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

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Effective January 2024, Kaiser Foundation Health Plan (KFHP) entered intoa Medi-Cal Direct Contract with the Department of Health Care Services (DHCS) as part of the state's long-term plan to transform and improve the quality of the Medi-Cal program. This contract enables KFHP 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 Provider Regulatory Oversight & Validation team at Medicaid-PROV-Team@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 I n 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 1.1 million Medi-Cal enrollees, out of a total of 15 million[1] Medi-Cal enrollees in the state. Approximately 60 percent of KP's Medi-Cal enrollees are in the Southern 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: https://healthy.kaiserpermanente.org/southern-california/community-providers

➔ 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 assessment, 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 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 SMH services and 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

All medically necessary Medi-Cal for Kids and Teens services (formerly EPSDT) including Behavioral Health Treatment (BHT) services, are covered for MMC Members under 21 years of age. Medical necessity decisions are individualized, and MMC Member's and the recommended BHT services must meet specific eligibility criteria. To meet the criteria for MMC Members under the age of 21:

- MMC Members must receive a referral for BHT services from a licensed physician, surgeon, or psychologist that evidenced-based BHT services are medically necessary.
- 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]

Re-authorization for BHT services happens at least every six months with the submission of a person-centered and individualized behavioral health treatment plan developed, provided, and supervised in accordance with an MCP-approved behavioral treatment plan. The plan is developed reviewed, revised, and/or modified no less than once every six months by a BHT service Provider who meets the requirements in California's Medicaid State Plan: Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional.

The following BHT services are not covered under the Medi-Cal for Kids and Teens (formerly EPSDT) benefit:

- Services rendered when continued clinical benefit is not expected.
- Provision or coordination of respite, day care, recreational services, educational services, or reimbursement for a legal guardian's participation.
- Treatment where the sole purpose is vocationally or recreationally based.
- Custodial care, where BHT services aim to maintain safety and could be provided by persons without professional skills or training.
- Services, supplies, procedures performed in non-conventional settings - resorts, spas, camps; services rendered by a parent or legal custodian.
- Services that are not evidence-based behavioral intervention practices.

BHT services are not limited based on school attendance or other categorical exclusions, and treatment limitations for BHT services may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. KP Care Delivery and Behavioral Health Teams partner with MMC Members, families, clinicians and services providers across settings, such as regional centers, local educational agencies, or LEAs, schools, and County Mental Health Plans (MHPs), to arrange, coordinate, address gaps, and maintain continuity for all medically necessary BHT services covered by Medi-Cal for MMC Members under the age of 21. 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 PCPs to screen children enrolled in Medi-Cal for elevated Blood Lead Levels (BLL) as part of required prevention services offered through Medi-Cal for Kids & Teens (formerly EPSDT)

In accordance with Medi-Cal for Kids & Teens, the contracted PCP must:

- Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member of lead exposure risks.
- Order or perform blood lead screening tests on all child members meeting eligibility criteria, and follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

See "Medi-Cal for Kids & Teens formerly referred to as EPSDT" section for additional details on Medi-Cal for Kids and Teens[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.

Upon diagnostic evidence that a MMC Member under 21 years old may have a CCS eligible condition, KP must ensure the MMC Member's information is sent to the local CCS office for an eligibility determination. CCS eligibility is determined by the county CCS agency where the MMC Member lives.

KP is responsible for all medically necessary covered services that are unrelated to the county approved CCS eligible condition. KP is responsible for the coordination of services and joint case management between Plan providers, CCS specialty providers, and the local county CCS program. If the local county CCS program does not approve eligibility for any reason, KP remains responsible for all medically necessary covered services.

KP does not cover services provided by the CCS program except for MMC Members enrolled in Whole Child Model (WCM) counties. The WCM program incorporates CCS covered services for CCS eligible MMC Members. Under WCM, KP covers CCS eligible conditions for MMC Member residing the following county: Orange County.

➔ 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] . Children with a developmental disability are eligible for or being served by Regional Centers. Eligibility is established through diagnosis and assessment performed by regional centers. The following must be met to be determined eligible:

- Intellectual Disability
- Autism
- Epilepsy
- Cerebral Palsy
- Condition that closely resembles intellectual disability and/or results in the individual requiring similar services
- The disability originates prior to age 18, is expected to be lifelong and constitutes a substantial disability for the individual. "Substantial disability" means significant functional limitations in three or more of the following areas:
  - Self-care
  - Receptive and expressive language
  - Learning
  - Mobility

- Self-direction
- Capacity for independent living
- Economic self-sufficiency

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] Early Start is early intervention services in California for families with infants and toddlers who have developmental delays or disabilities. Any child under 3 years of age may be eligible if they:

- Have a developmental delay of at least 25% in one or more of the following: Cognitive (thinking and learning); expressive communication (talking and expressing self); receptive communication (understanding language); social and emotional (feeling, expressing, interacting); adaptive (everyday living skills like eating, dressing, caring for self); and physical and motor development, including vision and hearing (walking, moving, seeing, and hearing).
- Have an established risk condition of known cause, with a high likelihood of delayed development.
- Are likely to have a developmental delay due to a number of risks that have been confirmed by a professional.

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 must ensure that members have access to HIV testing and counseling services, including access through a Local Health department (LHD). KP must not require prior authorization or referral for members to access HIV testing services. 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 carved-out services and covered through DHCS Medi-Cal Dental Program, KP must cover and ensure that dental screenings and oral health assessments are included for all MMC Members. For MMC Members under 21 years of age, dental screenings/oral health assessments are performed as part of every periodic assessment. KP provides referrals to Medi-Cal Dental Providers for all MMC Members and on an annual basis for MMC Members under 21 beginning 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). KP provides other dental services that can be provided by a Medical Provider including medically necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. KP does not cover dental services exclusively provided by a Dental Provider or Dental Anesthetist. KP also covers services related to dental procedures that require IV moderate sedation and deep sedation/anesthesia when provided by individuals other than a dental provider.

➔ 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 identification, referral, and documentation of the referral of MMC Members in need of WIC services who fall in the category of pregnant, breastfeeding, post-partum, or a legal guardian for a MMC Member under the age of five. If need is identified during the evaluation of a pregnant, breastfeeding, postpartum MMC Member, or child under the age of five, KP will provide a referral to WIC with all required clinical elements and signatures to process the referral. The MMC Member will need the completed WIC referral form to take with them to the WIC agency or it may be transmitted directly to the agency. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.[23]

➔ Major Organ Transplant Services

Major Organ Transplants (MOT) 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.[24] 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 1-888-551-2740 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

For Adult MMC Members ages 21 and older with an allowable diagnosis, KP covers chiropractic services, limited to the treatment of the spine by manual manipulation. All other services provided by a chiropractor are excluded from coverage.

Chiropractic services from American Specialty Health network providers. We work with American Specialty Health to arrange chiropractic services for the following MMC Members:

- Children under age 21, and after they turn age 21 that require treatment of an acute episode
- Pregnant MMC Members through 365 days postpartum
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility
- Enrollees in the Program of All-Inclusive Care for the Elderly (PACE), if applicable

For more information on chiropractic services, eligible MMC Members please call American Specialty Health at 1-800-678-9133 (TTY 711).

➔ Chiropractic services from County Facilities, Federally Qualified Health Centers, and Rural Health Centers**:** Medi-Cal may cover chiropractic services for MMC Members of all ages with an allowable diagnosis when received at county hospital outpatient departments, county outpatient clinics, FQHCs, or RHCs that are in Kaiser Permanente's network. FQHCs and RHCs may require a referral to get services. Not all county facilities, FQHCs or RHCs offer outpatient chiropractic services. To get more information, call Member Services at 1-855-839-7613 (TTY 711).

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.

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, respiratory therapy, Behavioral Health Treatment (BHT), and speech therapy providers. A pre-existing relationship means the MMC Member has seen the OON Provider for a nonemergency.

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.

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.[25]

Diversity, Equity, and Inclusion (DEI) Training

KP promotes access to and delivery of services in a culturally competent manner to all MMC Members and potential MMC Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.53.

KP is committed to providing equal access to our facilities, services, and programs 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's DEI training program be region specific and at minimum include consideration of health-related social needs that are specific to KP's servicing counties, regional demographics, and disparity impacts of all of KP's current MMC Members, including but not limited to:

- Seniors and Persons with Disabilities (SPDs)
- MMC Members with chronic conditions
- MMC Members with Specialty Mental Health Services (SMHS) and/or Substance Use Disorder (SUD) needs
- MMC Members with intellectual and Developmental Disabilities (DD)
- Children with Special Health Care Needs (CSHCN)

KP must ensure that its contracted Network Provider complete DEI training at least once every two years. This training helps reinforce KP's commitment to the effective delivery of health care services in a culturally competent, sensitive, and inclusive manner that meets the social, cultural, and linguistic needs of our MMC Members.[26]

DEI training materials are available on the KP Community Provider Portal at: https://healthy.kaiserpermanente.org/southern-california/community-providers/provider-info

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 at1-855-839-7613.

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.

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.[27]

- 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.
- May payment if the Provider is not complying with EVV requirements and might 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 may 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[28]:

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, DHCS 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.[29] 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.

Home and Community Based Services Waivers

1915(c) HCBS Waiver Programs Home and Community-Based Services (HCBS) Waiver Programs provide services aimed at serving individuals who would otherwise qualify for institutional care in community-based settings. [30]These MMC Members are enrolled in KP, and KP is responsible for identifying, referring, and coordinating services for MMC Members enrolled in HCBS. HCBS waiver services are provided directly by DHCS. In California, there are several waiver programs eligible Members can enroll in to receive these services, including but not limited to:

- Assisted Living Waiver: Care for MMC Members in residential care as an alternative to a SNF. Link here https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx
- Home and Community Based Alternatives Waive provides care management and services to support MMC Member's living in a community-based arrangement. Link here: https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx
- Multipurpose Senior Services Program Waiver provides HCBS to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. Link here: https://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx
- Medi-Cal Waiver Program (MCWP, formerly AIDS Waiver Program) provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. Link here: https://www.dhcs.ca.gov/services/ltc/Pages/AIDS.aspx
- HCBS Waiver for the Developmentally Disabled (HCBSDD) and Self Determination Program (SDP) Waiver administered by the California Department of Developmental Services (DDS), HCBS-DD provides services for developmentally disabled persons who are Regional Center consumers. Link here: https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

MMC Members can be enrolled in a 1915(c)-waiver program or ECM, but because both offer comprehensive care management, a MMC Member cannot enroll in both at the same time.

Initial Health Appointment (IHA)

The Initial Health Appointment (IHA) is a Medi-Cal managed care requirement for adults and children to ensure new MMC Members receive a comprehensive assessment by a PCP. The IHA is 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. Preventative screenings for adults and children as recommended by the United States Preventative Services Taskforce (USPSTF) do not need to be completed during the IHA, so long as MMC Members receive all required screenings consistent with USPSTF guidelines.

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, and the 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.[31]

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

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. For further information, please refer to the Additional Information: KP's Language Assistance Program section of the Provider Manual for HMO Members available at: https://healthy.kaiserpermanente.org/southern-california/community-providers/provider-info

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 1-866- 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. ➔ 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 1-866-551-9619 (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), Adult subacute facilities, Pediatric subacute facilities, and intermediate care facilities for developmentally disabled (ICF/DD). MMC Members meet medical necessity criteria for LTC services.[32]

➔ 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 1-866-551-9619 (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 1-866-551-9619 (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.[33]

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.

Medi-Cal for Kids & Teens (formerly Early Periodic Screening, Diagnosis, and Treatment Programs (EPSDT))

Under the Medi-Cal for Kids and Teens Program, KP provides and covers all medically necessary 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.

Medi-Cal for Kids & Teens 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 Medi-Cal for Kids & Teens specific training no less than every two (2) years. [34] 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

Please direct any MMC 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.

Medical Decisions

KP must ensure that medical decisions, including those by Providers and rendering Providers, are not unduly influenced by fiscal and administrative management.[35] 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:[36]

- 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.[37]

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.[38] 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.

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.

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 Medi-Cal for Kids and Teens (formerly 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.

Please direct any MMC 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)

ECM is a Medi-Cal benefit for members who meet specific criteria for complex social and medical needs. ECM provides in-person comprehensive care management to coordinate physical, mental, and dental care, as well as social services. Members who enroll in the program are assigned a Lead Care Manager who is embedded within the local community and serves as the member's "quarterback" to coordinate services. There are defined populations of focus that include adults and children and youth. The Department of Health Care Services (DHCS) has specific eligibility criteria for each population. To place a referral or for additional information, Providers can contact 1-866-551-9619.

➔ Community Supports

Community Supports (CS) are non-medical services offered to Medi-Cal members to address health-related social needs. KP provides these services as an investment in improved health and to potentially avoid more costly healthcare expenses. The services are provided by community-based providers that specialize in providing the specified service. There are many Community Supports including medically tailored meals, housing navigation, and home modifications. 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 (CHW) services are a covered Medi-Cal benefit. CHWs are non-licensed frontline workers based in the member's community. They work directly with members to help them reach a health-related goal. As an extension of the KP care team, they bring support services out of care facilities to meet

members where they are in their own community. CHWs are NOT social workers. CHWs provide non-clinical and culturally appropriate preventive health services that aim to help improve the member's physical, behavioral, or social health outcomes by increasing their health knowledge and self-sufficiency. They may assist Medi-Cal Members with vetted health education, health navigation, non-clinical screenings and assessments that do not require a license, and individual advocacy. 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 must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements. In addition, Providers are expected to 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; 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; and d) evaluate members on high-risk criteria, including Enhanced Care Management (ECM), NCQA Complex Case Management, Community Supports, and make referrals as appropriate.

Providers should be familiar with the CalAIM TCS expectations and requirements 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/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.[39]

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.[40] 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:[41]

- City/Region Header
- Providers or site name
- PCP number (if applicable)
- NPI number
- Primary Care Clinic or Medical Group/Independent Practice Association
- Provider address
- Telephone number
- Hours and days of operation
- How to use Plan services must be included
- Acronyms and symbols used must be included
- SPD Accessibility symbols and legend
- How/who to call for assistance
- Website URL for each location (if applicable)
- The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility, and if the Provider has completed cultural competence training

- Provider Hospital(s) (Optional)
- Instructions advising the MMC Member to contact member services to verify the availability of selected providers. Disclaimer should be on every page and instructions
- Closed Panel should only be used for providers not accepting new patients definitively.

Provider Enrollment

Federal and state requirements mandate that KP's Managed Care Plan (MCP) Network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program to render services to KP MMC Members.[42] Most Network Providers enroll in Medi-Cal through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway. Alternately, some Medi-Cal MCPs maintain Medi-Cal enrollment units to enroll Network Providers solely for the purpose of participating in the Medi-Cal MCP's network. Network Providers enrolled through a MCP's enrollment unit are recognized by other MCPs as enrolled for the purpose of participation in the Medi-Cal program. Per federal regulation, Network Providers enrolled solely for the purpose of participation in a MCP'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. For more information about the DHCS Medi-Cal enrollment process, please visit the state's PED site: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

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.[43]

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.[44]

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[45]

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.[46]

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.[47]

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) at no cost for KP-Assigned MMC Members and travel and lodging expenses related to NEMT.[48]

➔ Non-Emergent Medical Transportation (NEMT)

Medical Transportation in non-emergency situations if MMC Member has medical needs that do not allow them to use a car, bus, train, or taxi to get to their Medi-Cal appointments. These services must be prescribed by a provider. Medical Transportation must be used when MMC Member is a Medi-Cal member and:

- Not able to physically or medically use a bus, taxi, car or van to get to their appointment
- They need help from the driver to and from their residence, vehicle or place of treatment due to a physical or mental disability

Criteria for NEMT modality:

Wheelchair Van	Litter (Gurney) Van	BLS Ambulance
MMC Member requires: • Specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance • Is incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport • Requires to be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation	MMC Member requires: • To be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport • Specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance	MMC Member requires: • Continuous Intravenous Medication • Special Positioning Requiring EMT Supervision • Chemical Restraints • Acute Oxygen Need (Note: does not apply to MMC members with chronic emphysema who carry their own oxygen for continuous use) • Physical Restraints • Airway Monitoring (Aspiration Precautions) • Quarantine / Isolation • Supervision to Prevent Harm to Self or Others • Deep Suctioning **Note:** BLS should only be ordered if the patient meets the above clinical criteria

NEMT services must be prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender. Telephone authorizations for service requests requires a medically necessary service of urgent nature. Providers decide the correct type of transportation that a MMC member may need. Medical Transportation can be an ambulance, litter van, wheelchair van or air transport. If approved for services, MMC Members will receive a letter in the mail with details on how to schedule their transportation.

The order is valid for up to one (1) year from the date of the provider's signature. If the NEMT Referral Order is initiated/signed by a staff member other than below, a co-sign is required:

- Physician
- Dentist
- Podiatrist
- Physician Assistant
- Nurse Practitioner
- Certified Midwife
- Psychologist
- Mental Health Licensed Social Worker (LCSW)
- Behavioral Health Licensed Social Worker (LCSW)
- Chemical Dependency Licensed Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)

For additional resources regarding NEMT Referral Order: Southern California 1-877-277-8799, Member Line 1-833-226-6760, M-F 9AM - 5PM.

➔ Non-Medical Transportation (NMT)

NMT is available to all MMC Members requiring round-trip transportation to covered medical appointment or services, including lab work, X-rays, pharmacy, and any Medi-Cal Covered Services. Unlike NEMT, clinical authorization/medical necessity by the MMC Member's Provider is not required. NMT services are available for KP assigned MMC Members when the MMC Member has no other way to get to their scheduled appointment or service and when the MMC Member can ambulate without help from the driver.

KP covers MMC Members using a car, taxi, bus or other public/private way to get to their medical appointment for Medi-Cal-Covered Services. KP covers the lowest cost NMT type that still meets medical needs. Sometimes, KP can reimburse MMC Members for rides in a private vehicle that they arrange. This must be approved by us before the ride. MMC Members must tell us why they cannot get a ride in other ways, such as the bus. KP will not reimburse MMC Members for using a transportation broker, bus passes, taxi vouchers, or train tickets. To request authorization and the criteria used to make authorization decisions call KP's transportation provider at 1-844-299-6230 (TTY 711). The representative can also answer any questions about mileage reimbursement.

- For routine appointments, please call Kaiser Permanente's transportation provider at 1-844-299-6230 (TTY 711) at least three business days (Monday through Friday 5 a.m.-7 p.m.) before your appointment.
- For urgent requests, including being discharged from the hospital, call for a ride 24 hours a day, 7 days a week.

➔ Travel and Lodging (Covered Services)

KP will cover some travel related expenses for medically necessary services that are more than 100 miles from the MMC Member's home. KP could also cover someone who is traveling with the MMC Member to help them with their appointment or for someone who is donating an organ to them for an organ transplant.

- Lodging and meal arrangements must be located within a reasonable distance from the location where the MMC Member will obtain medically necessary services.
- KP will reimburse MMC Members for approved travel expenses incurred by the MMC Member and accompanying attendant, if applicable, for one (1) room plus tax, up to $200 per day. They will use the IRS per diem rates to provide reimbursement for approved meal expenses if those expenses are supported by receipts.

MMC Members may be able to get help with travel expenses, such as transportation, meals, lodging parking, tolls, if they do not have a way to get to medical appointment for a CCS qualifying condition.

For more details call Travel and Lodging Coordinators at the number listed here: Southern California Travel and Lodging Coordinator at 626-405-6164.

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

All MMC Members are eligible for a routine eye exam and eyeglasses once every 24 months. MMC Members are covered for eye exams to determine if they need eyeglasses and to provide a prescription for eyeglasses.[49] 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.

KP must cover and ensure the provision of eye examinations to include screening examinations and prescriptions for corrective lenses as appropriate for all MMC Members. KP must arrange for the fabrication of optical lenses for MMC Members through Prison Industry Authority (PIA) optical laboratories except when the MMC Member requires lenses not available through PIA. KP must cover the cost of the eye examination and dispensing of the lenses fabricated by PIA. KP must cover the cost of fabrication and dispensing of lenses not available through PIA.

MMC Members must seek Medi-Cal vision services, including eyeglasses (frame and lenses) benefits, through in-network providers who accept Medi-Cal managed care plans or Fee-for-Service Medi-Cal.

➔ Special Contact Lenses

Contact lens testing may be covered if the use of eyeglasses is not possible due to eye disease or condition (i.e., missing an ear).

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.

➔ Other Vision Services

- Low vision testing for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine or surgery that interferes with a person's ability to perform everyday activities (i.e., age-related macular degeneration).
- Artificial eye services and materials for those individuals that have lost an eye or eyes to disease or injury

References

[1] Executive Summary: https://www.dhcs.ca.gov/dataandstats/Documents/Medi-Cal-Enrollment-April2023.pdf

[2] DMHC.CA.GOV: https://www.dmhc.ca.gov/healthcareincalifornia/yourhealthcarerights/timelyaccesstocare.aspx

[3] MMCD APL 23-001 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/Att-A-APL-23-001-NAU.pdf

[4] MMCD APL 16-015 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-015.pdf

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

[6] MMCD APL 22-022 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-022.pdf

[7] MMCD APL 22-025 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf

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

[9] MMCD APL 22-006 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-006.pdf

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

[11] MMCD APL 21-014 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf

[12] MMCD APL 22-029 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-029.pdf

[13] MMCD APL 22-003 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL-22-003.pdf

[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

[16] MMCD APL 23-010 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-010.pdf

[17] MMCD APL 20-016 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf

[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 I, Section 4.3.20- Women, Infants, and Children (WIC) Supplemental Nutrition Program

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

[25] MMCD APL 23-013 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-013.pdf

[26] DHCS Contract Boilerplate, Exhibit A, Attachment 3.2.5, Section 5.2.11.C
MMCD APL 21-004 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-004.pdf
MMCD APL 23-025 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-025.pdf

[27] MMCD APL 23-014 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-014.pdf

[28] MMCD APL 22-017: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-017.pdf

[29] MMCD APL18-016 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-016.pdf

[30] DHCS Home and Community Based Services Waivers: https://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx

[31] MMCD APL 22-030 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf
DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 5.3.3-Initial Health Appointment

[32] MMCD APL 23-004 and MMCD APL 23-023 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-004.pdf
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-023.pdf

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

[34] MMCD APL 23-005 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

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

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

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

[38] Executive Order N-01-19 (Medi-Cal RX) and MMCD APL 22-012:
https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-12.pdf

[39] MMCDAPL23-009 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-009.pdf

[40] DHCS Contract Boilerplate, Exhibit A, Attachment 13, Section 5.1.4- Primary Care Provider Selection

[41] MMCD APL 19-003 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-003.pdf

[42] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing
MMCD APL 22-013 available at:
[43] MMCD-APL17-009 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-009.pdf

[44] MMCD APL 21-003 available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-003.pdf

[45] DHCS Contract Boilerplate, Exhibit A, Attachment 7, Section 8-Prohibited Punitive Action Against the Provider

[46] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 5.2.8; Family Planning Services

[47] MMCD APL 23-007 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-007.pdf

[48] MMCD APL 22-008 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf

[49] DHCS Contract Boilerplate, Exhibit A, Attachment III, Section 5.3.7.D-Vision Care Lenses