809, Pleasanton, CA 94566, for urgent/emergent appeals), for investigation and resolution. If the MMC Member or authorized representative files an appeal to a Notice of Action (NOA), the appeal may be filed verbally, but must be followed in writing. KFHP allows 60 calendar days from the date of the adverse benefit determination or the NOA for the MMC Member to file an appeal. If the member wants to continue care which the adverse benefit determination or the NOA is terminating, suspending, or reducing, KFHP allows 10 calendar days from the postmarked date of the adverse benefit determination or NOA, and before the intended effective date of the adverse benefit determination being disputed, for the MMC Member to file an appeal. Standard appeals are processed within 30 calendar days. Expedited appeals are processed within 72 hours. The MMC Member will be notified of the applicable timeframe within 5 calendar days for standard cases or 24 hours for expedited cases.

To request a State Hearing: A state hearing is a way to solve problems where members, or an authorized representative acting on behalf of a MMC Member, can present their case to the state. To ask for a state hearing, call the California Department of Social Services toll free at 1-800-952-5253 (TTY users call 1-800-952-8349), or write to them at:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

MMC Members, or an authorized representative acting on behalf of a MMC Member, have 120 days to ask for a state hearing from the date the MMC Member became unhappy. One can ask for a state

hearing at any time during this 120-day period, including before, during, or after the MMC Member files a grievance. Once the judge decides the case, the MMC Member cannot ask for binding arbitration. If the MMC Member asks for a state hearing, the MMC Member may not be able to get an independent medical review later.

Faster (Expedited) Process: MMC Members, or an authorized representative acting on behalf of a MMC Member, can ask the state to decide their state hearing request faster if it involves imminent and serious threat to the MMC Member's health, such as severe pain or potential loss of life, limb, or major body function. To ask for a faster decision, a MMC Member or their authorized representative may call the California Department of Social Services toll free at 1-800-952-5253 (TTY users call 1-800-952-8349), or write to them at:

California Department of Social Services
Expedited Hearings Unit State Hearings Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

Member Rights and Responsibilities

MMC Members have the following rights, guaranteed to them by DHCS:[38]

- To be treated with respect, giving due consideration to the MMC Member's right to privacy and the need to maintain confidentiality of the Member's Protected Health Information (PHI) and Private Information (PI).
- To be provided with information about KP and all services available to MMC Members.
- To be able to choose their Primary Care Provider (PCP) within KP's Network unless the PCP is unavailable or is not accepting new patients.
- To participate in decision-making regarding their health care, including the right to refuse treatment.
- To submit Grievances, either verbally or in writing, about KP, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination.
- To request an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.
- To request a State Fair Hearing, including information on the circumstances under which an expedited State Fair Hearing is available.
- To receive interpretation services and written translation of critical informing materials in their preferred threshold language, including oral interpretation and American Sign Language.
- To have a valid Advance Directive in place, and an explanation to MMC Members of what an Advance Directive is.
- To have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of KP's Network.
- To have Emergency Services provided in or outside of KP's Network, as required pursuant to federal law.

- To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Service (IHS) Programs outside of KP's Network, pursuant to federal law.
- To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 CFR sections 164.524 and 164.526.
- To change Medi-Cal managed care plans upon request, if applicable.
- To access Minor Consent Services.
- To receive written MMC Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format, upon request and in accordance with 45 CFR sections 84.52(d), 92.102, and 438.10.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate for the MMC Member's condition and ability to understand available treatment options and alternatives.
- To freely exercise these MMC Member rights without retaliation or any adverse conduct by KP, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

If a MMC Member expresses dissatisfaction with the treatment plan and/or with a Provider's response to the Member's request for a service/item, and the Provider is unable to resolve the issue, it is appropriate to remind the MMC Member of his/her right to file a grievance and can contact KP's Member Services Call Center at 1-855-839-7613 for assistance. Requirements and timeline for filing a Grievances and Appeals are listed in the Medi-Cal Member handbook, please visit: https://healthy.kaiserpermanente.org/southern-california/shop-plans/medicaid/new-members.

A complaint (or Grievance) is when a MMC Member has a problem with KP or a Provider, or with the health care or treatment the MMC Member received from a Provider. An appeal is when the MMC Member doesn't agree with KP's decision not to cover or to change the MMC Member's services.

Minor Consent Services

Under California law, MMC Members under the age of 18 can see a doctor without consent from their parents or guardian for the following types of care. Medical records and/or information regarding medical treatment specific to these services must not be released to the parent(s) or guardian(s) without the minor's consent. These services include:

- Sexual assault, including rape
- Drug and alcohol abuse for children 12 years of age or older.
- Pregnancy services, including abortion
- Family planning services (except sterilization)
- Sexually transmitted disease and HIV/AIDS diagnosis and treatment in children 12 years of age or older
- Outpatient mental health for children 12 years of age or older who are mature enough to participate intelligently and where either (a) there is danger of serious physical or mental harm to the minor or others, or (b) the child is the alleged victim of incest or child abuse, sexual or physical abuse.[39]

Overpayments

DHCS regulation requires that providers notify KP when they have received an overpayment, to return the overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify in writing of the reason for the overpayment. Please report overpayments to KP within the required timeframe by calling Regional Claims Recovery at 1-844-412-0917.

Pharmaceutical Management

Outpatient prescriptions drugs are covered by Medi-Cal Rx through Fee-for-Service Medi-Cal, which is managed by Magellan Medicaid Administration. MMC Members may access medications at any Medi-Cal FFS pharmacy Provider.[40] KP is no longer managing the formulary applicable to MMC Members. The DHCS Drug Formulary, now called the Contract Drug List, can be accessed using the following link:

https://medi-calrx.dhcs.ca.gov/home/cdl/

In long-term care, Medi-Cal pharmacy services billed on a medical or institutional claim by a pharmacy, or any other Provider, must be billed through KP. If prescription drugs are not part of the bundled rate for services provided by a skilled nursing facility, and instead are billed on a fee for service basis, then the financial responsibility for those drugs is determined by the claim type on which they are billed. If the drugs are dispensed by a pharmacy, and billed on a pharmacy claim, then they are carved out and paid by Medi-Cal RX. If the drugs are furnished by the skilled nursing facility and billed on a medical or institutional claim, then KP is responsible. Per Long Term Care Benefit APL.

Additional information related to drug coverage can be found by visiting: https://medi-calrx.dhcs.ca.gov/home/.

Clinic-administered drugs that are provided to patients during inpatient stays, clinic encounters, home health visits, or as part of long-term care will still be covered by KP. KP will also ensure the provision of at least a 72-hour supply of a medically necessary, covered outpatient drug when the drug is prescribed in an emergency situation.

Grievances related to Medi-Cal Rx prescriptions should be submitted to Magellan's Medi-Cal Rx Customer Service Center (CS). MMC Members can submit a complaint either in writing or by telephone by going to www.Medi-CalRx.dhcs.ca.gov or calling Customer Service at 1-800-977-2273, 24 hours a day, 7 days a week.

For clinic-administered drugs or prescription items covered by KP under state law, MMC Members will continue to submit grievances to KP. Please see Member/Provider Complaints, Grievances & Appeals section above for more information on how to submit a grievance to KP.

Population Health Management (PHM)

KP has a PHM program that ensures all MMC Members have equitable access to necessary wellness and prevention services, care coordination, and care management. PHM is a model of care that addresses individuals' health needs at all points in the continuum of care, including the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychological well-being of individuals and address health disparities through cost-effective and tailored health solutions. These services include, but are not limited to:

➔ Member Risk Stratification

The PHM program involves assessing and stratifying the population of MMC Members to ensure they are connected to the appropriate services for their needs.

➔ Basic Population Health Management (PHM)

Basic Population Health Management (BPHM) is an approach to care that ensures needed programs and services are made to each MMC Member at the right time and in the right setting. This includes access to Primary Care Services, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers, wellness and prevention programs, chronic disease programs, programs focused on improving mental health outcomes, and case management services for children under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

All KP MMC Members have access to a variety of evidence-based comprehensive wellness programs that meet National Committee for Quality Assurance (NCQA) PHM standards including, but not limited to, managing stress, identifying depressive symptoms, access to preventive health visits, screenings, etc.

KP has Disease Management programs available to help empower individuals with chronic conditions to better understand and manage their disease. Disease management consists of population/care management programs for MMC Members with asthma, diabetes, Coronary Artery Disease (CAD), Congestive Heart Failure (CHF) and chronic pain.

The Complex Chronic Conditions (CCC) case management program uses an interdisciplinary care team, which includes nurses and social workers to support MMC Members with multiple chronic conditions and/or high utilization who would benefit from active case management to improve their self-management skills. This program is approximately 3 to 6 months in duration, depending upon MMC Member needs, and works actively with the MMC Member and their caregivers to achieve defined goals.

Providers who have identified KP MMC Members who would benefit from these programs are highly encouraged to refer them by contacting the relevant care management department at the closest KP facility or by using e-Consult to refer to CCC. Network Providers can contact the Outside Medical Department with CCC referrals.

Please direct any Member requests for the above listed services to their PCP. For additional information, Providers can contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

➔ Complex Care Management (CCM)

Complex Care Management is a service for MMC Members with complex needs who need extra support to avoid adverse outcomes. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting at the right time. CCM is intended for higher- and medium-rising-risk MMC Members with a medically complex condition or MMC Members with a medical condition and a complex social situation that impacts the medical management of the MMC Member's care. For additional information, Providers can contact 1-866-551-9619.

➔ Enhanced Care Management (ECM)

KP provides access to enhanced care management, which is person-centered care management provided to MMC Members who meet criteria for one of DHCS' ECM Populations of Focus. The benefit is provided primarily through in-person engagement where enrollees live, seek care, and choose to access services. To place a referral or for additional information, Providers can contact 1-866-551-9619.

➔ Community Supports (also known as "In Lieu of Services")

KP contracts with community-based organizations to offer Community Supports, such as housing supports for people experiencing homelessness, medically tailored meals, and supports in the home, which will play a fundamental role in meeting MMC Members' needs for health and health-related services that address social

drivers of health. To place a referral or for additional information, Providers can contact Providers can contact 1-866-551-9619.

➔ Community Health Worker Services (CHW)

Community Health Worker Services are defined as preventive health services delivered by a non-licensed CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs must have shared lived experiences with KP MMC Members and ties to the communities they serve. CHWs may assist MMC Members in achieving specific care goals related to health education, health navigation, screening and assessments performed by a non-licensed individual, and individual advocacy. CHW services require a written recommendation submitted to the MCP by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. For additional information, Providers can contact 1-866-551-9619.

➔ Transitional Care Services (TCS)

Per DHCS, care transitions are defined as a MMC Member transferring from one setting or level of care to another. While MMC Members are in non-KP facilities, Providers are expected to provide, and/or coordinate with KP, to ensure that all TCS requirements outlined in the most recent version of the DHCS Population Health Management (PHM) Policy Guide are complete. The requirements include but are not limited to a) notifying KP, preferably by Admission, Discharge and Transfer (ADT), of a MMC Member's admission and discharge to a non-KP facility; b) including the name and phone number of a KP-assigned Care Manager in the discharge packet. KP will provide the Care Manager's information as a single point of contact to assist Members throughout their transition and to ensure all required services are complete; and c) sharing the discharge packet with the MMC Member, MMC Member's parents or authorized representatives, and KP to facilitate communication and Continuity of Care.

Providers should be fluent in the CalAIM TCS expectations for each population (e.g., complex care management) and establish policies and procedures to support care transitions in compliance with CalAIM TCS regulations. The most recent version of the PHM Policy Guide can be found at the DHCS website https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

➔ Population Needs Assessment (PNA) and Population Health Management Strategy

KP will identify priority MMC Member health needs and health disparities in the communities it serves through KP's participation in the Population Needs Assessment (PNA). KP will meaningfully collaborate with local health departments (LHDs) on Community Health Assessments (CHAs)/Community Health Improvement Plans (CHIPs) starting in 2024. KP continues to be accountable for meeting cultural, linguistic and health education needs of MMC Members, as defined in state and federal regulations. KP expects all Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors to comply with all applicable state and federal laws and regulations, contract requirements and other DHCS guidance (e.g., APLs, Policy Letters, PHM Policy Guide, and the DHCS Comprehensive Quality Strategy), including all relevant requirements regarding health education and cultural and linguistic needs.

The PHM Strategy is submitted annually and requires that KP demonstrates that it is meaningfully responding to community needs as well as providing other updates on the PHM Program to inform DHCS's monitoring efforts. KP will regularly update its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors on activities, findings, and recommendations of the PNA/PHM Strategy.

Post-Stabilization Care

In accordance with Title 28 CCR section 1300.71.4, when a MMC Member is stabilized, but the health care Provider believes that they require additional Medically Necessary Covered Services and may not be discharged safely, KP "shall approve or disapprove a health care Provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request." To clarify, the "health care Provider" as referenced herein refers to both Out-of-Network Providers (i.e., noncontracting Providers) and Network Providers, as well as all applicable Subcontractor and Downstream Subcontractor Agreements. Please contact KP Emergency Prospective Review Program (EPRP) at 1-800-447-3777 available 7 days a week/24 hour a day for assistance.[41]

Primary Care Physician (PCP) Assignment

New MMC Members are assigned a PCP within 40 days of MMC Member enrollment and are notified via postal letter.[42] New MMC Members who choose their personal physician have their choice confirmed at the time of their selection (on the phone or online). PCPs may refer MMC Members to specialists, when medically necessary. Contracted PCPs should work within established KP protocols to coordinate specialty care.

Examples of Specialists that require a referral include:

- Surgery
- Orthopedics
- Cardiology
- Oncology
- Dermatology
- Physical, occupational, and speech therapies

Provider Directory

KP must include the following information in our Provider directory for all contracted Providers:[43]

- The Provider's name as well as any group affiliation;
- NPI number;
- Street address(es);
- All telephone number(s) associated with the practice site;
- Telephone number to call after normal business hours;
- Web site URL, as appropriate;
- Specialty, as appropriate;
- Whether the Provider will accept new enrollees;
- The Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office, and if the Provider has completed cultural competence training;
- Whether the Provider's office/facility has accommodations for people with physical disabilities, including accessibility symbols approved by DHCS that indicate the accessibility of the office/facility, exam room(s) and medical equipment;
- Primary Care Clinic or Medical Group/Independent Practice Association name (example: Eastside Clinic);
- Office hours;

- Languages (other than English) spoken at Provider site; and
- The link to the Medi-Cal RX Pharmacy Locator.

Provider Enrollment

Federal and state requirements mandate that managed care plan Providers recognized by DHCS as eligible to enroll be enrolled in Medi-Cal in order to render services to KP Medi-Cal Managed Care Plan Members.[44] Most Providers enroll in Medi-Cal through the DHCS enrollment unit. Alternately, some Managed Medi-Cal Plans maintain Medi-Cal enrollment units to enroll Providers solely for the purpose of participating in the Managed Medi-Cal Plan's network. Providers enrolled through a Managed Medi-Cal Plan enrollment unit are recognized by other Managed Medi-Cal Plans as enrolled for the purpose of participation in the network of the other Managed Medi-Cal Plan's network as well. Per federal regulation, Providers enrolled solely for the purpose of participation in a Managed Medi-Cal plan's network are not required to render services to Medi-Cal Fee-For Service Members. KP does not maintain a Medi-Cal Plan enrollment unit.

Provider Grievances

Providers may file a grievance for any issue. Grievances must be submitted orally or in writing within 180 days of the incident resulting in dissatisfaction. For assistance, please contact KP's Member Service Contact Center at 1-855-839-7613.

Provider Preventable Conditions

DHCS prohibits payment of Medi-Cal funds to a Provider for the treatment of a Provider-Preventable Condition (PPC), except when the PPC existed prior to the initiation of treatment for the MMC Member by that Provider. DHCS requires KFHP to report PPCs that are associated with claims for Medi-Cal payment (FFS or by a Managed Medical Plan) or for courses of PPC treatment prescribed to a MMC Member for which payment would otherwise be available. PPCs that existed prior to the initiation of treatment of the Member by the Provider are not reportable.[45]

After discovery of a PPC and confirmation that the patient is a Medi-Cal beneficiary, KP must report the PPC to the DHCS using the following website: https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx

Provider Suspension, Termination, or Decertification

KP must ensure timely compliance with all requirements associated with DHCS notification of a Provider's suspension, termination, or decertification from participation in the Medi-Cal programs.[46]

KP may terminate its contract with a Network Provider/Subcontractor and/or suspend payments to a Network Provider/Subcontractor in accordance with DHCS requirements.

For all terminations, KP must mail appropriate MMC Member notifications and remain accountable for all functions and responsibilities of the terminated Network Provider/Subcontractor to ensure that impacted MMC Members do not experience disruption in access to care. If a contract is successfully renegotiated with a Network Provider/Subcontractor before the effective date of the contract termination, and MMC Member notices were already mailed out, KP must mail another notice to inform MMC Members that the contract is not being terminated.

Punitive Action Prohibitions

KP may not take punitive action against a Provider who either requests an expedited resolution or supports a MMC Member's appeal. Further, KP may not prohibit, or otherwise restrict, a health care professional acting

within their lawful scope of practice, from advising or advocating on behalf of a MMC Member, who is their patient, as follows:

- For the MMC Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- For any information, the MMC Member needs to decide among all relevant treatment options
- On the risks, benefits, and consequences of treatment or non-treatment
- For the MMC Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions[47]

Sensitive Services

Sensitive services are defined as all health care services related to:

- Mental or behavioral health
- Sexual and reproductive health
- Sexually transmitted infections
- Substance use disorder
- Gender affirming care, and
- Intimate partner violence

Sensitive services include services described in Sections 6924—6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services. If a MMC Member requires assistance, please refer them to their care coordination team or PCP for support and care. Some services may be accessed in the community and our community partners will collaborate with applicable KP Providers for coordination of care.

Sterilization

California law requires that MMC Members requesting sterilization services meet the following criteria:

- Be at least 21 years of age at the time consent is obtained
- Not be mentally incompetent
- Be able to understand the content and nature of the informed consent process
- Not be institutionalized
- Have voluntarily given their written informed consent using the PM 330 form noted below
- At least 30 days, but not more than 180 days, have passed between the date of written informed consent and the date of sterilization, subject to very limited exceptions

As indicated above, MMC Members requesting sterilization services must complete a form (PM 330) attesting that they are giving informed consent for sterilization services. The form can be located by visiting the following site: https://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf. KP has internal processes for the completion of the PM 330 form. Please refer the patient to their PCP for further assistance. MMC Members may not waive the 30-day waiting period for sterilization.[48]

Telehealth

Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-

management of a MMC Member's health care. Telehealth facilitates MMC Member self-management and caregiver support for MMC Members.

Providers may provide Telehealth services to its MMC Members. The Provider must assess the appropriateness of the Telehealth modality to the MMC Member's level of acuity at the time of the service. Before the delivery of health care via Telehealth, the Provider initiating the use of Telehealth shall inform the MMC Member about the use of Telehealth and obtain verbal or written consent from the MMC Member for the use of Telehealth as an acceptable mode of delivering health care services and public health. The consent must be documented in the MMC Member's medical record.[49]

Transportation/Travel and Lodging

In addition to emergency medical and non-emergency ground/air ambulance, KP covers non-emergent medical transportation (NEMT), and non-medical transportation (NMT) for KP-Assigned MMC Members and travel and lodging expenses related to NEMT/NMT.[50]

- NEMT: Available to MMC Members requiring transportation to covered medical services (including pharmacy), but for whom traditional means of private or public transportation is medically contraindicated due to the MMC Member's medical or physical condition. Contact SCAL Regional Transportation HUB at 1-877-227-8799 for assistance. NEMT services must be authorized by KP, and the MMC Member must be a KP-assigned MMC Member, have no other way to get to their scheduled appointment or service, and be unable to reasonably ambulate or unable to stand or walk without assistance.
- NMT: Available to all MMC Members requiring round-trip transportation to covered medical appointment or services, including pharmacy. Unlike NEMT, clinical authorization/medical necessity by the MMC Member's Provider is not required. NMT services are available for KP-Managed Medi-Cal assigned MMC Members when the MMC Member has no other way to get to their scheduled appointment or service and when the MMC Member is able to ambulate without help from the driver. Providers or their staff may direct the MMC Member to call KP Transportation Services at 1-844-299-6230, TTY services dial 711. MMC Members may also contact the Member Services Contact Center or Local Member Services for assistance with NMT.
- Travel and Lodging: Covered for MMC Members receiving NEMT/NMT who are referred to medically necessary services that are not available within a reasonable distance from a MMC Member's home such that the MMC Member is unable to make the trip within a reasonable time. For general questions regarding travel and lodging or to request the reimbursement form, please call the travel and lodging coordinator at (626) 405-6162 or visit: kp.org/specialty-care/travel-reimbursements.

MMC Members may also contact the Member Services Call Center at 1-855-839-7613 for assistance with questions regarding NEMT, NMT or travel/lodging benefits.

Utilization Management

Utilization Management (UM) is a process that determines whether a health care service recommended by the treating Provider is medically necessary. If it is medically necessary, the services will be authorized, and the MMC Member will receive the services in a clinically appropriate place consistent with the terms of the MMC Member's health coverage. UM activities and function include the prospective, retrospective, or concurrent review of health care service requests submitted by Providers and the decisions to approve, modify, delay, or deny the request based in whole or in part on medically necessity. KP's utilization review program is subject to direct regulation under the Knox-Keene Act and must adhere to managed care accreditation standards.

For more information on KP's UM process, please go to https://kp.org/UM.

Vaccine for Children Program (VFC)

Providers serving MMC Members under the age of 19 may be eligible to participate in the Vaccine for Children Program (VFC). The VFC program provides all routine vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) at no cost to the participating healthcare provider. Providers can contact their state/local/territory VFC coordinator to request enrollment at CDC Centers for Disease Control and Prevention, Vaccines for Children Program (VFC): https://www.cdc.gov/vaccines/programs/vfc/state-vfc-websites.html.

Vision Benefits

➔ Eye Exams

MMC Members are covered for eye exams to determine if they need eyeglasses and to provide a prescription for eyeglasses.[51] Please direct any MMC Member requests for the services listed below, to KP's Member Services Call Center at 1-855-839-7613 for scheduling assistance.

➔ Eyeglasses, Lenses, and Frames

Eyeglasses (frame and lenses) may be covered every 24 months when a member has a prescription of at least 0.75 diopter. Members should check their Evidence of Coverage annually to confirm benefit.

New or replacement eyeglass lenses may be provided by the state. MMC Members should check their Evidence of Coverage (EOC) annually to confirm their benefit. KP may provide an allowance for new or replacement frames. MMC Members should refer to their Evidence of Coverage (EOC) for additional benefit details.

➔ Special Contact Lenses

KP may cover contact lenses under certain conditions:

- For aniridia (missing iris), up to two medically necessary contact lenses (including fitting and dispensing) per eye every 12 months at no charge.
- One pair of medically necessary contact lenses (other than contact lenses for aniridia) every 24 months at no charge. Contact lenses are covered only if a KP plan Provider or KP plan optometrist finds that they will give a MMC Member much better vision than they could get with eyeglasses alone. We cover replacement of medically necessary contact lenses within 24 months if a MMC Member's contact lenses are lost or stolen.

References

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[5] MMCD APL 18-022 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-022.pdf

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[8] MMCD APL 22-010 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-010.pdf

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[10] BHIN 22-016 available at: https://www.dhcs.ca.gov/Documents/BHIN-22-016-Authorization-of-Outpatient-Specialty-Mental-Health-Services.pdf

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[14] MMCD APL 22-005 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-005.pdf

[15] MMCD APL22-028 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-028.pdf

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[18] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 4.3.9 B. -Children with Special Health Care Needs

[19] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 5.34, G. -Local Education Agency Services

[20] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 4.3.16 -Developmental Disabilities

[21] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 4.3.9, C. -Early Intervention Services

[22] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section Home & Community-Based Services (HIV/AIDS)

[23] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 4.3.17 A Dental

[24] DHCS Contract Boilerplate, Exhibit A, Attachment I, Section 4.3.20- Women, Infants, and Children (WIC) Supplemental Nutrition Program

[25] MMCD APL 21-015 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015.pdf

[26] MMCD APL 15-003 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-003.pdf

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[37] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 1.1.5-Medical Decisions

[38] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 5.1.1 A - Member Rights and Responsibilities

[39] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 5.2.8 D-Minor Consent

[40] Executive Order N-01-19 (Medi-Cal RX) and MMCD APL 22-012:
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