



**HERITAGE PROVIDER NETWORK
&
AFFILIATED MEDICAL GROUPS**

2016 Provider Manual

Approval Signatures:

Dr. Ian Drew, Committee Chair

Date:

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GENERAL INFORMATION

This manual has been designed to provide contracted Physician Groups and Health Care Delivery Organizations with information about the delivery of services to Heritage Provider Network, Inc. (HPN) affiliate's members. The information summarizes the processes HPN, Inc. has put into place to comply with all the regulatory requirements.

STATEMENT OF CONFIDENTIALITY

Any information submitted to HPN, Inc. will be viewed exclusively by HPN, Inc. in compliance with the regulatory requirements of the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) and all State and Federal laws. Physician Groups and their associated providers will maintain the confidentiality of all HPN, Inc. members' medical records and treatment information in accordance with the same and similar State and Federal laws.

HERITAGE PROVIDER NETWORK STRUCTURE

Heritage Provider Network (HPN) and its affiliates will have the infrastructure necessary to improve the utilization management, care coordination, quality and safety of clinical care and services we provide to our members. Heritage Provider Network affiliates are defined as:

An affiliate is a subsidiary company with operations under the control and oversight by the larger corporation, namely Heritage Provider Network.

Heritage Provider Network and its affiliates vary in model, and structure used to deliver health care to our members. The model may be singular, or a combination of the following delivery system types:

Network model: Heritage Provider network contracts with multiple independent practice associations, staff models, and mixed model organizations to provide health care services.

Staff model: The physicians are salaried employees of Heritage Provider Network, or its affiliates. Medical services are delivered in medical facilities that generally are open only to our members. The physicians adopt the principles of Heritage Provider Network and its affiliates.

IPA (Independent or Individual Practice Association) model: Is an organized system of independent, private-practice physicians or an association of such physicians. Physicians in this model generally are paid on a modified fee-for-service or capitated basis.

Mixed model: The affiliate uses a combination of staff model and the IPA model described above.

The Heritage Provider Network, Inc. network is composed of ten (10) affiliated Medical Groups:

1. Affiliated Doctors of Orange County
2. Bakersfield Family Medical Center
3. Coastal Communities Physician Network

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4. Desert Oasis Health Care
5. Greater Covina Medical Group
6. High Desert Medical Group
7. Heritage Victor Valley Medical Group
8. Lakeside Medical Group
9. Regal Medical Group
10. Sierra Medical Group

HPN, INC.'S MISSION, VISION AND VALUES

MISSION:

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

VISION:

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

1. Our patients as their care givers of choice
2. Our employees as their employer of choice
3. Our provider and health plan partners as their healthcare network of choice

VALUES:

IT'S EMPLOYEES AND THEIR DEVELOPMENT

We will foster trust and respect within the organization.

We will train and educate employees for the future.

We will promote from within whenever appropriate.

OPEN AND HONEST COMMUNICATION:

We value open, constructive, timely and clear communications.

We will protect an individual's right to freely exchange ideas and express opinions and concerns.

TEAMWORK:

We recognize our success together is a direct result of our efforts as a team.

We will develop and empower teams to identify and resolve organizational issues and concerns.

We will be collectively responsible for the organization's successes and/or failures.

THE CUSTOMER:

We will make understanding and satisfying customer needs our top priority.

We will treat each other as well as we treat our external customers.

HIGHEST PERSONAL AND PROFESSIONAL STANDARDS:

We will recruit, reward and retain employees and physicians of the highest caliber.

We will hold each other accountable to act in ways consistent with our values.

DELEGATED FUNCTIONS

HPN, Inc. is required by Section 1367.01 (c) (g) to have adequately and effectively implemented a process to determine if the contracted entity is suitable to have certain functions delegated. Delegation is the formal process by which HPN, Inc. gives a contracted Physician Group/IPA the responsibility and authority to perform functions on its behalf. It is the policy of Heritage Provider Network, Inc. to delegate UM and Credentialing activities, and partially delegate QM activities to contracted provider groups and to perform

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oversight of delegated functions for all contracted provider groups. HPN, Inc. shall retain responsibility for the quality of care and service for our members. These activities will be delegated to those contracting Physician Groups/IPAs who demonstrate the ability to comply with HPN, Inc. standards, policies, and procedures.

MONITORING OF PERFORMANCE

HPN, Inc. Clinical Service Staff will perform an oversight audit of each its affiliates annually to determine compliance with regulatory and accreditation agency requirements. HPN, Inc. will also review required submission reports to validate compliance with applicable standards and to identify areas that may require HPN, Inc. to intervene for correction or improvement. The specific requirements are covered in the Quality Improvement, Utilization Management and Credentialing sections of this manual.

CORRECTIVE ACTION

If HPN, Inc. identifies deficiencies in the HPN affiliate's adherence to the prescribed regulatory or accreditation agency requirements, affiliate must submit a corrective action plan with documented evidence that a correction(s) have been put in place within 30 days of receipt or as specified in the current delegation agreement. The continuation of delegation is contingent upon the successful completion of the corrective action plan.

CONFIRMATION OF DELEGATED STATUS

Upon HPN, Inc.'s approval, a confirmation letter is sent to the affiliate indicating the delegation status for each area of delegation. The notification for QI, UM and Credentialing includes a copy of the Delineation of Responsibilities and Reporting Requirements.

QUALITY IMPROVEMENT PROGRAM

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

PURPOSE/PROGRAM DESCRIPTION

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

SCOPE OF PROGRAM

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

AUTHORITY FOR HPN, INC. QUALITY IMPROVEMENT ACTIVITIES

Heritage Provider Network's Governing Body is the Executive Committee, which is the body responsible for the establishment and implementation of the QI Program. The Executive Committee appoints the Chief Medical Officer/QI Medical Director and the VP of Clinical Services to act as facilitators for all QI activities and

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they are the responsible entities for the oversight of the QI Program. There is a Quality Improvement Council (QIC) and a Utilization Management Committee (UMC) which are accountable and report to the Executive Committee.

The Executive Committee directs all contracted HPN affiliates to participate and cooperate with QI activities and provide the required reports to HPN, Inc. The contracts are also required to allow HPN, Inc. access to practitioner medical records and for practitioners to maintain confidentiality of member information and medical records.

The Executive Committee will provide sufficient resources to the QI Program to achieve its objectives. These resources will include staff, data sources, analytical resources such as statistical expertise and programs.

HPN, Inc. delegates QM to its affiliates that are deemed competent to meet HPN, Inc.'s expectations and NCQA guidelines after an initial delegation oversight audit.

QUALITY MANAGEMENT PROGRAM ORGANIZATION

The quality management program organization is comprised of the HPN, Inc.'s:

1. Executive Vice President of Clinical Affairs/Plan Medical Director who oversees the Quality Program and its activities.
2. VP of Clinical Services who facilitates all CQI activities and supports the various committees.
3. Quality Improvement Council which is responsible for developing, implementing and overseeing the QI Program.

Information about the Quality Improvement Program, its description and a progress report are produced annually and are available to its members and practitioners.

QUALITY IMPROVEMENT GOALS

The quality Improvement goals for the organization are:

1. Ensuring ongoing communication and collaboration between the QI Department and the other functional areas of the organization, such as, but not limited to: Medical Management, Credentialing, and Member services, Behavioral Health, Provider Network and Case Management.
2. Ensuring members have full access to care and availability of primary care physicians and specialists.
3. Monitoring and evaluation of the standards of health care practice through evidence-based guidelines (Practice Guidelines) as the basis for clinical decision-making.
4. Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the delivery system and network.
5. Utilizing a multi-disciplinary approach to assess, monitor and improve our policies and procedures.
6. Promoting physician involvement in our QI Program and activities.
7. Collaboration with contracted hospital practitioner and health delivery organizations to assure patient quality and safety of care services provided.
8. Fostering a supportive environment to help practitioners and providers improve the safety of their practices.
9. Assess and meet the standards for cultural and linguistic needs of our members.
10. Monitoring our compliance to regulatory agency standards through annual oversight audits, and survey activities.
11. Promoting preventive health services and care management of members with chronic conditions.
12. Ensuring there is a separation between medical and financial decision making.
13. Seek out and identify opportunities to improve the quality of care and services provided to our

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members.

QUALITY IMPROVEMENT COUNCIL - AUTHORITY

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

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

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

QUALITY IMPROVEMENT COUNCIL - COMPOSITION

The Quality Improvement Council is composed of:

1. Executive V.P. Clinical Affairs/Plan Medical Director
2. Network Medical Directors
3. Vice President Clinical Services
4. Director of Clinical Services
5. Clinical Compliance Specialists – QI and Health Education
6. Director of HealthCare Informatics
7. Director of Behavioral Health
8. All contracted Medical Group/IPA Medical Directors and QM Directors or other QM staff as appropriate
9. Two physicians from each contracted medical group and IPA
10. Other members may be added at the discretion of the Committee with approval of the Executive Committee and the Network Medical Director
11. Behavioral Health practitioner

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12. Full service Health Plan representatives may attend QIC meetings with prior approval of the Executive Committee, Health plan representatives attending must sign a confidentiality statement

QIC – ORGANIZATION

The Quality Improvement Council is required to:

1. Have a voting quorum of three (3) physician members.
2. Meet a minimum of 4 times annually, once a quarter, and as necessary to meet operational needs.
3. All members have voting privileges unless issue is in regards to medical quality. Medical quality issues can only be voted on by the physician members.
4. Define the term of membership:
 - a. Employees: Permanent and as long as employed in position or are excused and replaced by the Network Medical Director or the Executive Committee.
 - b. Independent Physicians - Two (2) years, membership may be renewed at the request of the Network Medical Director.
 - c. Signed Statements:
 - I. Confidentiality
 - II. No Conflict of Interest
5. Develop minutes - Complete and accurate minutes will be prepared and maintained for each QIC meeting conducted. Minutes will reflect the date and duration of the meeting and the persons present, names and titles, as well as those of any guests will be recorded. The minutes will show the major topics discussed, decisions and dispositions, as well as all statistics presented.

REPORTING REQUIREMENTS TO EXECUTIVE COMMITTEE

HPN, Inc.'s QIC has developed the reporting requirements in compliance with DMHC and NCQA. They are:

1. YEARLY WORK PLANS which are completed by February 15th each year and submitted to the Quality Improvement Committee for approval. The annual work plan is to include:
 - a. Quality improvement goals and objectives, program scope, areas of program focus, safety of clinical care, service improvement related activities and studies that are to occur.
 - b. Planned monitoring of previously identified issues, including tracking issues over time. Quality Improvement Program Evaluation findings are used to develop the yearly action plan for the upcoming year.
 - c. Planned annual evaluation of the Quality Improvement Program.
 - d. Action steps to include target date for completion and responsible party.
2. SEMI-ANNUAL REPORT. This report describes:
 - a. Quality Improvement activities completed by HPN, Inc. and its affiliates.
 - b. The organization's performance in quality of clinical care and quality of service is trended.
 - c. An analysis of whether there have been any demonstrated improvements in the quality of clinical care and quality of service.
 - d. A description of how these improvements were meaningful to the organization's population should be included.
3. PROGRAM EVALUATION. An annual review of the QI program for overall effectiveness and changes needed. It is approved by the Quality Improvement Committee. The assessment includes:
 - a. A summary of quality improvement completed and ongoing activities that address the quality and safety of clinical care and quality of service.

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- b. A trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- c. An analysis of the results of QI initiatives, including barrier analysis.
- d. An evaluation of the overall effectiveness of the QI Program, including progress toward influencing network wide safe clinical practices.
- e. The impact the process has had on the need for Quality Improvement Program revisions and modifications.
- f. Prioritized findings that will be used to develop the yearly Quality Improvement Work Plan for the upcoming year.

CONTRACTS

HPN, Inc. has contracts with its affiliates that require:

1. Participation and cooperation with QI activities.
2. Quarterly reports, annual work plan and annual program evaluation to HPN, Inc.
3. Access to practitioner medical records.
4. Practitioners to maintain confidentiality of member information and medical records.
5. Contracts with practitioners to allow open practitioner-patient communication regarding appropriate treatment alternatives and does not penalize practitioners for discussing medically necessary or appropriate patient care. All contracts executed post 07-01-1998 must include an affirmative statement indicating that practitioners may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
6. Require Group/IPA contracts with specialists to require timely notification to members affected by the termination of a specialist or the entire specialty group.

CULTURAL COMPETENCE

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

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

Provider C&L Requirements:

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

ACCESSIBILITY OF SERVICES

HPN, Inc. and its affiliates will ensure that all primary care practitioners/providers are in compliance with DMHC Timely Access to Care Standards (Appendix A). Compliance with these standards is monitored through

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Member complaints and grievances, PQI's, Member Satisfaction Surveys, disenrollments, and annual access surveys.

Medical Care Access Standards	Regulatory Time Frames
a. PCP: regular and routine appointments	Within 10 Business Days of the Request for Appointment
b. Specialist: regular and routine appointments	Within 15 Business Days of the Request for Appointment
c. Specialist: urgent care appointments (Not Requiring a Prior Authorization)	Within 48 Hours of Request for Appointment
d. Specialist: urgent care appointments (Prior Authorization Required)	Within 96 Hours of Request for Appointment
e. Ancillary Service: regular and routine for diagnosis or treatment of injury, illness, or other health conditions.	Within 15 Business Days of the Request for Appointment
f. Telephone screening and triage (S&T)	24 hours day, 7 days per week. S&T calls must be handled by a telephone answering machine/telephone service/or office staff. Telephone logs must be maintained: Answering services/machines/staff must inform the caller of: a. Length of wait for a return call, and b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to T&S by phone, or if needed, deliver urgent or emergency care by calling 911 or going to the nearest emergency room.
g. Telephone Screening not triage (S&T) wait time	Not to exceed 30 minutes and appropriate to the member's condition.
h. After-hours care	24 hours day, 7 days per week phone availability to direct care. After hour calls must be handled by a telephone answering machine/service/or office staff. Telephone logs must be maintained. Answering services/machines must include a message to the member that if they feel they have a serious acute medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.
i. Member Services by Telephone	9 am to 5 pm – Monday-Friday

BH ACCESS STANDARDS

Behavioral Health Care Access Standards	Regulatory Time Frames
a. Life threatening emergency	Immediately
b. Non-life threatening emergency	Within 6 hours
c. Urgent Care	Within 48 hours
d. Regular and Routine appointments	Within 10 Business Days of the Request for Appointment
e. Non Physician BH Provider: regular and routine appointment	Within 10 Business Days of the Request for Appointment
f. Telephone is answered by a live voice	Within 30 seconds
g. Abandonment rates	Not to exceed 5 percent at any given time.

ASSESSMENT AGAINST ACCESS STANDARDS

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

AVAILABILITY OF PRACTITIONERS

HPN, Inc. and its affiliates annually perform an assessment of the availability of its practitioners. The ratio of providers to members and geographic distribution of PCPs and Specialists are set by State and Federal regulations as well as the full service Health Plans.

PCPs are defined as Internists, General Practitioners, Family Practitioners, Pediatricians, and Nurse Practitioners and Physician Assistants who function as PCPs unless otherwise defined by the full service Health Plan. High volume specialists are defined as Obstetrics/Gynecology, Cardiologists, Dermatologists, and other specialties contracted medical groups and IPAs determined to be high volume.

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

HPN, Inc. will annually assess its performance against the standards established for the availability of PCPs and SCPs and will ensure that the Medical Groups/IPAs have credentialed all providers according to the Credentialing standards developed by NCQA.

MEMBER SATISFACTION/GRIEVANCE/APPEALS

Grievance Process

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

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

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

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

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

DISEASE MANAGEMENT

Heritage Provider Network and its affiliates have designed Disease Management Programs which provide a multidisciplinary, continuum-based approach to health care delivery. These programs proactively identify populations with, or at risk for chronic medical conditions i.e. Diabetes and Congestive Heart Failure. Disease management supports the practitioner-patient relationship and plan of care which emphasizes the

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prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

CLINICAL PRACTICE GUIDELINES (CPGs)

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

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

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

CONTINUITY AND COORDINATION OF MEDICAL CARE

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

The Medical Groups must:

1. Identify members with special health care needs, including those that would benefit from Disease Management.
2. Ensure an assessment by an appropriate health care professional of ongoing needs of each member identified as having special health care needs or conditions.
3. Identify medical procedures and/or behavioral health services to address and/or monitor the need or condition.
4. Ensure adequate care coordination among providers, including other practitioners, behavioral health providers, as necessary.
5. Ensure a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care need, (e.g., a standing referral for an approved number of visits).

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

CONTINUITY AND COORDINATION BETWEEN MEDICAL AND BEHAVIORAL HEALTH CARE

Heritage Provider Network and its affiliates collaborate with our contracted behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.

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HPN ensures timely updates from primary care providers to behavioral health providers regarding a member's change in health status. The update will include but is not limited to: diagnosis of chronic conditions, support for the petitioning process for long term care, and all medication prescribed.

Annually HPN collects data about opportunities for collaboration, and assesses for:

1. Exchange of information between behavioral healthcare and primary care practitioners, medical/surgical specialists, organizational providers or other relevant medical delivery systems.
2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care settings.
3. Appropriate use of psychotropic medications and consistent guidelines for prescribing by behavioral and medical practitioners. (HEDIS Antidepressant Medication Management, and/or Follow-Up Care for children prescribed ADHD Medication).
4. Screening and managing of patients with coexisting medical and behavioral conditions. Consultations of medical or surgical inpatients with secondary mental illness or substance abuse disorder.
5. Development and adoption of primary prevention programs for behavioral healthcare. Primary education programs to promote prevention of substance abuse, stress management programs, depression management programs, bereavement counseling, and nutrition and body image programs for adolescents.
6. Development and adoption of programs to meet the needs to members with severe and persistent mental illness.

HPN and its affiliates identifies opportunities to improve coordination and continuity of care between medical and behavioral health providers through routine medical and treatment record reviews, review of behavioral healthcare referrals, review of behavioral healthcare consultations, HEDIS antidepressant medication studies, grievance reviews, and member experience surveys. Actions and interventions are taken to improve our members' experience, and the coordination and continuity of care between our primary care physicians, and the behavioral healthcare providers.

PREVENTIVE HEALTH CARE SERVICES (PHGs)

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

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

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

CLINICAL MEASUREMENT ACTIVITIES

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

EFFECTIVENESS OF THE QI PROGRAM

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

STANDARDS FOR MEDICAL RECORD DOCUMENTATION

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

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

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

DELEGATION

For any delegated activity, there is a mutually agreed upon document describing:

1. The responsibilities of HPN, Inc. and the contracted entity.
2. The delegated activities.
3. At least semi-annual reporting to HPN, Inc.
4. The process by which HPN, Inc. will assess the performance of the delegated entity.
5. The remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.
6. Any use of protected health information is to meet HIPAA regulations and follow HPN, Inc.'s HIPAA policies.

Oversight audits of delegated entities are performed annually and Corrective Action Plans may be requested if deficiencies are identified. HPN, Inc.'s Quality Improvement Council will review Quality Improvement reports from all delegated entities to include the Quality Improvement Program and work plan at least annually.

GRIEVANCE SYSTEM

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

The Vice President of Clinical Services as an HPN, Inc. officer under the guidance of the Quality Improvement Council, has the primary responsibility for the monitoring of activities.

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DEFINITIONS

A Grievance is a written or oral expression of dissatisfaction regarding HPN, Inc. and/or any of its providers, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by an enrollee or the enrollee's representative.

A Complaint is the same as a grievance.

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

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

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

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

AUTHORITY

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

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

MEMBER NOTIFICATION

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

PROCESS FOR MEMBERS TO FILE A GRIEVANCE

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

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

grievance for at least 180 calendar days following any incident or action that is the subject of the member's dissatisfaction.

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

PROTOCOL FOR PROCESSING A GRIEVANCE RECEIVED AT HPN, INC. OR ITS CONTRACTED PROVIDER GROUPS

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

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

EXPEDITED 72-HOUR REVIEW REQUESTS

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

Definitions:

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

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

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

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TRACKING AND MONITORING

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

HMO HELP CENTER GRIEVANCES

Grievances received by the DMHC's HMO Help Center are sent to the full service health plans for review. The full service health plans are to notify HPN, Inc. or its affiliates of the grievance and its origination with the DMHC. The affiliates are to notify HPN, Inc. of the grievance and its origination with the DMHC. HPN, Inc. will monitor the notification logs and review for trends. The trended information will be presented to the QIC. The QIC will review and issue CAPs and assign follow up as indicated.

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

MEMBER'S RIGHTS AND RESPONSIBILITIES

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

Health services are provided to members in a non-discriminatory, cultural, competent manner:

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

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

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

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

Member Rights and Responsibilities include the:

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

PRACTITIONER CREDENTIALING

PURPOSE

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

POLICY

Practitioners who fall within the Scope of Authorization and Action will undergo initial credentialing prior to appointment to the HPN Groups panel. Practitioner credentials will be re-reviewed at the time of recredentialing every three (3) years.

SCOPE OF AUTHORIZATION AND ACTION

Licensed practitioners who treat members in the inpatient and/or outpatient setting are covered under the Credentialing Plan. This includes:

1. employed practitioners
2. independent practitioners or groups of practitioners
3. contracted licensed hospitalists

Independent practitioners or groups of practitioners include any allied health practitioner or behavioral health care specialist who is licensed, certified, or registered by the State to practice independently.

PRACTITIONERS NOT COVERED UNDER CREDENTIALING PLAN

Practitioners who practice exclusively within the inpatient hospital setting and have no independent relationship with HPN is not subject to the Credentialing Plan, specifically:

1. Radiologists
2. Anesthesiologists
3. Emergency room physicians
4. Pathologists
5. Behavioral healthcare practitioners
6. Hospitalists
7. Telemedicine consultants

Practitioners who practice in freestanding facilities, such as, mammography centers, urgent care centers, surgical centers, and ambulatory behavioral health care facilities. However, if these practitioners provide care in addition to the care provided in the inpatient setting or emergency room, they are subject to the Credentialing Plan.

PHYSICIAN EXTENDERS

Licensed independent practitioners who fall within the scope of Physician Extenders include Physician Assistants (PA) and Nurse Practitioners (NP). Physician Extenders are required to properly identify themselves to patients as non-physician practitioners.

State licensing authorities have developed specific guidelines and standardized procedures for Physician Extenders. The Medical Director designates a Supervising Physician to provide physician collaboration/supervision of the Physician Extender that is consistent with the Physician Extender's scope of practice. Supervising physicians have continuing responsibility for all medical services provided by the Physician Extender under his/her supervision.

The Physician-to-Physician Extender ratio is as follows:

The supervising physician will not supervise more than 4 PAs at one time.

The supervising physician will not supervise more than 4 NPs at one time.

Nurse Practitioner: Standardized Procedures outlining Nurse Practitioner roles, duties, and responsibilities are approved by the Medical Director, Supervising Physician, and Nurse Practitioner. Nurse Practitioners who prescribe drugs and/or devices will be in accordance with standardized procedures or protocols developed by the Nurse Practitioner and supervising physician. A copy of the agreement is kept in the credentialing files of the Supervising Physician and Nurse Practitioner. The supervising physician is not required to be physically present. Availability by telephonic contact is adequate.

Physician Assistant: A Delegation of Services Agreement outlining the authorized services to be performed by the Physician Assistant when acting under the Supervising Physician will be approved by the Supervising Physician and Physician Assistant. A copy of the agreement is kept in the credentialing files of the Supervising Physician and Physician Assistant. At all times, the supervising physician must be physically or electronically available to the PA for consultation, except in emergency situations. In cases of emergency, the physician assistant, to the extent permitted by the laws relating to license or certificate involved, may render emergency services to a patient pending establishment of contact with the physician.

DELEGATION OF DECISION MAKING AUTHORITY

HPN delegates authority for performing the function of credentialing to the HPN Groups in accordance with

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the mutually agreed upon document for each delegate. The agreement describes the responsibilities of the delegated entity and the activities that are delegated. HPN maintains responsibility for ensuring that the function is being performed according to its expectations, contracted Health Plan delegation agreements, National Committee for Quality Assurance (NCQA) standards, DMHC, DHS, Medicare, Medi-Cal and other Federal and State regulations by performing an annual delegated oversight audit of the HPN and reviewing the MG/IPAs submitted reports.

PRACTITIONERS' RIGHTS AND RESPONSIBILITIES

Right to Review Information:

The practitioner has the right to review information obtained by HPN or HPN's affiliated medical groups for the purpose of evaluating the practitioner's credentialing/recredentialing application. This includes information obtained from outside sources, e.g., state licensing boards. The practitioner will not be permitted to review peer references/recommendations or any other information protected from disclosure by law. The practitioner may schedule an appointment to review such information by sending a written request to the Medical Director.

Right to Correct Erroneous or Variant Information:

The practitioner has the right to correct information that is believed to be erroneous. When information received from a primary source substantially varies from information provided on the practitioner's application, the Credentialing Department will contact the practitioner and request either verbally or in writing to provide an explanation.

Examples of information with substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges, or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application. Sources will not be revealed if the information received is not intended for verification of credentialing elements or is protected from disclosure by law. Documentation, which may include re-verification from the primary source, will be kept in the credentialing file.

The practitioner will be given a 30-day time period in which to respond to the request for clarification of any discrepancy. The response must be in writing and submitted to the Credentialing Department. The Credentialing Department will provide a receipt of the corrections to the provider. If the response by the practitioner is not received by the Credentialing Department in 30 days, it will be assumed that the practitioner has voluntarily withdrawn his/her application.

Right to be Informed of Application Status:

The practitioner has the right, upon request, to be informed of the status of their credentialing/recredentialing application. This update will verify documents received in support of the practitioner's application and pending requests required for the completion of the credentialing process. Specific information/comments made by peer references or other information protected by law will not be discussed with the practitioner.

Practitioner's Burden to Produce Information:

The practitioner has the burden to produce information for an adequate evaluation of the practitioner's qualifications and suitability for participation, of resolving any reasonable doubts about these matters, and of satisfying requests for information. Failure to produce information could cause delay and/or eventual termination of the application process.

Notification of Practitioner's Rights:

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Notification to the practitioner of their right to review information, right to correct erroneous or variant information, right to be informed of application status, and burden to produce information is included as part of the initial and recredentialing applications.

CONFIDENTIALITY

Upon request to the Medical Director, access is provided to an applicant or participating practitioner who would like to review information submitted in support of their application. This includes information submitted from outside primary sources, but does not include information protected from disclosure by law. Reviews will be accomplished in the Credentialing Department during normal business hours, or otherwise under conditions designed to provide reasonable protection of the confidentiality of the records. Requests for copies will be considered on an individual basis.

ELIGIBILITY CRITERIA

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

State Licensure:

Valid, current professional licensure issued by an appropriate board in State of California.

DEA or CDS Certification:

Valid, current DEA or CDS Certification (if applicable).

National Provider Identifier (NPI):

Valid, current NPI.

Education & Board Certification:

At the time of initial application an applying practitioner must meet this criterion by either one of the following:

1. Graduation from a professional school (allied and behavioral health practitioners only), school of medicine, osteopathy, chiropractor, or dentistry.
2. Completion of Internship and Residency training in good standing in the practitioner's practicing medical or surgical specialty, as applicable.
3. Board Certification by the American Board of Medical Specialties, American Osteopathic Association, a board or association with equivalent requirements approved by the Medical Board of California, or a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.
4. Exceptions may be made for those practitioners whom are grandfathered into their specialty under special circumstances. (i.e., Family Practice Board 1970-1978).
5. Exceptions may also be made for rural areas. Work history and professional training will be reviewed for these practitioners.

Clinical Privileges:

Current, unrestricted clinical privileges that are consistent with the practitioner's practicing medical or surgical specialty, as applicable.

** This requirement may be waived if acceptable inpatient coverage arrangements are made. Practitioner(s) providing such coverage will have met all established credentialing eligibility criteria and participate on the*

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HPN's panel.

Hospital Privileges:

Absence of past or present denial, suspension, restriction or termination of hospital privileges.

** This requirement may be waived if evidence exists that any such action does not adversely affect the practitioner's ability to perform his or her professional duties.*

Malpractice Insurance:

Current professional malpractice insurance with minimum coverage of:

1. MDs, DOs, DDSs, DPMs, Allied Health Practitioners, Behavioral Health Practitioners and Nurse Practitioners: \$1,000,000 per occurrence, \$3,000,000 aggregate.
2. Physician Assistants: \$500,000 per occurrence, \$1,000,000 aggregate.
3. Chiropractors: \$200,000 per occurrence, \$500,000 aggregate.

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

Malpractice Involvement:

Absence of past or present involvement in a malpractice suit, arbitration, or settlement.

** This requirement may be waived if evidence exists that involvement does not adversely affect the practitioner's ability to perform his or her professional duties.*

Disciplinary Actions:

Absence of past or present disciplinary actions affecting the practitioner's professional licensure, DEA, or other required certification.

** This requirement may be waived if evidence exists that any such action does not adversely affect the practitioner's ability to perform his or her professional duties.*

Sanctions:

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

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

Medicare Participation:

Absence of past or present voluntary "opt-out" from Medicare participation. The HPN Groups will not contract or employ practitioners who have opted opt out of Medicare or have been excluded/sanctioned from participation in Medicare.

** This requirement may be waived if evidence exists that the practitioner is not currently "opting out" of Medicare participation or practitioner does not provide services to Medicare enrollees.*

Felony Convictions:

Absence of felony convictions.

** This requirement may be waived if evidence exists that conviction does not adversely affect the practitioner's ability to perform his or her professional duties.*

Illegal Use of Drugs:

Absence of present illegal use of drugs.

Impairment:

Absence of impairment or likely impairment of practitioner's ability to adequately perform the professional duties for which the practitioner is employed or contracted, with or without reasonable accommodation,

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according to the accepted standards of professional performance and without posing a direct threat to the safety of patients.

Office Site Visit:

Satisfactory results of office site visit, including medical record review, as applicable.

Language:

Proficient in the English language.

PRIMARY SOURCE VERIFICATION

Primary source verification (“PSV”) of practitioner credentials will be written, oral or via internet web site. Verifications will be no more than 180 calendar days old at the time of credentialing decisions.

1. Written verifications must come directly from the California State Licensing Agency and the printed date on the document will be used to calculate the 180-day timeline, not the date received.
2. Oral verifications will be documented by a dated, signed note in the credentialing file, stating the information verified who verified the information, and how it was verified.
3. Internet web site and electronic verifications will come from the appropriate state licensing agency and will be dated by the credentialing staff member who verified the information.

HPN will re-verify credentialing factors that are no longer within the credentialing time limits and those that will be effective at the time of the Credentialing Committee’s review.

CREDENTIALING APPLICATION

Acceptable Applications include: California Participating Physician Application (CPPA); or, CAQH Online Credentialing Application Database Service.

Applicant Attestation - Verification Time Limit - 180 calendar days

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

1. Reasons for any inability to perform the essential functions of the positions, with or without accommodation.
2. Lack of present illegal drug use.
3. History of loss of license and/or felony convictions.
4. History of loss or limitation of privileges or disciplinary action.
5. Current malpractice insurance and amount of coverage.
6. Correctness and completeness of application.

Supporting Documentation

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

1. Current Curriculum Vitae.
2. Copy of valid, current professional licensure issued by the State of California.
3. Copy of valid, current DEA.
4. Copy of valid, current board certificate or letter from the certifying board announcing certification.
5. Copy of valid, current malpractice face sheet that includes coverage limits and expiration date.

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6. Copy of ECFMG certificate.

INFORMATION FROM DESIGNATED ORGANIZATIONS

Information received from designated organizations will be no more than 180 days old at the time of Credentialing Committee review and decision.

National Practitioner Data Bank/ Healthcare Integrity and Protection Data Bank (NPDB/HIPDB):

To receive information on claims that have resulted in settlements or judgments, the National Practitioner Data Bank will be queried. To receive information on healthcare practitioners, providers and suppliers regarding criminal convictions, civil judgments, exclusion from Government healthcare programs, State and Federal licensure actions, as well as other adjudicated actions.

State Board Queries:

To receive information regarding past or present state sanctions and restrictions on licensure and/or limitations on scope of practice, the following queries will be made to obtain information during the most recent five (5)-year period:

1. Physicians (MD's and DO's): National Practitioner Data Bank.
2. DC's: State Board of Chiropractic Examiners, NPDB/HIPDB or Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
3. DDS's: State Board of Dental Examiners, NPDB/HIPDB.
4. DPM's: State Board of Podiatric Examiners, NPDB/HIPDB or Federation of Podiatric Medical Boards.
5. Non-physician Healthcare Professionals: Appropriate state agency, HIPDM or state board of licensure or certification.

Medicare Opt-Out Report:

To determine if the practitioner has opted out (excluded) of Medicare or on Medicare sanctions. The latest report from Medicare will be checked.

Medi-Cal Provider Suspended and Ineligible List:

To determine if the practitioner is excluded or ineligible from the state Medi-Cal program. The latest report from Medi-Cal will be checked. Reports of disciplinary actions and their outcomes, NPDB reports of malpractice settlements, HIPDB adverse actions, 805 reports, and MBOC accusation or adverse action reports will be filed in a separate confidential Peer Review file in the Credentialing Department. These documents are protected by law and will not be reproduced or distributed. Proof of queries will be kept in the credentialing file.

Office Site Review for Complaints:

HPN has established performance standards and thresholds for a Practitioner's Office regarding the physical accessibility, the physical appearance, the adequacy of waiting and examining room space and adequacy of medical/treatment record keeping.

Complaints regarding physical accessibility, physical appearance and adequacy of waiting-and-examining room space and adequacy of equipment will be brought forth to the Credentialing Committee to determine the severity of the complaint and if a site visit is warranted. If the Committee deems that a site visit is required, the visit will be performed within 60 days of the receipt of the complaint. Complaints regarding the adequacy of equipment warrant an automatic site visit. The office will be surveyed according to that corresponding section in the Office and Facility Survey with Corrective Action Plan Tool (See Attachment B).

If a deficiency is found, a corrective action plan for improvement will be required for all items that do not meet thresholds. Follow-up of those identified deficiencies will take place at least every six months until deficiencies are resolved, which may include a re-evaluation of the site. The follow-up actions and practitioner responses will be documented in the practitioner's credentialing file.

Scoring:

The office site review initiated via a complaint and medical record review are evaluated against set standards and thresholds set forth by HPN, and will be based on a point system, indicating percentage of compliance. The office site and medical record review are scored together and totaled according to the following guidelines:

Approved:	100%
Corrective Action Plan:	≤ 99%

All complaints triggering a site visit will be captured on the Office and Facility Survey with Corrective Action Plan Tool and reviewed by the Credentialing Committee annually. (See Attachment "B").

If another complaint about the same office site is received within one year, regarding the same office-site criteria standard, a follow-up site visit will be conducted within 60 calendar days but only those elements will be reviewed. If another complaint is received regarding a different office-site criteria standard, then another site visit will be performed within 60 calendar days. Member complaints will be monitored for all practitioner sites at least every six months. When appropriate, complaints will be forwarded to the applicable health plan upon receipt.

RECREREDENTIALING CRITERIA

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

Exceptions:

If HPN cannot recredential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave, or a sabbatical, but the contract between HPN and the practitioner remains in place, HPN may recredential the practitioner upon his or her return. HPN must document the reason for the delay in the practitioner's file.

If a practitioner is given administrative termination for reasons beyond HPN's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, HPN may recredential the practitioner as long as it provides documentation that the practitioner was termed for reasons beyond its control and was recredentialled and reinstated within 30 calendar days of termination. HPN must initially recredential the practitioner if reinstatement is more than 30 calendar days after termination.

RECREREDENTIALING APPLICATION

Acceptable Applications include: California Participating Physician Recredentialing Application (CPPR); or CAQH Online Credentialing Application Database Service.

Applicant Attestation: Verification Time Limit - 180 calendar days

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The recredentialing application includes a current and signed attestation by the applicant and addresses the following:

1. Reasons for any inability to perform the essential functions of the positions, with or without accommodation.
2. Lack of present illegal drug use.
3. History of loss of license and/or felony convictions.
4. History of loss or limitation of privileges or disciplinary action.
5. Current malpractice insurance and amount of coverage.
6. Correctness and completeness of application.

Supporting Documentation:

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

1. Copy of valid, current professional licensure issued by the State of California.
2. Copy of valid, current DEA.
3. Copy of valid, current board certificate or letter from the certifying board announcing certification.
4. Copy of valid, current malpractice face sheet that includes coverage limits and expiration date.

NONDISCRIMINATORY CREDENTIALING/RECREREDENTIALING

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

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

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

COMMUNICATION OF COMMITTEE ACTION

The practitioner will be notified in writing within sixty (60) calendar days of the Credentialing Committee's decision. A copy of the written correspondence will be kept in the credentialing file. Documentation of adverse decisions will be kept in a file.

PRACTITIONER TERMINATION AND REINSTATEMENT

If a practitioner receives an adverse decision which entitles the practitioner to a hearing, then that practitioner shall not be eligible to reapply until one (1) year after the adverse decision is final and the practitioner has exhausted all applicable hearing rights. If a practitioner terminates and later wishes to rejoin, the practitioner must undergo the initial credentialing process if the break in service is greater than 30 days. The credentials of the practitioner will be re-verified following the same guidelines as described in the Initial Credentialing Procedure and Credentialing Committee Review and Action. It is not required to re-verify credentials that do not expire, such as, completion of education and training and board certification that is not time-limited.

ONGOING MONITORING

The following Boards are monitored on a regular basis for any adverse actions. Reported practitioners are immediately brought to the attention of the Medical Director to address issues of continued practitioner participation and payment of Medicare/Medicaid claims.

Medical Board of California (MBOC) Disciplinary Notifications:

1. Osteopathic Medical Board of California Enforcement Actions
2. Board of Podiatric Medicine Disciplinary Actions
3. Board of Behavioral Sciences Enforcement Actions
4. Board of Psychology Enforcement Actions
5. California Board of Chiropractic Examiners Disciplinary Actions
6. Acupuncture Board Disciplinary Actions
7. Dental Board of California Disciplinary Actions
8. Board of Occupational Therapy Disciplinary Actions
9. California Board of Optometry Enforcement Actions
10. Physical Therapy Board of California Enforcement and Disciplinary Actions
11. Physician Assistant Committee Enforcement Actions
12. California Board of Registered Nursing Enforcement Actions (Nursys)
13. Speech-Language, Pathology and Audiology Board Disciplinary Actions

MEDICARE/MEDICAID SANCTIONS AND EXCLUSIONS

HPN will only contract with/or employ practitioners who are not excluded from or are not sanctioned by Medicare/Medicaid. The Department of Health and Human Services, Officer of Inspector General database is reviewed to identify participating practitioners who have been sanctioned or excluded from Medicare/Medicaid programs.

MEDICARE OPT-OUT REPORT

HPN will only contract with/or employ practitioners who have not opted-out from Medicare or have not been excluded/sanctioned from participation in Medicare. The Medicare Opt-Out Provider Reports for Northern and Southern California are reviewed to identify participating practitioners who have opted out to provide services to Medicare recipients.

MEDI-CAL SUSPENDED OR INELIGIBLE PROVIDERS REPORT

HPN will only contract with/or employ physicians who have not been suspended or terminated from Medi-Cal. The Medi-Cal Suspended and Ineligible Provider are reviewed to identify participating practitioners who have been terminated or suspended from Medi-Cal.

HIV/AIDS SPECIALIST IDENTIFICATION (AB2168)

An "HIV/AIDS specialist" is a practitioner who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following criteria:

1. Member of the American Academy of HIV Medicine.
2. Board certified in Infectious Disease and in the past 12 months has clinically managed at least 25 HIV patients and completed 15 hours of category I CME in HIV medicine, five hours of which was related to antiretroviral therapy.
3. In the past 24 months, has provided clinical management to 20 HIV patients and in the past 12 months has completed board certification in Infectious Disease.
4. In the past 24 months, has provided clinical management to 20 HIV patients and in the past 12

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months has completed 30 hours of category 1 CME in HIV medicine.

5. In the past 24 months, has clinically managed at least 20 HIV patients and in the past 12 months has completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of the HIV Medicine.

HPN Groups will review the current and previous year's lists and send a letter to these practitioners to identify or reconfirm if he/she meets the HIV/AIDS specialist definition. If the practitioner wishes to be designated as an HIV/AIDS specialist, he/she will attest to the best of their knowledge that they can provide documentation to support their qualifications.

ALTERING CONDITIONS OF PRACTITIONER PARTICIPATION & APPEAL RIGHTS

Please refer to the Corrective Action Plan and Judicial Review Hearing Plan.

PRACTITIONER CORRECTIVE ACTIONS

PURPOSE

To provide a fair and efficient means to identify, investigate, and resolve problems arising from the conduct of a practitioner who falls within the Scope of Authorization and Action that may adversely affect patient care or the operations of HPN Medical Groups.

POLICY

An investigation or corrective action may be requested when a practitioner engages in or exhibits acts, statements, demeanor, or professional conduct, either within or outside of the workplace, reasonably likely to be detrimental to patient safety or the delivery of quality patient care and reasonably likely to result in the imposition of sanctions by any governmental authority (local, state or federal).

CORRECTIVE ACTION PROCEDURE

A proposed investigation or corrective action will be initiated by HPN on its own initiative or by a written request, which identifies the specific activities or conduct that are alleged to constitute grounds for proposing an investigation or corrective action.

Preliminary Review:

Prior to investigation, HPN may, but is not obligated to, conduct a preliminary review of any allegation made in support of a request for an investigation or corrective action.

Practitioner Interview:

The practitioner, although not required, may be granted an interview. If any interview is granted, the practitioner will be informed of the general circumstances and may present any relevant information. Discussions and findings resulting from the interview will be documented. Interviews will not be constituted or deemed an "investigation" or "hearing". Following the interview, HPN may choose to proceed with the investigative process.

Investigation:

The Medical Director will identify members to participate in a committee or ad hoc committee to investigate the alleged issue or problem. The Chairperson of the assigned committee will prepare a written report as soon as feasible. No investigative process will be constituted or deemed a "hearing", as described in the Judicial Review Hearing Plan. The investigative process may be terminated at any time to proceed with action as described in Section 6.5.

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Action:

At the conclusion of the investigative process, but not more than sixty (60) days after receipt of the proposed investigation or corrective action, unless deferred pursuant to this policy, such action may include, without limitation, the following:

1. No corrective action
2. Rejection or modification of the proposed corrective action
3. Letter of admonition, reprimand, or warning
4. Terms of probation or individual requirements of consultation
5. Limitation of privileges
6. Suspension of privileges until completion of specific conditions or requirements
7. Revocation of privileges
8. Other action appropriate to the facts which prompted the investigation

Nothing set forth herein shall prohibit HPN from implementing summary suspension at any time, in the exercise of its discretion.

Deferral of Action:

If additional time is needed to complete the investigation process, the action may be deferred. Action must be taken within the deferred time specified, or if no time specified, within thirty (30) days of the deferral.

Procedural Rights:

Any action that constitutes grounds for a hearing will entitle the practitioner to procedural rights as provided in the Judicial Review Hearing Plan. When this is the case, the practitioner will be notified in writing of the adverse action and his/her rights to request a hearing.

SUMMARY AND AUTOMATIC SUSPENSIONS

Whenever a practitioner's conduct requires immediate action to reduce a substantial likelihood of imminent impairment of health or safety of any patient, prospective patient, employee, or other person, the Medical Director and at least two (2) other voting Credentialing Committee members shall have the authority to summarily suspend all or any portion of the practitioner's privileges.

Such summary suspension becomes effective immediately upon imposition, and the person responsible will promptly give verbal or written notice of the suspension to the practitioner. The notice of suspension will constitute a request for corrective action and the Corrective Action Procedure will be followed. Any patients whose treatment by the practitioner is terminated by the summary suspension will be assigned to another practitioner to be determined by the Medical Director.

Professional Licensure:

Revocation or Expiration: Automatic and immediate termination of privileges will occur upon revocation or expiration of a practitioner's license by a licensing authority, which will remain effective for the term of revocation or expiration.

Restriction: Automatic and immediate limitations and restrictions will be placed upon a practitioner's privileges within the scope of limitations or restrictions by a licensing authority, which will remain in effect for at least the term of revocation or expiration.

Suspension: Automatic and immediate suspension of privileges will occur upon suspension of a practitioner's licensure by a licensing authority, which will remain in effect for at least the term of suspension.

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Probation: A practitioner's privileges will be modified, as necessary, to comply with the terms and conditions of probation by a licensing authority. Modifications will remain in effect for the term of probation.

Drug Enforcement Administration Certificate:

Revocation or Expiration: Automatic and immediate revocation of a practitioner's right to prescribe medication will occur upon revocation of a practitioner's DEA certification, which will remain in effect for at least the term of revocation or expiration.

Restriction: Automatic and immediate suspension of a practitioner's right to prescribe medication will occur upon suspension of a practitioner's DEA certificate, which will remain in effect at least for the term of suspension.

Probation: A practitioner's right to prescribe medications covered by the DEA certification will be modified as necessary, to comply with the terms and conditions of probation. Modifications will remain in effect at least for the term of probation.

Failure to Satisfy Special Appearance Requirements:

A practitioner who fails, without good cause, to appear and to satisfy the requirements of a special appearance, of which that practitioner had notice, will automatically be suspended from exercising all or such portion of his/her privileges until he/she appears and satisfies the requirement of that special appearance.

Further Investigation and Action:

After automatic suspension, consideration of facts surrounding the automatic suspension will be reviewed and considered, which could initiate an investigation and/or further corrective action.

Procedural Rights:

Unless the suspension is terminated, it will remain in effect during the pendency and completion of the corrective action process of the hearing process. The practitioner will not be entitled to procedural rights as provided in the Judicial Review Hearing Plan until final action, and then only if the final action taken constitutes grounds for a hearing as set forth in the Judicial Review Hearing Plan.

Reinstatement of Privileges:

A practitioner who has been subject to suspension or restriction will not be automatically reinstated to his/her status and/or privileges, even if the event which gave rise to the automatic suspension is cured. Instead, the practitioner must submit a written request for reinstatement along with a completed application. The practitioner will bear the burden of producing clear and convincing evidence of his/her qualifications.

REPORTING REQUIREMENTS

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

Medical Board of California (MBOC):

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

Termination or Revoked Privileges: A practitioner's status is terminated or revoked for medical disciplinary

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cause or reason, fraud, or in the case of imminent harm to the member.

Timeframe: An 805 report will be filed within fifteen (15) days after conclusion of all proceedings.

Restrictions on Privileges: Restriction on privileges are imposed, or voluntarily accepted for a cumulative total of thirty (30) days or more for any 12-month period for a medical disciplinary cause or reason.

Timeframe: An 805 report will be filed within fifteen (15) days after conclusion of all proceedings.

Resignation or Leave of Absence: The practitioner resigns or takes a leave of absence following notice of an impending investigation based on information indicating a medical disciplinary cause or reason.

Timeframe: An 805 report will be filed within fifteen (15) days after the effective date.

Summary Suspension: A summary suspension remains in effect in excess of fourteen (14) days.

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

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

Diversion Report: A report will be filed with the Diversion Program of the MBOC when formal investigation of a practitioner's ability to practice safely due to a disabling mental or physical condition may pose a threat to patient care.

Timeframe: A diversion report will be filed within fifteen (15) days of initiating the formal investigation. No hearing rights will be afforded prior to filing this report. A follow-up report will be filed when the investigation is completed.

805.01 Reporting Requirement

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

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

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

National Practitioner Data Bank

Professional Competence or Conduct: An action based on a practitioner's professional competence or conduct that adversely affects or could affect the health or welfare of a patient and remains in effect for

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more than thirty (30) days.

Timeframe: A NPDB report will be filed within fifteen (15) days from the date the adverse action was imposed.

Surrender or Restriction of Authority While Under Investigation: Acceptance of the practitioner's surrender or restriction of authority to provide care to patients while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting an investigation or professional review action.

Timeframe: A NPDB report will be filed within fifteen (15) days from the date the adverse action was imposed or authority to provide care to patients is voluntarily surrendered.

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

Healthcare Integrity and Protection Data Bank

Civil Judgments: Civil judgments related to the delivery of a health care item or service (except those resulting from medical malpractice).

Timeframe:

1. Within thirty (30) days from the date the final adverse action was taken.
2. Within thirty (30) days of the date HPN became aware of the final adverse action.
3. By the close of the next monthly reporting cycle.

Adjudicated Actions or Decisions: Adjudicated actions or decisions related to delivery of a health care item or service taken against a health care practitioner, (excluding clinical privileging actions). Other adjudicated actions or decisions that are formal or official final actions that:

1. Are taken against a health care practitioner by a Federal or State Government Agency or a Health Plan.
2. Include the existence of a due process mechanism.
3. Are based on acts or omissions that affect or could affect the delivery or payment of a health care item or service.

Timeframe:

1. Within thirty (30) days from the date the final adverse action was taken.
2. Within thirty (30) days of the date HPN became aware of the final adverse action.
3. By the close of the next monthly reporting cycle.

HEALTH PLAN NOTIFICATION

Health Plans will be notified of final adverse actions.

Timeframe: Within fifteen (15) days of the final adverse action.

PRACTITIONER HEARING AND APPEALS RIGHTS PROCESS

GENERAL PURPOSE

To provide intra-professional resolution of matters bearing on professional conduct or competency of any practitioner defined by the Scope of Authorization and Action.

SCOPE OF AUTHORIZATION AND ACTION

Practitioners covered under the Judicial Review Hearing ("Plan") include MDs, DOs, DDSs, DPMs, and DCs. Allied health practitioners and non-physician behavioral health practitioners are not entitled to either information review or hearing rights pursuant to the Judicial Review Hearing Plan.

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POLICY

HPN Medical Groups may deny, terminate, suspend or limit network participation with or without cause; subject to the terms of an executed Provider Services Agreement. When HPN denies, suspends, limits or terminates an Agreement without cause, the affected practitioner will not be entitled to any hearing or review under this Judicial Review Hearing Plan.

When HPN denies, suspends, limits, or terminates any Professional Services Agreement, based on a medical disciplinary cause or reason, the affected practitioner will be entitled to request a hearing (appeal) under this Judicial Review Hearing Plan. For the purpose of this Judicial Review Hearing Plan, the term "medical disciplinary cause or reason" will refer to an aspect of a practitioner's competence or professional conduct, which is reasonably likely to be detrimental to patient safety or to the delivery of patient care. The term "staff privileges" will refer to any arrangement under which a practitioner is allowed to practice or provide care for patients in a health care facility.

GROUNDINGS FOR A HEARING

Any one or more of the following actions or recommended actions will constitute grounds for a formal hearing:

1. A practitioner's application for staff privileges is denied or rejected for a medical disciplinary cause or reason.
2. A practitioner's staff privileges are revoked, terminated, or not renewed for a medical disciplinary cause or reason.
3. Restrictions are imposed on staff privileges for a cumulative total of thirty (30) days or more in any 12-month period for a medical disciplinary cause or reason.
4. The imposition of summary suspension of staff privileges for a medical disciplinary cause or reason, if the summary suspension stays in effect for a period in excess of fourteen (14) days.

HEARING PROCEDURES

Notice of Action or Proposed Action

Whenever there are grounds for a hearing, and such action or proposed action is specifically stated to be for a medical disciplinary cause or reason, the practitioner will be given written notice of the proposed action and of the practitioner's right to request a hearing under the Judicial Review Hearing Plan. (Appeal Rights).

The notice will include:

1. Written notification indicating that a professional review action has been brought against the practitioner including reasons for the action and a summary of the appeal rights and process. (Judicial Review Hearing Plan).
2. That the action, if adopted, must be reported to the Medical Board of California under the Business and Professions Code, Sections 805 or 805.01, and/or the National Practitioner Data Bank under 45 Code of Federal Regulations, Part 60.
3. The practitioner has the right to appeal the action and request a hearing.
4. That the practitioner must request the hearing within thirty (30) days of receipt of the notice and the request must be in writing to the HPN Medical Director.
5. That the practitioner may be represented by an attorney or another person of the practitioner's choice.
6. That a Hearing Officer or a panel of individuals will be appointed by the HPN groups to review the appeal.
7. That the practitioner will be provided a written notification of the appeal decision that contains the specific reasons for the decision.
8. That the decision of the Judicial Hearing Committee may be more or less stringent and/or restrictive

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than the proposed corrective action.

9. That both the action and decision must be reported to the Medical Board of California under the Business and Professions Code, Sections 805 or 805.01 and the National Practitioner Data Bank under 45 Code of Federal Regulations, Part 60 and the health plans.

Practitioner Right to Appeal & Request for a Hearing

There is an appeals process for instances in which HPN chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service. The practitioner will be provided their appeal rights and will have thirty (30) days following the date of receipt of a notice of an adverse action to submit a written request for a hearing to the Medical Director of the HPN Medical Group. If the practitioner does not request a hearing within the timeframe and in the manner described, the practitioner will be deemed to have accepted the recommendation, decision, or action involved and it may be adopted as the final action.

Time and Place

Upon receipt of the practitioner's written request for a hearing, HPN will promptly schedule and arrange for the hearing. The practitioner will be notified of the time, place, and date of the hearing. The date of commencement of the hearing will not be less than thirty (30) days and not more than sixty (60) days from receipt of the request for the hearing.

Notice of Charges and Witnesses

A notice of the charge(s) will be sent to the practitioner, either along with the notice of the hearing or separately, specifying the acts or omissions with which the practitioner is being charged. This supplemental notice will provide a list of the patient records, if any, which are to be discussed at the hearing, only if the information has not been supplied previously.

Upon the request of either party, each party, at least ten (10) days prior to the hearing, will furnish to the other a written list of names and addresses of individuals, reasonably known or anticipated, who will give testimony or evidence in support of that party at the hearing. The witness list will be amended when additional witnesses are identified. A failure to comply with this requirement is good cause to postpone the hearing.

Judicial Hearing Committee

The Medical Director will appoint a Judicial Hearing Committee consisting of at least three (3) participating HPN practitioners who are eligible for voting rights on medical interpretation and peer review activities and have the requisite expertise to ensure an efficacious and fair hearing. The majority of members of the Hearing Panel will be peers of the affected physician. The Medical Director will chair the Judicial Hearing Committee and handle all pre-hearing matters. The hearing panel members will be impartial, will not have actively participated in the formal consideration of the matter at any previous level (i.e., acted as accuser, investigator, fact finder or initial decision-maker in the same manner), will not be in direct economic competition with the affected practitioner, and will stand to gain no direct financial benefit from the outcome of the hearing.

Hearing Officer

HPN will appoint a Hearing Officer to attend the hearing. The Hearing Officer will be an attorney at law, who is qualified to preside over a formal professional peer review hearing. He/she will not be bias for or against the practitioner, will gain no financial benefit from the outcome, and must not act as a prosecuting officer or an advocate for any party. The Hearing Officer may participate in deliberations and act as a legal advisor to the Judicial Hearing Committee, but will not be entitled to vote.

Presiding Officer

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The Presiding Officer at the hearing will be the Hearing Officer as described above. The Presiding Officer will act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence in an efficient and expeditious manner. The Presiding Officer will assure proper decorum is maintained, and if either party is not proceeding as described, the Presiding Officer may take such discretionary action as seems warranted by the circumstances. The Presiding Officer will be entitled to determine the order of or procedure for, presenting evidence and argument during the hearing and will have the discretion, in accordance with the Judicial Review Hearing Plan provisions, to do the following:

1. Grant continuances.
2. Rule on disputed discovery requests.
3. Decide when evidence may or may not be introduced.
4. Rule on challenges to hearing committee members.
5. Rule on challenges to him/her serving as the Hearing Officer.
6. Rule on questions raised prior to or during the hearing pertaining to matters of law, procedure, or the admissibility of evidence.
7. Exercise discretion in formulating additional procedures not consistent with these hearing policies and procedures that are deemed reasonably necessary to affect an expeditious and efficient fair hearing.

Pre-Hearing Procedure

It will be the duty of HPN and the affected practitioner to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural irregularity as far in advance of the scheduled hearing as possible, in order for decisions concerning such matters can be made expeditiously. Objection to any such pre-hearing decisions shall be raised at the hearing, and when so raised, reflected on the record.

DISCOVERY

Rights of Discovery and Copying - The affected practitioner may inspect and copy (at his/her own expense) any documentary information relevant to the charges that HPN has in its possession or under its control. HPN or its representative may inspect and copy (at its expense) any documentary information relevant to the charges that the affected practitioner has in his/her possession or under his/her control. The right of inspection and copying does not create or imply an obligation to modify or create documents in order to satisfy a request for information. Requests for discovery must be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing will be good cause for a continuance of the hearing.

Limits on Discovery - The Presiding Officer, upon the request of either side, may impose safeguards including, but not limited to, denial of discovery request on any of the following grounds:

1. The information refers solely to individually identifiable practitioners other than the affected practitioner.
2. The safeguard is warranted to protect peer review.
3. The safeguard is warranted to protect justice.

Discovery Disputes - In ruling on discovery disputes, the factors that may be considered include:

1. Whether the information sought may be introduced to support or defend the charges.
2. Whether the information is "exculpatory" in that it would dispute or cause doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendations.
3. The burden on the party of producing the requested information.
4. What other discovery requests the party has previously made.

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Pre-Hearing Document Exchange:

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents will be made available at least thirty (30) days prior to the hearing. Failure to comply with this rule is good cause for the Presiding Officer to grant a continuance. Repeated failure to comply is good cause for the Presiding Officer to limit introduction of any documents not provided to the other side in a timely manner.

Representation:

Both HPN and the practitioner have the right to be represented by an attorney or other representative; however in no case may an attorney represent HPN if the practitioner is not otherwise represented. The foregoing will not deprive either party of their right to legal counsel for the purpose of preparing for the hearing.

Failure to Appear:

Failure without good cause of a practitioner to appear and proceed at the hearing will be deemed to constitute voluntary acceptance of the recommendation or action involved, and it will become the final action of HPN.

Postponements and Extensions:

Postponements and extensions beyond the times expressly permitted in the Judicial Review Hearing Plan may be requested by any affected person and will be permitted by the Presiding Officer on a showing of good cause. The presiding Officer will ensure that hearing proceedings are conducted in a reasonably expeditious manner under the circumstances.

Record of the Hearing:

The Judicial Hearing Committee will maintain a record of the hearing by using a Certified Transcription Reporter to record the hearing or tape record the proceedings. The practitioner will be entitled to receive a copy of the transcript or recording upon paying reasonable costs for preparing the record. The Presiding Officer may, but is not required to, order that oral evidence be taken only on an oath, administered by a person entitled to notarize documents in the State of California or by affirmation under penalty of perjury to the Presiding Officer that the testimony that he/she is about to give is true and correct.

Rights of Parties

Both parties have the following hearing rights to:

1. Ask the Judicial Hearing Committee members and/or the Presiding Officer questions that are directly related to determining whether they meet the qualifications set forth in this Judicial Review Hearing Plan and to challenge such members or the Presiding Officer.
2. Call and examine witnesses.
3. Introduce relevant documents and other evidence.
4. Receive all information made available to the Judicial Hearing Committee.
5. Cross-examine or otherwise attempt to impeach any witness who testified orally or on any matter relevant to the issues.
6. Rebut any evidence.
7. Submit a written statement at the close of the hearing, which the Judicial Hearing Committee may request be filed following the conclusion of the presentation of oral testimony.

Additional Hearing Rights:

1. The practitioner may be called by HPN and examined, as if under cross-examination.
2. The Judicial Hearing Committee may interrogate witnesses or call additional witnesses if deemed

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appropriate.

Rules of Evidence

Rules of law relating to the examination of witnesses and presentation of evidence in courts of law will not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, will be admitted by the Presiding Officer if it is the sort of evidence that responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

If the charges and recommendations are actions imposed by the Credentialing Committee as a result of a decision based on the initial credentialing process or recredentialing process, HPN may object to the introduction of any evidence that was requested of an applicant, but not provided, during the applicable process. The Presiding Officer will sustain such objections unless the applicant can prove that the information could not have been produced previously in the exercise of reasonable diligence.

BASIS OF DECISION

The decision of the Judicial Hearing Committee will be based on the evidence produced at the hearing and any written statements submitted to the Judicial Hearing Committee. If the Judicial Hearing Committee should find the charges to be true, it will recommend such form of discipline as it finds warranted. The recommended discipline may confirm or be more or less harsh and/or restrictive than that recommended by HPN.

BURDEN OF GOING FORWARD AND BURDEN OF PROOF

Initial Burden – In all cases, HPN will have the burden of initially presenting evidence to support the charges and its recommendation. Thereafter, the burden differs; depending upon whether the practitioner is applying for a Professional Services Agreement or already has a Professional Services Agreement.

Denial of Initial Agreement – At any hearing involving denial of an initial Professional Services Agreement, the practitioner has the burden of proving by a preponderance of the evidence (i.e., more likely than not) that he/she is qualified for an Agreement in accordance with the eligibility standards of HPN. The practitioner must produce information that allows for an adequate evaluation and resolution of any reasonable doubts concerning his/her current qualifications, subject to HPN's right to object to the production of certain evidence pursuant to the Rules of Evidence listed above.

Termination of Agreement or Suspension, Reduction or Limitation of Privileges – In all other cases involving a practitioner who already has a Professional Service Agreement, HPN will have the burden of proving by a preponderance of evidence that the action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives available, and not necessarily that the action is the only measure or the best measure that could be taken in the opinion of the Judicial Hearing Committee.

ADJOURNMENT AND CONCLUSION

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. The hearing will be conducted within a reasonable amount of time. The Presiding Officer may set guidelines for introduction of evidence to achieve a timely conclusion. Upon conclusion of the presentation of oral and written evidence and argument, the hearing will be closed. The Judicial Hearing Committee will thereupon conduct its deliberations and render a decision and an accompanying report, outside of the presence of the parties. Final adjournment will not occur until the Judicial Hearing Committee has completed its deliberations.

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DECISION

The Judicial Hearing Committee will render a decision within thirty (30) days of the final adjournment of the hearing. A written report that contains findings of facts and conclusions that articulate the connection between the evidence produced at the hearing and the decision rendered will accompany the decision. The report will include sufficient detail to enable the affected practitioner and HPN to determine the basis for the decision of the Judicial Hearing Committee on each matter contained in the Notice of Charges. The decision and report will be delivered to the affected practitioner and HPN within 15 days of the committee decision. The decision of the Judicial Hearing Committee is the final decision.

REPORTING

All required reports will be filed in accordance with Division 2, Article II, Section 800 of the California Business and Professions Code when there are adverse decisions resulting from the peer review process.

PRIVILEGES AND IMMUNITIES

All activities conducted pursuant to this Judicial Review Hearing Plan are in reliance on the privileges and immunities afforded by the Federal Health Care Quality Improvement Act and applicable laws in the State of California.

UTILIZATION MANAGEMENT

PHILOSOPHY

The philosophy of Heritage Provider Network, Inc. (referred to herein as HPN, Inc.) Utilization Management is to provide continuous quality improvement and appropriate utilization of resources to its members.

UTILIZATION MANAGEMENT STRUCTURE

Heritage Provider Network, Inc. and its affiliates will have the UM infrastructure necessary to:

1. Provide ongoing monitoring and evaluation of delegated medical management activities to address over/under utilization and coordination of medical resources.
2. Support continuum-based case management activities, continuity-of-care.
3. Maintain a systematic process for the education of HPN and its affiliates staff and providers regarding Utilization Management.

The HPN Utilization Management Program is designed to achieve congruence with the following services:

1. Quality Health Care
2. Care Management
3. Utilization Management
4. Efficient and Effective Health Care
5. Resource Management
6. Customer Satisfaction
7. Provider Orientation and Updates Regarding Utilization

HPN Clinical Service's interest is to ensure that systems and resources of the HPN's affiliates can meet the quality of medical care and service demands of its members in a cost effective manner. The HPN Utilization Management Program will be a resource and guide to its affiliates to ensure compliance with regulatory and accreditation agency standards, requirements of HPN Utilization Management Program, and appropriate data collection and reporting to meet the needs of employer accounts, contracted health plans and any other external customers.

HPN CS will distribute the approved UM Program and relevant policies and procedures to its affiliates and they will be responsible for adopting and distributing these documents to their practitioners and contracted providers at least annually to ensure that all are advised of services requiring UM pre-service determinations such as:

1. Ambulatory
2. Inpatient
3. Emergency
4. Skilled Nursing
5. Home Health
6. Hospice
7. Behavioral Health
8. Rehabilitative Services (such as physical, occupational and speech therapies)
9. Pharmaceuticals
10. Medical Equipment and/or Supplies

There are services that do NOT require pre-service determinations such as:

1. Emergency Services
2. Family Planning and Sensitive Services
3. Preventive Services
4. Basic Prenatal Care (in-network)
5. Sexually Transmitted Disease Services
6. HIV Testing/Counseling
7. Language Assistance Program/Interpretation services
8. Health Education

HPN, Inc. and its affiliate providers are not restricted in advocating on behalf of a member or advising a member on medical care. This includes, but is not limited to the risks, benefits, and consequences of treatment or non-treatment; member's right to refuse medical treatment and self-determination in treatment plans.

PROGRAM OVERSIGHT

1. **Governing Body:**

The HPN Executive Committee is the Governing Body that shall have authority and responsibility for the Utilization Management Program. This body shall establish and maintain an effective and efficient UM program. The Executive Committee will ensure that each of its affiliates receives and complies with all aspects of the UM Program. The Executive Committee reviews, evaluates and makes any necessary revisions to the UM Program at least annually.

2. **Utilization Management Committee:**

The Utilization Management Committee (UMC) and any ad-hoc committees or subcommittees of the UMC will report to the Executive Committee. The Utilization Management Committee will meet, at least, quarterly to review, evaluate and provide the Executive Committee with recommendations for revisions to the UM Program.

Minutes and records are kept for all the UM Committee activities for which the UM Committee is responsible. Such materials are considered confidential and are maintained in locked quarters; therefore, are only available to the appropriate staff, as well as contracted full services health plan auditors or designees for annual review or follow up.

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Each attendee, including guests, at each Committee meeting will sign confidentiality and a conflict of interest statement.

The composition of the UM Committee shall include but is not limited to:

- a. Executive Vice President of Clinical Affairs/Plan Medical Director
- b. Medical Directors of each Primary Medical Group
- c. Vice President of Clinical Services
- d. Director of Clinical Services
- e. Director Clinical Operations
- f. Other clinical staff as appropriate, i.e. Behavioral Health Specialist
- g. All HPN, Inc. affiliate's UM VP and/or Directors and/or other UM physicians and staff as appropriate
- h. Additional personnel and technical experts as requested by the UMC or Executive Committee

The UM Committee responsibilities shall include:

- a. Evaluation of its affiliates' capacity to perform UM activities
- b. Review and approval of the UM Program annually
- c. Review regular reports from the affiliates
- d. Evaluate the affiliate's activities to ensure they are being conducted in accordance with HPN's expectations and regulatory standards
- e. Ensuring all member information is confidential and protected from unauthorized dissemination

3. Designated Physician:

HPN, Inc. shall employ or designate a Medical Director who holds an unrestricted license to practice medicine in this State of California issued pursuant to Section 2050 of the Business and Professions Code. The Medical Director is fully credentialed by HPN, Inc. This designated physician is involved in the UM Program development and evaluation; oversees all UM activities; supports the various committees; ensures there are appropriate staff and resources; and, makes recommendations based on various analyzed clinical care and administrative data.

4. Designated Behavioral Health Care Practitioner:

The HPN, Inc. affiliates may contract with, but not delegate UM responsibilities to their respective Behavioral Health (BH) Care Provider Organization. The Medical Director of this contracted Behavioral Health Care Organization shall be a behavioral healthcare physician or a doctoral level behavioral healthcare practitioner who is involved in the behavioral aspects of the UM program development and evaluation. The BH Medical Director is available for assistance with behavioral health UM procedures and processes; complaints; development of behavioral health guidelines; recommendations on service and safety; provide behavioral health UM statistical data; follow-up on identified issues; and, attend the UM Committee Meeting when required.

HPN, INC. AFFILIATE UM DEPARTMENTS

The HPN, Inc. affiliates may employ clinical and non-clinical persons in their UM Departments to process requests for medical services for their respective members. The affiliates shall employ or designate a Medical Director who holds an unrestricted license to practice medicine in the State of California to provide primary oversight of their UM Department. The UM staff may consist of licensed physician reviewers, licensed nurse reviewers and non-clinical support staff. Each affiliate will maintain a current department organizational chart identifying all key UM positions, decision makers and department/staff oversight.

PROGRAM SCOPE AND PURPOSE

1. Utilization Review Program Responsibilities:

HPN, Inc. will provide each affiliate the policies and procedures that are needed to support UM decisions. HPN, Inc.'s policies and procedures meet all California Health and Safety codes and regulations. All HPN, Inc. affiliates' Medical Directors will ensure that these policies and procedures are reviewed and adopted by their respective UM Committees and that all clinical and non-clinical staff responsible for UM activities are educated on the most current policies and procedures. Medical decisions are to be made by credentialed, qualified medical providers, unhindered by fiscal and administrative management using objective criteria based on medical evidence. Consistent with HPN, Inc.'s approved policies and procedures and utilizing evidence of coverage and benefit limitations as well as approved clinical criterion, medical review guidelines and policies in accordance with all state and federal regulation, the following will occur:

- a. A senior licensed physician will supervise all UM staff responsible for making UM determinations.
- b. Licensed physician reviewers may approve or deny any services based on benefit coverage and medical necessity.
- c. Licensed nurse reviewers may approve any services, deny benefit driven services and provide recommendations to physician reviewers for medical necessity denials.
- d. Non-clinical staff may verify benefit coverage, retrieve information necessary for clinical review, approve limited services and deny benefit driven services as assigned.
- e. The affiliate Medical Director will be responsible for all final decisions to deny any and all services based on medical necessity.
- f. Determinations of coverage and medical necessity for behavioral health services will include involvement of a behavioral health practitioner.
- g. The HPN, Inc. affiliates and their staff may utilize contracted health care professionals and specialists to assist with clinical reviews and/or recommendations but may not delegate or sub-delegate UM activities to any other entity.
- h. The clinical information used to make UM determinations may include, but is not limited to, the following:
 - I. Office and hospital records
 - II. A history of the presenting problem
 - III. A clinical exam
 - IV. Diagnostic testing results
 - V. Treatment plans and progress notes
 - VI. Patient psychosocial history
 - VII. Information on consultations with the treating practitioner
 - VIII. Evaluations from other health care practitioners and providers
 - IX. Photographs
 - X. Operative and pathological reports
 - XI. Rehabilitation evaluations
 - XII. A printed copy of criteria related to the request
 - XIII. Information regarding benefits for services or procedures
 - XIV. Information regarding the local delivery system
 - XV. Patient characteristics and information
 - XVI. Information from responsible family members

The affiliate may not rescind or modify an approved service authorization after the provider renders the health care service in good faith for any reason, including, but not limited to, subsequent rescissions, cancellations or modification of the member's contract or when the affiliate did not

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originally make an accurate determination of the member's eligibility. All UM information must be kept on file for at least 36 months.

2. Program Goals and Objectives:

The UM Program will be implemented by all HPN, Inc. affiliates as directed by the HPN Utilization Management Committee. The goal of the Utilization Management Program is to ensure that HPN, Inc. affiliate's practitioners provide quality care in the most cost-effective manner.

3. Objectives:

- a. To evaluate the utilization of services, member benefits and resources related to the provision of care by reviewing requests for services prior to authorization, conducting concurrent review, discharge planning, retrospective review, and case management.
- b. To ensure that all members receiving inpatient and skilled nursing facility care will have a completed continuity-of-care plan developed prior to discharge to a lower level of care.
- c. To encourage effective, efficient use of services and resources through communication and education of employees, providers, patients, and their families.
- d. To ensure all practitioners and UM reviewers have access to and are using the most current criteria, guidelines and policies as approved by the HPN UM Committee.
- e. To develop systems to ensure that criteria and reviewer decisions are applied consistently and that services delivered are medically necessary and consistent with the patient's diagnosis and level of care required.
- f. To monitor and improve the coordination of medical and behavioral health care.
- g. To target and case manage patients with complex health care needs across the continuum of community and facility-based services to ensure that the goals of health, promotion, risk reduction, and the prevention of illness complications are met.
- h. To communicate and interact effectively with the primary care physicians, specialists and other contracted services through committee meetings, newsletters, verbal correspondences and education forums.
- i. To work in conjunction with the Quality Improvement Council on reviewing those issues which require quality oversight or review.
- j. To develop Corrective Action Plans, when deficiencies or issues are identified, to improve practice or system issues.
- k. To work with contracted health plans in disseminating information related to their Language Assistance Programs (LAP) for Limited English Proficient (LEP) Enrollees, where appropriate.
- l. To identify utilization issues and problems and use the Continuous Quality Improvement process to develop interventions to the UM process.
- m. To ensure there is a process by which members and practitioners are informed of their rights and how to appeal a determination.

UM Program achievements will be measured by the UM Committee through the evaluation of UM work plans, annual program evaluation and other utilization activity reports.

4. Review and Monitoring of Activities:

The HPN UM Committee will routinely review and monitor the services that are provided by the affiliates including, but not limited to:

- a. Prospective Hospitalizations Review:
 - I. Necessity of admission according to review criteria.
 - II. Appropriateness of workup on all elective cases - Medical Director or designee.
 - III. Assigns a specific number of days - Case Manager or designee using proprietary criteria as a guideline.

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- IV. Completes written authorization process.
- V. Automatic authorizations are approved according to the UM Policy and Procedure Manual.
- VI. Prospective review is accomplished daily by the Medical Director or designee.
- VII. Prospective review of psychiatric and substance abuse admissions are conducted daily by the Medical Director and/or designee with involvement of behavioral health professional(s).
- VIII. Referral to a Psychiatric Assessment Team (PAT) team/disease management, when appropriate.

b. Concurrent Hospital Review:

- I. Performed daily by Case Managers in the acute hospital setting or telephonically.
- II. Concurrent review of psychiatric and substance abuse admissions are conducted daily by Case Managers and/or designee with involvement of behavioral health professional(s).
- III. Case Managers, Social Services designees, Discharge Planners, Inpatient Physicians, and Medical Director will review the member's stay daily to determine medical necessity of continued stay, level of care, intensity of service, diagnostic studies, treatment plans, and the quality of care being rendered.
- IV. Referral to outpatient case management or disease management programs, when appropriate.
- V. Documentation of the inpatient case review will be maintained in the member's file.
- VI. For affiliates that perform onsite reviews, there is a written policy or procedure in place, which guides identification of the onsite provider groups' staff, scheduling of onsite visits, and awareness of facility rules.
- VII. Care shall not be discontinued until the member's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

c. Retrospective Review – Hospitalizations:

- I. Appropriateness of admission and disposition of discharge
- II. Severity of Illness and Intensity of service
- III. Patient outcome
- IV. Proper documentation
- V. Complications of patient care
- VI. Appropriateness of the length of stay
- VII. Delays of service

d. Emergency Room/Ambulance Service:

Services necessary to screen, stabilize and transport members without preauthorization of emergency services in cases where a prudent layperson, acting reasonably would have believed that an emergency medical condition exists will be covered.

Retrospective claims, primarily consisting of emergency room/ambulance services, are reviewed only in an effort to track utilization criteria for improved patient care and/or PCP availability to patient population.

5. **Post Stabilization Transfer:**

Prior authorization for post stabilization services is required. No person needing emergency services and care may be transferred for any non-medical reason unless certain conditions are met, including,

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but not limited to a provision that the person is examined and evaluated by a physician and/or surgeon prior to transfer. A patient is considered stabilized when, in the opinion of the treating provider, the patient's medical condition is such that within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient.

6. Prospective and Retrospective Review - Outpatient Services

All prospective and retrospective referrals will be reviewed by the Medical Director or designee for:

- a. Medical indication for referral.
- b. Specific number of visits or services specified on the form.
- c. Sufficient clinical information is documented so that the consulting provider has all known significant information relating to the requested services.
- d. Correct coding – level of care.
- e. Contractual Arrangements.

7. Out of Network/Non-Contracted Provider Referrals:

Contracted providers will be utilized whenever possible. If a contracted provider is not available, then a referral for an out of network or non-contracted provider will be reviewed for medical necessity by the Medical Director or designee. For services determined to be medically necessary and not available in network, a Letter of Agreement (LOA) will be generated prior to the patient's visit by the affiliate's designated staff. All out of network or non-contracted provider referrals will be reviewed by the Medical Director or designee.

8. Home Health Agency Care:

When a patient is referred for Home Health services, the attending physician must order the referral for evaluation and then approve the treatment plan submitted by the Home Health agency. The treatment plan must be approved by the Utilization Management Department or designee. If there are any questions regarding approval, the Medical Director will be consulted. Continued home health care must be concurrently approved by the Utilization Management Department, Case Manager or designee.

9. Urgent Care Review:

When a member uses an Urgent Care, the Urgent Care encounter forms will be submitted to the Claims or Finance Department(s). The respective department(s) will routinely collate and analyze the urgent care services, e.g., Volume and Peer Review of Urgent Care records. This analysis will be sent, as appropriate, to either the Utilization Management Committee or Quality Management Committee for review.

10. Behavioral Health Care Review:

The HPN, Inc. affiliate will contract with Behavioral Health Care Provider Organizations to provide behavioral health services for their members.

HPN, Inc. requires that:

- a. The designated behavioral healthcare practitioner will:
- b. Be involved in the implementation of the behavioral healthcare aspects of the UM program and policy development.
- c. Participate in UM Committee meetings.
- d. Review behavioral health UM cases as needed.

11. Second Opinions:

Member's request for a second opinion from a qualified health care professional will be covered at no cost (with the exception of standard copays and deductibles) to the Member.

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The affiliates will not deny a member's request for a second opinion with a contracted, qualified health professional. Requests for second opinions by a non-contracted provider will be reviewed for availability of a contracted qualified health professional prior to referral to the contracted health plan for consideration.

12. Over and Under-Utilization Review of Services:

The HPN, Inc. affiliate UM Committee will regularly monitor utilization data of high volume care (i.e., specialists, outpatient services, inpatient hospital care and skilled nursing facility care) to detect potential adverse utilization patterns (practice-specific and/or provider-specific) and/or other barriers to the authorization process.

Corrective action and/or other appropriate intervention will be implemented based on the Committee's findings. The Committee will allow sufficient time to elapse prior to evaluating effectiveness of the corrective action(s). Comparisons will be made with the previous findings.

13. Reporting Requirements:

- a. Annual Initial Work Plans – The HPN, Inc. affiliates will complete and submit an annual initial work plan to the UMC by January 15th of each New Year. The annual work plan is to include:
 - I. Utilization Management goals and objectives, program scope, areas of program focus and the specific utilization related activities and studies that are to occur.
 - II. Planned monitoring of utilization data, including tracking statistics over time.
 - III. Planned annual evaluation of the Utilization Management program.
 - IV. Action steps include target date for completion and responsible party.
- b. Quarterly Work Plan Evaluations - The HPN, Inc. affiliates will update and submit a quarterly work plan to the UMC. Based on regulatory and plan contracting requirements, quarterly work plan evaluations are due to the UMC by April 15th, July 15th and October 15th unless otherwise noted. Quarterly work plan updates must include:
 - I. Utilization management activities completed.
 - II. The organization's performance in Utilization Management should be trended.
 - III. An analysis of whether there have been any demonstrated improvements in the utilization management program.
 - IV. A description of how these improvements were meaningful to the organization's population should be included.
- c. Monthly/Quarterly/Semiannual/Annual UM Reports – Based on regulatory and plan contracting requirements all UM reports are due to HPN CS by the 10th of each month (e.g. NOMNC, Part C Reporting, CCS Log, ESRD Log, etc.).
- d. Final Work Plan Evaluation: HPN, Inc. affiliates will complete and submit a final work plan evaluation to the UMC by January 15th of each New Year.

The final assessment will include a full review and analysis of each component as listed on the UM Work Plan and an overall evaluation summary in each section as to the affiliate's attainment to written goals.

CLINICAL CRITERIA FOR UM DECISIONS

The Utilization Management review process uses a wide range of criteria, guidelines, and reference tools to assist in determinations of benefit coverage, behavioral health needs and medical appropriateness.

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Supporting clinical and benefit information, relevant to each particular case will be reviewed when making medical necessity coverage determinations.

HPN, Inc.'s affiliates maintain written policies addressing the application of objective and evidence-based criteria in making UM determinations while taking into account the local delivery system, individual circumstances and the member's needs such as: age, comorbidities, and complications, progress of treatment, psychosocial situation and home environment, when applicable.

1. Review materials include, but are not limited to:
 - a. McKesson® InterQual.
 - b. Milliman® Care Guidelines.
 - c. United States Preventative Services Task Force (USPSTF).
 - d. American Psychiatric Association Guidelines.
 - e. Policy and Procedure Manual(s) from each contracted Health Plan.
 - f. Availability of SNF, sub-acute or Home Care in service area.
 - g. Coverage of benefits which may include SNF, Sub-Acute, or Home Care.
 - h. Availability of local hospitals to provide recommended services within the length of stay (LOS).
 - i. Additional sources of data and information (i.e. literature searches, conversations and/or consultations with appropriate physicians/specialists, review of patient medical records, etc.).
 - j. Quality Screens and outpatient Case Management activities triggered by utilization review.

2. The approved clinical guidelines, criteria or medical policies will be applied as follows:
 - a. Commercial and Medi-Cal Members
 - I. Specific Health Plan Benefit Coverage, Medical Policy or Clinical Guidelines.
 - II. National/Specialty Guidelines (e.g., McKesson InterQual, USPSTF, AHA/ACC, American Imaging Management).
 - III. Medicare Policy (LCD > NCD > other locality's LCD).
 - IV. Evidence-Based Prior Authorization Guidelines (provided by the Medical Group).

 - b. Medicare Advantage Members:
 - I. Medicare Policy (LCD > NCD > other locality's LCD).
 - II. Specific Health Plan Benefit Coverage, Medical Policy or Clinical Guidelines.
 - III. National/Specialty Guidelines (as above).
 - IV. Evidence-Based Prior Authorization Guidelines (as above).

 - c. Cal Medi Connect: Members:
 - I. Medicare Prime (Follow Medicare Advantage).
 - II. Medi-Cal Secondary (Follow Commercial/Medi-Cal).

The HPN, Inc. affiliates will utilize reports and case management services to ensure that practitioners assist with a member's transition to other levels of care, if necessary, when medical necessity is not met or benefits end and the member still needs care.

The HPN, Inc. affiliate shall offer to educate the member (or the member's designated representative) about alternatives for continuing care, how to obtain care and/or access to community resources, as appropriate.

1. Annual Review of Criterion:

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All criteria is reviewed and approved at least annually. Only appropriate clinical and behavioral health practitioners with relevant experience are involved in the development, adoption and reviewing of the criteria. The criteria complies with Medicare, local and national coverage determinations and relevant Medicaid requirements. Upon final approval, all criterion are made available to UM staff and practitioners in writing either by mail, fax or e-mail or on the affiliate website according to affiliate standard communication/dissemination processes.

2. Availability of Criteria, Guidelines, Policies:

Upon request, HPN, Inc. affiliates will make available all criteria, clinical review guidelines and medical review polices utilized for decision making to members and practitioners. With each determination made by the affiliate, members and providers are notified in writing of the process for requesting a free copy of the criteria guideline or policy used to make the determination. Additionally, all criteria, guidelines, and polices utilized will be maintained and made available onsite at each affiliate for review at all times.

3. Consistency in Applying Criteria, Guidelines, Policies:

To ensure case review consistency and uniformity in decision making among the physician and non-physician reviewers, Inter-Rater Reliability audits will be conducted at least annually by the affiliate. Using the "8/30" methodology, randomly selected authorization files shall be reviewed by a same level staff (physician, nurse, non-clinical) who was not responsible for the initial decision.

At minimum, the Inter-Reviewer Reliability survey shall contain the following elements:

a. Outpatient Services:

- I. The case was completed within the line of business of Standard Timelines.
- II. The reason for the referral delay was clearly documented, if applicable.
- III. There was sufficient clinical documentation to support the decision.
- IV. The files were correctly categorized.
- V. The appropriate UM Criteria or benefit provision was applied.
- VI. There was appropriate referral to the Medical Director/Physician Advisor.
- VII. Medical necessity Denials included MD signatures.

b. Inpatient Services:

- I. Documentation supports the medical necessity for admission and continued stay.
- II. There was sufficient clinical documentation to support the decision.
- III. The appropriate UM Criteria or Benefit provision was applied.
- IV. Disposition of patient is documented on worksheet.
- V. There was appropriate referral to the Medical Director/Physician Advisor.
- VI. Continuity of care and discharge planning initiated and family involved, when applicable.

c. Physician Reviews:

At least five (5) randomly selected denials shall be reviewed by a Medical Director not responsible for the initial decision, and all selected denials shall be reviewed by an independent physician to ensure determinations are made based on adopted clinical guidelines against the following criteria:

- I. The case was approved with appropriate UM Criteria applied.
- II. The case was pended, if applicable, and determination was made within required Timelines.
- III. The case was denied using appropriate UM Criteria and process.
- IV. There was sufficient clinical documentation to support the decision.
- V. Physician review was clearly documented.

These results of these reviews will be presented to the affiliate UMC for review and discussion within their organization. The affiliate will act on opportunities to improve consistency in applying criteria, as applicable. Corrective action shall be implemented for any reviewer not meeting the established benchmark of 100% in either category. Results of such surveys shall be documented by the affiliate on the work plan and will subsequently be reviewed by the HPN, Inc. UM and QI Committees.

COMMUNICATION SERVICES

HPN, Inc. will ensure that the affiliates provide access to staff for members and practitioners seeking information about the UM process and the authorization of care. Inbound and outbound communications may include communication with practitioners and members in person, in writing by mail or fax, by telephone, or by electronic communications (e.g. sending e-mail messages or leaving voicemail messages.)

1. Communication requirements shall include:
 - a. Staff available at least 8 hours a day during normal business days for inbound calls regarding UM issues.
 - b. Ability of staff to receive inbound communication after normal business hours regarding UM issues.
 - c. Out bound calls regarding inquiries about UM during normal business hours, unless otherwise agreed upon.
 - d. Staff identifies themselves by name, title and organization name when initiating or returning calls regarding UM issues.
 - e. A toll-free number or a staff who accepts collect calls regarding UM issues.
 - f. Access to staff for callers with questions about UM process.
 - g. TDD/TTY services for deaf, hard of hearing or speech-impaired members.
 - h. Language assistance for members to discuss UM issues.

2. Communication services and availability will also be posted on each affiliate's website. HPN, Inc. and its affiliates will maintain written policies and procedures regarding the above communication requirements and standards. Additionally, Provider Manuals will include, at minimum:
 - a. The business hours during which staff are available.
 - b. Instructions for obtaining specific information about a request.
 - c. Instructions for faxing or leaving a voicemail message outside of business hours that prompt members and practitioners to provide contact information for responses by the UM staff on the next business day.
 - d. Instructions on how out-of-area callers can obtain information in accordance with HPN, Inc.'s privacy and information security policies as well as all state and federal regulations regarding use and disclosure of PHI, providers, practitioners; and,
 - e. All HPN, Inc. affiliate's staff with access to patient information must maintain the confidentiality of member information and records in the course of any written, verbal or electronic communications.

APPROPRIATE PROFESSIONALS

1. HPN, Inc. requires that only qualified licensed health professionals:
 - a. Assess the clinical information used to support UM decisions
 - b. Supervise all medical necessity decisions
 - c. Review denials of care based on medical necessity

2. The health care professionals who provide medical necessity review will have the education, training or professional experience in medical or clinical practice.
3. A licensed physician shall be required to have a current, unrestricted license to practice in the State of California and will review any clinical, non-behavioral health denial based on medical necessity for covered services such as:
 - a. Decisions about covered medical benefits defined by the organization, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits.
 - b. Decisions about pre-existing conditions when the member has creditable coverage and the organization has a policy to deny pre-existing care or services.
 - c. Decisions about care or services that could be considered either covered or non-covered, depending on the circumstances, including decisions on requests for care that the organization may consider experimental.
 - d. Decisions about dental procedures that are covered under the member's medical benefits. If dental and medical benefits are not differentiated in the organization's benefits plan, the organization must identify the services or care as if there is differentiation. This means identifying only care or services associated with medically necessary medical or surgical procedures that occur within or adjacent to the oral cavity or sinuses.
 - e. Decisions about medical necessity for "experimental" or "investigational" services.
 - f. Decisions about pharmacy-related requests regarding step-therapy or prior authorization cases.
4. A behavioral health practitioner will review any behavioral health denial of care based on medical necessity.
5. Board certified physician consultants may be used, as needed, to assist in making medical necessity determinations, such as:
 - a. Pharmacists: Pharmaceutical denials.
 - b. Dentists: Dental denials.
 - c. Chiropractors: Chiropractic denials.
 - d. Physical therapists: Physical therapy denials.
6. Staff members who are not qualified health care professionals may collect data for preauthorization and concurrent review for medical necessity determinations under the supervision of appropriately licensed health professionals. They may also have the authority to approve (but not to deny) services based on medical necessity for which there are explicit criteria. Staff members who are not qualified health care professionals may approve or deny coverage determinations such as:
 - a. A benefit determination is a denial of a requested service that is specifically excluded from a member's benefit plan, which the plan is not required to cover under any circumstances (e.g., in vitro fertilization). Benefit determinations include the following.
 - b. Decisions about services that are limited by number, duration or frequency in the member's benefit plan.
 - c. Denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan.
 - d. Decisions about care that do not depend on any circumstances, such as the member's medical need or a practitioner's order.
 - e. Decisions on personal care services, such as transportation, cleaning and assistance with other activities of daily living (ADL), are considered benefit determinations and are not subject to UM file review. However, these benefit decisions may be appealed and are

included in the scope of appeal file review.

7. All staff that provides UM determinations will have a current job description on file at the assigned affiliate. The job description will include the qualifications that are required, including but not limited to:
 - a. Education level (Masters, Doctoral)
 - b. Training or professional experience in medical or clinical practice
 - c. A current license to practice without restriction
8. The UM staff or behavioral health care professional responsible for making a determination for approval, benefit or administrative denial or medical necessity denial must be clearly documented by use of initials, unique electronic identifier, signature or notation in the electronic record.
9. Compensation for individuals who review service requests will not contain incentives, direct or indirect. Practitioners, providers and staff who make utilization related decisions and those who supervise them must annually affirm the following:
 - a. UM decision making is based only on appropriateness of care and service and existence of coverage.
 - b. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
 - c. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
 - d. To encourage appropriate utilization, discourage underutilization and clearly, indicate that the affiliate does not use incentives to encourage barriers to care and service, these affirmative statements will be distributed by the affiliates annually to all members, staff, providers, and practitioners involved with UM determinations.
 - e. Distribution may be accomplished by any of the following methods:
 - I. Mailings
 - II. Newsletters
 - III. Email
 - IV. Published on the Intranet
 - V. Included in provider/member handbooks

TIMELINESS OF UM DECISIONS

In accordance with HPN policy, affiliates will provide medical and behavioral health determinations and notifications for approvals and denials according to the following timeliness standards:

1. Commercial Timelines:

This includes inpatient, outpatient, skilled nursing facility, residential, and ambulatory care.

 - a. Emergent: Physician available 24 hours a day, 2 hour maximum.
 - b. Urgent Pre-Service: Within 72 hours of receipt of request.
 - c. Urgent Concurrent Review: within 24 working hours of receipt of the request.
 - d. Non-urgent Pre-service: Within 5 business days of receipt of request.
 - e. Post-Service (Retrospective): Within 30 calendar days of receipt of request.

All UM determinations for Commercial members will be compliant with the timeliness standards outlined in the UM Timeliness Standard policy.

2. Medicare Timelines (CMS):

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This includes inpatient, outpatient, skilled nursing facility, residential, and ambulatory care.

- a. Emergent: Physician available 24 hours a day, 2 hour maximum.
- b. Expedited Initial Determinations: Within 72 hours of receipt of request (includes weekends and holidays).
- c. Standard Pre-Service: As soon as medically indicated (within a maximum of 14 calendar days after receipt of request).
- d. Post-Service (retrospective) - Within 14 calendar days of receipt of request only in instances where the claim has not been received.

All UM determinations for Medicare Advantage members will be compliant with the timeliness standards outlined in the UM Timeliness Standard policy.

3. Medicaid Timelines (Medi-Cal):

This includes inpatient, outpatient, skilled nursing facility, and residential and ambulatory care.

- a. Expedited Pre-Service: Within seventy-two (72) hours of receipt of the request.
- b. Urgent Concurrent: Within twenty-four (24) hours of the receipt of the request.
- c. Non-Urgent Concurrent: Within five (5) working days or less.
- d. Non-Urgent Pre Service: Within five (5) working days of receipt of the request.
- e. Post Service (Retrospective): Within thirty (30) calendar days from receipt of request.
- f. Hospice: Within twenty-four (24) hours of the receipt of the request.

All UM determinations for Medi-Cal Managed Care members will be compliant with the timeliness standards outlined in the UM Timeliness Standard policy.

4. For the purpose of determining timeliness standards, "Urgent" shall mean a condition or situation that:

- a. Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.
- b. In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Members and Member Representatives may request an expedited review verbally or in writing. For urgent care decisions, the affiliate will allow a health care practitioner with knowledge of the member's medical condition (e.g. a treating practitioner) to act as the member's authorized representative. Physicians who request or support a member's request for expedited review will not encounter punitive or other disciplinary actions.

CLINICAL INFORMATION

When the affiliate receives a request from a Practitioner, member or member representative for health or behavioral health care services, the affiliate will obtain relevant clinical information and consult with the member's treating practitioner in order to make a determination of medical necessity.

In the event, the reviewer believes additional information may be needed to support medical necessity and that by obtaining the necessary medical information, a request for service may be approved, the reviewer or the reviewer designee may delay or defer the request in order to obtain the necessary information.

An authorization request may only be deferred one time. If sufficient information is not available to render a decision following one deferral, the Medical Director or designee is to contact the requesting provider

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directly. Documentation of this verbal communication will be added to the referral package and a decision will be rendered.

DENIAL NOTICES

Denial of medical or behavioral health services will be managed by the affiliates as follows:

1. Only a board certified Medical Director or a board certified California licensed physician reviewer, from the appropriate education, training, and professional expertise or specialty may initiate a denial for medical necessity.
2. In the event the denial is for behavioral health care, a psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist will review any denial based on medical necessity; however, the final denial determination may only be made by the Utilization Review Committee or a Medical Director.
3. Written notification is sent to both patient and requesting provider.
4. Regulatory (Federal and State), plan specific or best practice (Industry Collaboration Effort) approved pre-service denial, delay, modification notification forms/letters and all pertinent inserts and attachments will be utilized to communicate determinations to members and requesting providers.
5. Communications regarding decisions to approve or deny a providers request to provide health or behavioral health care services, must specify the services that were approved or denied.
6. Communications regarding decisions to deny, delay or modify a provider's treatment request must be communicated to the affected member and requesting provider in writing although initial communications can be made by telephone, facsimile, or online notification.

These communications must include:

1. A clear and concise explanation of the reasons for the denial decision that is specific to the member's diagnosis, condition or situation in easy to understand language, so that the member can understand the reason for denying the service.
2. A description of the benefit provision, criteria or guidelines used as a basis for the decision.
3. Other clinical information used as a basis for a decision regarding medical necessity.
4. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
5. Information as to how the enrollee may file a grievance with the plan pursuant to Section 1368; and for Medi-Cal enrollees, an explanation of how to request an administrative hearing and paid pending under Sections 51041.1 and 51042.2 of Title 22 of the California Code of Regulations.
6. A description of the member's appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
7. An explanation of the appeal process, including the right to member representation and appeal time frames.
8. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
9. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
10. Information will be included, where applicable, of the member's right to file a complaint with the Department of Managed Health Care.
11. Provider notification will include the name and direct telephone number of the physician who reviewed the referral if the provider wishes to discuss the case.
12. Alternative plan of care will be identified in the case of medical need issues.
13. Only reasonably, necessary, adequate and appropriate information will be gathered and considered to make initial denial determination.

A tracking system for status of authorizations, denials and appeals will be maintained electronically by appropriate Department.

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If the affiliate delays a determination because it cannot make a decision regarding a treatment request within the required timeframe because the affiliate has not received all of the information reasonably necessary and requested, or the affiliate requires consultation by an expert reviewer, or the affiliate has asked that an additional examination or test be performed upon the member, the affiliate will, immediately upon the expiration of the specified timeframe, or as soon as the affiliate becomes aware that it will not meet the time frame, whichever occurs first, the provider and the member will be notified in writing that a determination cannot be made within the required timeframe. The notification will indicate the information needed, the expert consultation to be obtained, or the test or examination required, as well as the anticipated date on which a determination will be made.

If the affiliate receives additional information after issuing an initial denial the reviewer may reopen, re-review and/or reconsider the case with the new information and reverse the decision (if appropriate). The affiliate may also reopen a case in the event of a clerical/data entry error. Members, practitioners and/or health plans may request a case to be reopened or reconsidered, either verbally or in writing. The Member shall be notified in writing of the determination.

Notice of Medicare Non-Coverage (NOMNC):

In the event the affiliate decides to terminate approved service coverage, such as, Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice or Comprehensive Outpatient Rehab Facility (CORF), the affiliate shall provide the Member with a Notice of Medicare Non-Coverage (NOMNC) no later than two days before the proposed end of the services. The NOMNC shall include:

1. The date of the enrollee's financial liability for continued services begins.
2. A description of the enrollee's right to a fast-track appeal via the Quality.
3. Improvement Organization (QIO) and their contact information.
4. The enrollee's right to submit evidence to the QIO.
5. Alternative appeal mechanisms if the enrollee fails to meet the deadline for a fast-track appeal.

Detailed Explanation of Non-Coverage (DENC):

Should the member appeal the affiliate's decision to terminate services, the affiliate must provide the Detailed Explanation of Non-Coverage (DENC) (CMS-10095-B), an explanation as to why the provider services are no longer reasonable or necessary or are no longer covered. The DENC shall include:

1. Applicable CMS rules, instruction, or policy including citations.
2. How the enrollee may obtain copies of such documents.
3. Other member specific facts or information relevant to the non-coverage decision in easy to understand language.

Detailed Notice of Discharge (DND):

If the QIO reverses the affiliate's decision to terminate services, the affiliate shall notify the Member with a new notice consistent with the QIO determination. Upon notification that a Member has been advised that inpatient care is no longer necessary and the Member has requested an immediate review of the determination, the affiliate or contracted Hospital shall provide the Member with a Detailed Notice of Discharge (DND) no later than 12pm on the day prior to the notification. During the review process, the affiliate shall ensure that all information the QIO needs to make its determination is provided, either directly (with hospital cooperation) or by delegation, no later than noon of the day after the QIO notifies the Delegate that a request for an immediate review has been received from the enrollee.

The DND shall include:

1. A detailed explanation of why services are no longer reasonable, necessary and/or are no longer covered in an inpatient hospital setting.

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2. A description of any applicable CMS coverage rules, instructions, and/or other CMS policies used in this determination. Including information about how the Member may obtain a copy of the CMS policies; any applicable organization policies, contract provisions, or rationale upon which the discharge determination was based.
3. Facts specific to the enrollee and relevant to the coverage determination sufficient to advise the enrollee of the applicability of the coverage rule or policy to the Member's case.

POLICIES FOR APPEALS

The HPN affiliates maintain an established, impartial process for resolving member disputes and responding to member requests, to reconsider a medical or behavioral health decision they find unacceptable regarding their care and service as outlined in HPN UM Appeal policies.

Concurrent with denial notification, all members and/or providers are given a description of the internal and external appeal rights and the opportunity to submit a verbal or written appeal, including an expedited appeal, if applicable, to the full service Health Plan. The full service Health Plan will notify the member and the delegated affiliate of the outcome.

Members will be informed in the denial notification that they have at least 180 days to appeal an adverse organization decision.

When applicable, the member will be provided information regarding their right to continued coverage under their medical benefit pending the outcome of an internal appeal.

APPROPRIATE HANDLING OF APPEALS

The HPN affiliates have a full and fair process for resolving member disputes and responding to members' requests to reconsider a medical or behavioral health decision they find unacceptable regarding their care and service as outlined in HPN UM Appeal policies. The PMGs will:

1. Coordinate all appeals with the full service Health Plan and will document.
2. Investigate and (when appropriate) respond to each appeal.
3. Provide non-subordinate reviewers who were not involved in the previous determination and same-or-similar-specialist review, as appropriate.
4. Resolve pre-service, post-service and expedited appeals within the specified time frames:
5. Pre-service appeals within 30 calendar days of receipt of the request.
6. Post-service appeals within 60 calendar days of receipt of the request.
7. Expedited appeals within 72 hours of receipt of the request.

The internal appeal notification will include:

1. Specific reasons for the appeal decision, in easily understandable language.
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.
4. Notification that the member is entitled to receive reasonable access to and copies of all documents, upon request.
5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
6. Signature of appeal reviewer.
7. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.

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In the event of an external IRO review resulting in a decision to overturn the initial determination, the affiliate will implement the IRO decisions in all cases reviewed.

EVALUATION OF NEW TECHNOLOGY

The Medical Director or designee may initiate a review of new technologies or new uses for existing technologies which may be requested by a Health Plan, Provider or Member. The UM Committee or Committee member designee will review all recommendations for new technologies or changes to existing technologies. Review will include at least a review of Government Standards, medical literature or other sources, and reviewed by the appropriate specialty physicians, and health plan. All necessary parties will be notified at least 24 hours prior to implementation of new technologies.

New technologies may include, but is not limited to:

1. Medical procedures
2. Behavioral health procedures
3. Pharmaceuticals
4. Devices

EXPERIENCE WITH THE UM PROCESS

The affiliate will assess the Member and Provider satisfaction with the UM process by utilizing surveys designed to document positive and negative experiences of members and providers.

The surveys will include indicators to measure satisfaction with the Utilization Management Program. Opportunities for improvement will be identified and corrective action(s) will be taken at that time.

Results of patient satisfaction and physician satisfaction UM surveys performed by the contracted provider groups will be analyzed at least annually by the affiliate Utilization Management Committee.

EMERGENCY SERVICES

Emergency services are available to members 24 hours a day, 365 days a year.

Emergency service providers, acting as an authorized representative on behalf of the affiliate, shall:

1. Authorize the provision of emergency services.
2. Screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

The affiliates will not deny emergency services based on medical necessity. Claims for non-emergent care may be denied retrospectively but the member may not be billed for these services.

PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

The HPN affiliates' policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals as determined by a licensed physician and/or pharmacist and based on sound clinical practice. The affiliate will:

1. Use a list of pharmaceuticals recommended by the affiliate's Pharmacist or by a contracted Pharmacy Benefits Management (PBM) vendor, generally known as an open formulary.
2. Use a list of pharmaceuticals for which the organization requires prior authorization.
3. Limit the number of refills, doses or prescriptions available to members based on medical necessity and benefit coverage.
4. Use a generic substitution, therapeutic interchange or step-therapy protocols.
5. Will maintain an expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.

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6. Will notify members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification.

Development, review and adoption of pharmacy policies will follow the standard HPN process for all other HPN policy, guideline, and criteria. The HPN Pharmacy policies will include, but are not limited to, processes for:

1. Making an exception request based on medical necessity.
2. Obtaining medical necessity information from prescribing practitioners.
3. Using appropriate pharmacists and practitioners to consider exception requests.
4. Timely request handling.
5. Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.
6. Annually and after updates, the affiliate communicates to members and prescribing practitioners.
7. A list of pharmaceuticals, including restrictions and preferences.
8. How to use the pharmaceutical management procedures.
9. An explanation of limits or quotas.
10. How prescribing practitioners must provide information to support an exception request.
11. The process for generic substitution, therapeutic interchange and step-therapy protocols.

TRIAGE AND REFERRAL FOR BEHAVIORAL HEALTHCARE

Triage and referral (T&R) functions for behavioral healthcare services are provided via direct access to the affiliate contracted behavioral health (BH) care group practice organization (treatment source) and/or via the affiliate Member Service Department staff who provide information about the BH practitioners but do not make judgments regarding the needed level of care or type of practitioner the member should see.

Protocols maintained by the affiliate's behavioral health (BH) care group practice organizations (treatment source) address all relevant mental health and substance abuse situations, the level of urgency and the appropriate care setting and treatment. Affiliates require all behavioral health (BH) care group practice organizations protocols to be reviewed and/or revised a minimum of every two years.

A licensed psychiatrist or a licensed doctoral-level clinical psychologist will oversee triage and referral decisions.

The affiliates may utilize a contracted behavioral health (BH) care group practice organizations to perform T&R and oversee behavioral health review but will not delegate or sub-delegate an UM responsibilities or activities.

DELEGATION OF UM

HPN fully owns and oversees each of its affiliates. HPN develops all operational programs, work plans and policies, including but not limited to:

1. Adopting criteria
2. Monitoring the quality and timeliness of decisions
3. Preservice decisions, by service
4. Urgent concurrent review and decisions
5. Post-service review and decisions by service
6. Approvals and denials
7. Appeals
8. Assessing member and practitioner satisfaction with the UM process
9. Establishing, applying and maintaining pharmaceutical management procedures

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10. Evaluating new technology
11. Communicating with members about the UM process and authorization of care
12. Managing triage and referral of behavioral healthcare

HPN monitors and evaluates the following UM activities performed by each of its affiliates:

1. Number of UM cases handled by type (pre-service, urgent concurrent or post service) and by service (inpatient or outpatient)
2. Number of denials issued
3. Number of denials appealed
4. Uses and disclosure of protected health information as outlined in HPN privacy and information security policies

HPN does not delegate or sub-delegate UM responsibilities to its affiliates and the HPN affiliates shall not delegate or sub-delegate ANY UM responsibilities without prior written approval of the HPN Executive body.

PRIMARY CARE PHYSICIAN SCOPE OF PRACTICE

Internal Medicine, Family Practice, and General Practitioners as well as Pediatricians provide primary care services. Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives under the supervision and direct monitoring of the primary care physician may also be included.

The scope of service for the Primary Care Physician (PCP) for HPN and its affiliates is defined as noted in California Health and Safety Code Section 1367.69 and existing Knox-Keene regulations:

As physicians who have the "responsibility for providing initial and primary care for patients, for maintaining the continuity of patient care, and for initiating referral for specialty care". This includes, but is not limited to, preventive services (as outlined in the current HEDIS clinical indicators), acute and chronic conditions and psychosocial issues.

The PCP is responsible for providing the majority of and coordinating all the services required for the member, except when precipitous emergency circumstances preclude the role of the PCP. The PCP:

1. The PCP is to provide periodic evaluation of all body systems, preventive services, acute and chronic care, and to address psychosocial issues.
2. The PCP is required to perform all duties expected of a PCP such as on-call rotation and/or coverage for emergencies.
3. When care by a specialist is necessary, the PCP coordinates all services required by the specialist.
4. The PCP provides those services within his/her skills and obtains authorization for consultations, when additional expertise or skills are required.
5. The PCP is expected to relay the affiliate's or health plan's decisions in a positive manner. When the purpose of the visit is for a non-covered service, the PCP must inform the member the service is non-covered. This needs to be documented in the patient's medical record.
6. The PCP is responsible for communicating abnormal test results to his/her patient in a timely manner.
7. The PCP is responsible for returning patient telephone calls in a timely manner. Emergent calls are returned within two (2) hours from the time the call was received, urgent calls are returned by the end of the business day, and non-urgent calls are returned within twenty-four (24) hours.

HPN CARE COORDINATION PROGRAM

INTRODUCTION

Heritage Provider Network's (HPN), Care Coordination (CC) program anticipates and addresses our member's needs in a safe, timely, effective, efficient, and respectful manner. CC recognizes the importance of

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coordination of care for members who are managed by several providers at various sites of services and various levels of care.

The core of the CC program is a seasoned, expertly trained cross-functional team. A central point of contact is responsible for seamless service delivery of preventive, diagnostic, therapeutic, and chronic management services through a collaborative effort by interdependent professionals; paraprofessionals and ancillary personnel.

CC uses an organizational design with empowered teams, to implement informational, technological, and evidence based solutions customized to the member's preferences, needs and values. The CC team continuously stabilizes or reduces the burden of illness and disability by focusing on the health and wellbeing of our members, while respecting their ability to make choices and have individual preferences. The CC Team uses proactive processes to identify, coordinate and evaluate appropriate high quality services which may be required on an ongoing basis in the most cost-efficient setting.

CC coordinates resources and creates appropriate, cost-effective treatment alternatives and sites of service for catastrophically, chronically ill or injured members on a case by case basis to achieve realistic treatment goals. The CC program is evaluated and updated annually and approved by Utilization Management Committee.

CARE COORDINATION CORE TEAM COMPOSITION

The CC core team is composed of the following: the member, their primary caregiver/family (if applicable), the Primary Care Physician, a Medical Director, and Nurse Care Manager/Care Coordinator. The extended team may include any of the following: consulting physicians, SNF providers, hospitalists, home health providers, facility discharge planning staff, pharmacists, ancillary providers, data analysts, health plan staff, social worker, team coordinator, and others, as applicable to member needs.

THE CC TEAM MEMBER COMPETENCIES

CC team members will have complementary competencies to quickly and effectively produce the following results:

1. Coordinate and clearly document the management of high-quality cost-effective services to meet the member's healthcare goals.
2. Apply benefits appropriately and coordinate with health plan staff to flex benefits.
3. Monitor care which is easily accessible with no access barriers to contracted eligible benefits.
4. Promote early and intensive diagnostic and treatment interventions in the least restrictive setting.
5. Apply approved Utilization Management (UM) decision criteria to the management of complex and chronic care management.
6. Comply with approved time frames and standards for timeliness of UM decision-making.
7. Provide accurate and up-to-date information to providers regarding clinical practice criteria and member information.
8. Create Individualized Care Coordination Plans (ICP), which are revised as the member's healthcare preferences and needs change and incorporates an interdisciplinary approach in meeting those needs and preferences.
9. Utilize multidisciplinary clinical, rehabilitative and support services.
10. Arrange broad spectrum (comprehensive) and appropriate resources for members which include preventive, medical, mental health, social, translational and linguistic services with coordination through a central point of contact with seamless transition across care settings, care providers and services.

11. Deliver highly personalized care management services to promote appropriate utilization of services in all settings.
12. Incorporate member satisfaction as part of the evaluation and improvement of the care management process.
13. Improve member's health status by developing prioritized, measureable goals identified and stratified by the member.
14. Promote member independence and self-management to improve the member's health status through improved mobility, functional status, and their perception of their quality of life.
15. Maintain the strict rules of member confidentiality.

MEMBER SELECTION

1. Members are accepted into the CC program after assessment by the Care Management and Coordinating staff.
2. Members can be referred for assessment by providers contracted with our groups, member caregivers, or through data mining of clinical data, care gap analysis, pharmacy, utilization management, health plan referrals, or claims data. Same day assessments are available upon request by inpatient Care Manager/Care.
3. Coordinator's or hospitalists providing care to members in the emergency room and inpatient facility.
4. Members assessed and found not to be eligible for inclusion in the CC program will be referred to the appropriate disease or care management program sponsored by HPN's affiliated groups, contracted health plans, or other community services available to the member or referred back to their primary care provider.

MEMBER ASSESSMENT AND DOCUMENTATION

The CC team uses evidence-based clinical guidelines and algorithms, as well as, member goals and preferences, to conduct assessment and management of the member's needs. Information is documented as to the date, time and actions taken for each member by each CC team member interacting with that member. Documentation is completed in HPN's and affiliate groups' systems. The care coordination/care management plan drives the prompts for follow-up.

Initial and Periodic Health Assessments (IHA):

Providers shall have processes in place to ensure the provision of an IHA (complete history and physical examination) to each new member within the 120 days of the effective date of enrollment. This is a one-time preventive physician exam. The one-time exam includes a thorough review of:

1. Health Issues
2. Health Education
3. Preventive services

Individual Health Education Behavioral Assessment:

The Individual Health Education Behavioral Assessment (also called "IHEBA" or "Staying Healthy.") The assessment tool sponsored and approved by DHCS is called the Staying Healthy Assessment (SHA). Providers are responsible for ensuring the use of the Individual Health Education Behavioral Assessment for new Medi-Cal and Cal Medi-Connect members. The goals of the SHA are to:

1. Identify and track patient high-risk behaviors.
2. Prioritize patient health education needs related to lifestyle, behavior, environment, and cultural and linguistic needs.
3. Initiate discussion and counseling regarding high-risk behaviors.
4. Provide tailored health education counseling, interventions, referral, and follow-up.

The Clinical Social Assessment (CSA) includes:

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1. The care management procedures to address the member's right to decline or disenrollment from the program.
2. Initial, as well as ongoing assessments of the member, including condition specific issues.
3. Documentation of clinical history, including medications.
4. Initial assessment of mental health status, including cognitive functions.
5. Initial assessment of life-planning activities.
6. Initial assessment of activities of daily living.
7. Evaluation of cultural and linguistic needs, preferences or limitations.
8. Evaluation of caregiver resources.
9. Evaluation of available benefits.
10. Development of a care (care management) plan (prioritized goals) with the primary care physician, healthcare providers, and member participation.
11. Identification of barriers to meet goals or comply with the care plan (i.e. non-compliance or deficits).
12. Development of a schedule for follow-up and communication with members.
13. Development, communication, and documentation of member self-monitor and self-management plans.

Risk Stratification of the Member's Needs:

Each member entered into the CC program will be risk stratified into the appropriate levels of care so that interventions are provided to meet the member's needs. The initial stratification using HPN's Clinical Social Assessment (CSA) or the health plan generated Health Risk Assessment (HRA) or Hierarchical Code Conditions (HCC) and/or other data will be done within 72 hours of acceptance into CC. Milliman guidelines are utilized in the development of the condition specific care plans and interventions, as well as member individualized goals and preferences.

The CC program uses three risk stratification levels - Low, Medium, and High and they are defined as follows:

Low: The HPN's Clinical Social Assessment (CSA) or health plan completed HRA for Special Needs Program (SNP)/CalMedi Connect (CMC) and/or other assessments are performed at least annually.

Moderate: The following activities may be rendered by the care coordinator/caremanager, social worker or other healthcare professional. (Member Needs Ongoing Education):

1. The HPN's Clinical Social Assessment (CSA) or health plan completed HRA for Special Needs Program (SNP)/CalMedi Connect (CMC) and/or other assessments are performed at least annually.
2. Condition specific assessments and conditions detail, as well as member individualized goals and preferences, are performed at least annually for members who have the top 3 HCC conditions or renal failure (primary condition assessed).
3. Care may be coordinated with external entities (i.e. Health Plans, DSS, DHCS, Medicaid), when necessary.
4. Referral for disease management as needed.
5. Follow up calls for chronic disease management, such as Congestive Heart Failure. Follow up calls for potential status changes such as ER visits, hospitalizations, Case Management/ICT follow up (including ICT meeting and care plan update) with member/caregiver is at least semi-annually and when there are any status changes.

High: The following Activities will be rendered by a nurse (Member not stable or being stabilized):

1. The HPN's Clinical Social Assessment (CSA) or health plan completed HRA for Special Needs Program (SNP)/CalMedi Connect (CMC) and/or other assessments are performed at least annually.
2. The HPN CSA for Acute or SNF admissions done upon discharge from the facility.

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3. Condition specific assessment and condition detail, as well as member individualized goals and preferences, are performed at least annually for members who have the top 3 HCC conditions or renal failure (primary condition assessed).
4. Perform condition detailed assessment for major condition at least semi- annually.
5. Develop and revise the plan of care in collaboration with ICT at least quarterly or as needed.
6. Care may be coordinated with external entities (i.e. Health Plans, DSS, DHCS, Medicaid) when necessary.
7. Referral for disease management.
8. Follow up calls for chronic disease management, such as Congestive Heart Failure and for potential status changes such as ER visits, hospitalizations, Case Management/ICT follow up (including ICT meeting and care plan update) with member/caregiver is at least semi-annually or as needed and when there are any status changes. The frequency of the Care Manager/Care Coordinator follow up should meet the minimum contact within each stratification level. More follow up may be required, i.e., care management at the High Level may require daily or weekly follow up.

CARE PLAN GENERATION

The CC team develops the care plan which is shared with, acknowledged, and endorsed by the member, member care givers, professional staff providing services to the member, and the CC team. The care plan will address member specific goals and preferences, as well as active social, psychological, and health issues present. The issues will have associated plans of care with specific designation of the CC's members primarily responsible for implementation of the care plan as well as secondary or tertiary professionals also responsible for care plan implementation. The member and associated care givers are intricate members of the CC team and will be encouraged to actively participate in care plan implementation. The care plan will identify resources available as a contracted health plan benefit, as well as, community or other resources available to assist in care plan implementation. The care plan will be located in the member's medical record/file.

DESIGNATING THE RESPONSIBLE PROVIDER

The primary care physician and a participating provider or Interdisciplinary Care Team (ICT) members will be identified for each active care issue within the care plan. All ICT team members will have responsibility for care plan implementation for the specific identified issue. Careful and precise communication amongst the member, care givers, designated responsible provider(s), and CC team is required to effectively develop and implement effective care plans. The designated provider(s) may or may not be a licensed healthcare professional. The designated provider(s) will never be assigned responsibilities for tasks outside the scope of their professional designation, demonstrated competencies, or agreed upon duties.

CARE PLAN EXECUTION

The care plan will be implemented and monitored so that it is consistent with the member's acuity scoring. The member's acuity may change over time. A critical component of the care plan is the intermittent Clinical Social Assessments (CSA) or health plan generated Health Risk Assessment (HRA) of the member's physical, psychosocial, and functional needs. The assessment(s) can be performed face-to-face, telephonic, electronic or by mail. To achieve this, the information/data collected from the CSA or HRA is evaluated to determine individual member's needs and assists with development of a Care Plan within 10 business days of CSA or HRA completion and enrollment into CC or other group care program. The CC Care Manager/Care Coordinator reviews the CSA or HRA results to identify members who are at risk for chronic or catastrophic medical conditions and then uses this data to stratify members based on complexity and severity of any existing disease processes or conditions and their risk for hospitalization. The CSA or HRA results are shared with the CC team members for coordination of care and development and implementation of an individualized care plan.

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Care plan implementation requires the CC Care Manager/Care Coordinator use these guidelines to evaluate the members:

1. Evaluation of clinical and psychosocial information through review of CSA or HRA results, interviews with the member or family/caregiver, review of medical information, and communication with the member's physician(s) and other assigned professionals, when applicable.
2. Identification of current and potential problems and care needs based on the initial assessment.
3. Evaluation of the need to develop an individual plan of action, which includes the physician(s) treatment plan, member/caregiver preferences and goals, and any appropriate community-based services and care facilities.

Care Plan implementation may be limited to arranging temporary home visits after a hospital discharge, or it may serve to integrate long term health care, nursing home, social services, hospice and community services such as IHSS, LTSS, MSSP, meal assistance, senior transportation and community education and wellness classes. Care plan interventions, implementation notes and an ongoing evaluation will be documented in the system and shared with the member, caregiver, and associated providers of care, as needed to meet the goals of the care plan(s). The Care Plan, member needs, and health status are re-evaluated on a regular basis and updated as member's health status changes to ensure that the Care Manager has the most current physical, psychosocial, and functional information for effective, timely and continuous member care coordination.

To achieve the member oriented goals, procedures are followed using evidence based clinical guidelines or algorithms. (i.e.: Milliman Chronic Care Guidelines), as well as the member's preferences and personal goals for self-maintenance.

The Care Manager/Care Coordinator identifies and documents the following information, including information from the assessment process in the members care record, and takes this information to the ICT review within 21 days of enrollment to CC:

1. Members of the Interdisciplinary Care Team (ICT) currently involved in the member's care, including Specialty.
2. Physical care needs – what care is the member receiving and what else may be needed such as home health care, home infusion, specialty services, etc.
3. Equipment and supplies – are the services in place or being requested appropriate to the member's needs; are or will they be provided by a participating provider; should purchase of DME or supplies be considered.
4. Caregivers and other sources of social support that provide physical, emotional, and spiritual assistance.
5. Alternative benefits or financial resources the member has access to or requires to meet his/her needs.
6. Available community resources –what resources is the member accessing now, if any.
7. What might he/she need for additional support such as DHCS/State Programs, meal assistance, transportation services, etc.
8. Member's cultural and linguistic needs or requirements.
9. Member's healthcare preferences and prioritization of goals.
10. Intervention prioritization - what needs to be done, what is urgent, what is a long term Intervention.

The Care Manager/Care Coordinator will identify specific individual problems or concerns, in collaboration with the Interdisciplinary Care Team to establish the course of action for each

prioritized goal to meet the member's needs and preferences. Each problem will have at least one goal and one intervention with documented barriers, if they exist. The Care Manager/Care Coordinator documents each problem in the care plan.

DEVELOPMENT OF GOALS

1. After identifying the member's problems and concerns using information obtained from the member, ICT team members, caregivers, CSA or HRA, and the members risk profile; the Care Manager/Care Coordinator collaborates with the member/caregiver and the ICT, to establish measurable prioritized goals to meet the member's needs/preferences and develop interventions required to meet the goals. The previously identified problems will drive goal statements and facilitate the direction in which the member/caregiver participates in the care plan.
2. Goals should be aimed at improved member health/mental status and prevention/reduction of transitions of care through improved:
 - a. Independence and self-management.
 - b. Mobility and functional status.
 - c. Pain and symptom management, perception of their quality of life, and satisfaction with health status and healthcare services.
3. Goals should be specific, measurable, aligned and directly linked to the identified problems using focused charting. Prioritized goals address acute and immediate clinical, psychosocial and financial needs and delineate activities to sustain health improvements, optimal health status, or provide optimal support at the end of life. Prioritized goals also define the criteria for graduation or case closure for non SNP members.
4. The Care Manager/Care Coordinator develops goals that are member driven (what is important to the member) and should be "SMART":
 - a. Specific – clear with target result that must be achieved by the member.
 - b. Measurable – measurable with criteria that indicate how the result will be quantified. Some examples of measurability dimensions are quantity, frequency, quality, etc.
 - c. Achievable – realistic, clinically appropriate, member driven, and credible (Care Manager/Care Coordinator, Medical Director, member or provider believes and is confident that he/she has the ability to attain the goal).
 - d. Results-oriented – stated in terms of an outcome that must be achieved and requires focused interventions and effort.
 - e. Time bound – time bound by a specific timeframe by which the goal must be achieved. Deadline focuses attention and effort on achieving the goal results.
5. A goal should be able to be well supported:
 - a. Based on member's documented preferences, assessment(s) and problems.
 - b. All care team members are aware of the goal and understand their role in achieving it (member/family/provider).
 - c. All care team members agree with the goal(s) and are committed to achieving them.
 - d. The Care Manager/Care Coordinator documents the goals in the member's record.

DEVELOPMENT OF INTERVENTIONS

1. Each problem and its associated goal(s) have identified barriers, if any, and interventions that are required to achieve the goal. The Care Manager/Care Coordinator will document the specific type of barrier, if any, and intervention, date established and the date completed.

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2. Each intervention is either acted on at the time the Care Manager/Care Coordinator is establishing the Care Plan or is scheduled for follow up.
3. Specific Care management intervention activities are based on member preferences, appropriateness, availability, and accessibility of medical, psychosocial and financial resources. These may include:
 - a. Interventions provided for the member to achieve specific member/caregiver goals.
 - b. Referrals to other programs (internal and external).
 - c. Skills training interventions structured with incremental time frames as appropriate to achieve educational and self-management goals.
 - d. Discharge goals established to target optimal health condition and prevent re-admissions.
 - e. Development and communication of a self-management plan for the member and/or her/his family.
4. The Care Manager/Care Coordinator will indicate the priority of the interventions based on the urgency of the problem or issue, and what is important to the member and/or his family/representative. Documentation will include the schedule for follow up and communication with the member and/or his/her representative based on the member's acuity level and clinical judgment of the Care Manager/Care Coordinator.
5. Once the Care Manager/Care Coordinator has identified the problems, barriers, interventions, and goals, agreement is reached with the member and the care team in implementing the Care Plan. The approval of the Care Plan is documented in the member's record, and a letter of participation is sent via US mail to the member and the primary care provider, indicating the members/caregivers agreed participation in the plan of care.

SUPPORTING THE CARE PLAN THROUGH RESOURCE IDENTIFICATION AND BENEFIT

1. A care plan may include a recommendation for alternative resources/services. Alternative community-based resources, i.e. meals, transportation, etc., should always be used if available for non-covered services.
2. The Care Manager/Care Coordinator reviews the member's benefits and alternative resources, including community-based resources, to determine how to best support the Care Plan. In some instances the member may not have benefits to cover services required to support an alternative care plan. The Care Manager/Care Coordinator determines what alternative funding such as secondary coverage, third party liability, community-based resource, etc. may be available.
3. The Care Manager/Care Coordinator provides continuity over the continuum of care for members with complex conditions or illnesses. When a member has multiple conditions and/or providers, the Care Manager/Care Coordinator has a key role in coordinating the member's care and providing continuity of the communication between providers/professionals.
4. The Care Manager/Care Coordinator's established relationship and rapport with the member and/or their representative and provider(s) help facilitate not only care coordination, but also opportunities for the Care Manager/Care Coordinator to identify, develop and recommend alternative treatment services.
5. The Care Manager/Care Coordinator helps the member obtain services that they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage and community-based resources. The Care Manager/Care Coordinator reviews each program's rules and benefit structure to provide appropriate care coordination within the program.

IMPLEMENTATION OF THE CARE PLAN

1. Working with the member and/or member's representative and the ICT, the Care Manager/Care Coordinator implements the activities and interventions in the Care Plan.
2. The Care Manager/Care Coordinator ensures that:
 - a. The care plan contains services and interventions which are consistent with the member's health care needs, health plan medical policies, provided by appropriate service providers, and the member's benefits or, if no benefits are available, accessible through alternative funding or community resources.
 - b. The care plan addresses the appropriateness, level, frequency, duration and specific issues such as assessing for language or culturally based barriers to utilization of local community based resources.
 - c. The care plan includes interventions, which support the functions of service coordination and monitoring.
 - d. Referrals are made to available contracted service providers (whenever possible), vendors, Health Plan programs or resources. These may include a referral to Disease Management, Behavioral Health Depression Programs or other health care professionals, or programs. These referrals will be discussed with the Interdisciplinary Care Team (ICT) and documented appropriately.
 - e. Referrals are made to any appropriate community resources such as disease specific or other support groups and resources, and when appropriate.
3. Care management reviews are conducted among peers to promote discussion of care management issues, improve continuity of care, and identification and resolution of barriers to care plan development.
4. The process also allows a forum for the Care Manager/Care Coordinator to learn of new technologies, identify best practice standards, facilitate care across the continuum, and combine successful care management interventions.

MONITORING AND EVALUATION THE CARE PLAN

1. The Care Manager/Care Coordinator continually monitors the quality of care, services and products delivered to the member to determine if the goals are being met or if any new problems have developed.
2. Through ongoing assessment, using the system assessment tools and risk profiles the Care Manager/Care Coordinator determines with the help of the ICT team, whether the goals continue to be appropriate and realistic, and what interventions may be implemented to achieve or enhance positive outcomes.
3. As part of the monitoring process, the Care Manager/Care Coordinator contacts the member or the member's authorized representative and provider(s) at established timeframes based on the:
 - a. Need for specific interventions and/or the Care Manager/Care Coordinator's judgment.
 - b. Minimum frequency as defined by the member's acuity level. If the Care Manager/Care Coordinator determines the frequency needs to be decreased or increased, he/she should modify the acuity level of the case, document the change and discuss this with the ICT.
4. As the Care Manager/Care Coordinator monitors the Care Plan and the progress towards meeting the goals, he/she evaluates the need for modification. The Care Manager/Care Coordinator may base the assessment of progress on information obtained from the member or member's representative,

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family members, attending physician, professional and caregivers, Interdisciplinary Care Team members and risk profiles.

5. If progress is not being made toward meeting the goals, the ICT should reassess the case to identify any barriers to meeting the established goals or complying with the Care Plan. These barriers may include:
 - a. Insufficient information.
 - b. Member or member's representative not willing to participate in case management.
 - c. Lack of member or family/caregiver readiness to change.
 - d. Lack of communication between member and his family or providers or other psychosocial concerns.
 - e. Lack of advance directives.
 - f. Ineffective strategy for managing after hours care or care transitions.
 - g. Unidentified or un-manageable psychosocial issues with the member and/or his family or caregivers.
 - h. Lack of rapport between the member and the Care Manager/Care Coordinator or the attending provider(s) and the Care Manager/Care Coordinator.
 - i. Lack of resources for non-covered benefits/services.
6. When barriers are identified the Care Manager/Care Coordinator is responsible for addressing the barriers. Barriers can be discussed at the case reviews (ICT's) or at any time with the member/caregiver and/or primary care provider/medical director(s).
7. As the care plan is monitored and evaluated it may need to be revised. Revisions to the care plan should be considered whenever there is:
 - a. A significant change in the member's condition, treatment plan, prognosis, or their support systems.
 - b. Case review by the unit manager or medical director with a request to revise the care plan.
 - c. Changes are noted in the clinical, psychosocial, or financial status.
 - d. The member is not making progress towards goals and objectives.
 - e. The member is not adhering to the agreed upon care plan.
 - f. Qualities of care, access or other issues with a provider are noted.
8. If modification to the Care Plan is required, the Care Manager/Care Coordinator continues to work with the member's ICT team to modify the care plan as appropriate and guide the member toward health and wellness, rehabilitation or adaptation and self-care, or when needed, acceptance of an end of life condition.
9. The Care Manager/Care Coordinator documents all care plan activities. Throughout the management of the care coordination, the Care Manager/Care Coordinator encourages the member and their family to make choices, to experience a sense of achievement and/or control, and to modify or continue participation in the treatment process.
10. The Care Manager/Care Coordinator documents the achievement of goals and the date, and notes which goals were not achieved through care management interventions and why.
11. Members graduate from the program as they become capable to self-monitor and manage their care and have not had any inpatient admission(s) for three months, unless the member is in a Special Needs Program (SNP) or in the Cal Medi Connect Program (CMC) then the member is placed on a lower level of care and followed up is performed as needed.

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PROGRAM VALUE

Care Coordination (CC) produces value by focusing time, attention, talent, and resources on the small percentage of members who are not well served by the current health delivery system. By identifying and providing additional clinical, administrative, and community services the members in the CC program will experience improved quality of life and more effective, productive use of healthcare resources. Participating providers derive value by accessing and utilizing additional clinical care management services to coordinate care plan development and implementation without incurring additional expense or inconvenience. The Health Plans derive value by confirming that their most dependent members have their care needs accurately identified and addressed using evidence based guidelines in addition to community resources, while encouraging the member/caregiver to participate in their own care processes.

PROGRAM METRICS

The Care Coordination Program is measured through a series of established utilization metrics on set timeframes.

CONTINUOUS QUALITY IMPROVEMENT

The CC team uses the Plan/Do/Study/CC method of quality improvement. Member identification, assessment, stratification, monitoring, communication, care plan generation, and care plan implementation are reviewed and revised annually, or as needed, to improve quality and performance. CC members, family members, and caregivers complete satisfaction surveys. Referring providers are surveyed as well, to gain insight into effective activities and to identify improvement opportunities.

CMS REGULATIONS

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

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

42 CFR § 422.64 Information about the MA Program

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

42 CFR §422.80 Approval of Marketing Materials and Election Forms

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

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

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- b. Or if CMS disapproves the distribution of the new material or form.
2. Marketing materials include any informational materials targeted to Medicare beneficiaries which:
 - a. Promote the MA organization, or any MA plan offered by the MA organization.
 - b. Inform Medicare beneficiaries that they may enroll, or remain enrolled in, an MA plan offered by the MA organization.
 - c. Explain how benefits of enrollment in an MA or rules that apply to enrollees.
 - d. Explain how Medicare services are covered under an MA plan, including conditions that apply to such coverage.

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

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

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

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

42 CFR §422.100 General Requirements

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

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

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

1. Enrollees of MA organizations may directly access (through self-referral) screening mammography and influenza vaccines.
2. MA organizations may not impose cost-sharing for influenza vaccines and pneumococcal vaccines on their MA plan enrollees.

42 CFR §422.110 Discrimination against Beneficiaries Prohibited

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

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

42 CFR §422.111 Disclosure Requirements

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

42 CFR §422.112 Access to Services

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

1. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

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- a. MA regional plans, upon CMS pre-approval, can use methods other than written agreements to establish that access requirements are met.
2. Establish the panel of PCPs from which the enrollee may select a PCP. If an MA organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the MA organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.
3. Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits. The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs.
4. If seeking a service area expansion for an MA plan, demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served.
5. Demonstrate to CMS that its providers in an MA plan are credentialed through the process set forth.
6. Ensure that:
 - a. The hours of operation of its MA plan providers are convenient to the population served under the plan and do not discriminate against Medicare enrollees.
 - b. Plan services are available 24 hours a day, 7 days a week, when medically necessary.
7. Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and from diverse cultural and ethnic backgrounds.
8. Provide coverage for ambulance services, emergency and urgently needed care services, and post-stabilization care services.
9. Ensure that all its contracted provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that:
 - a. The provider makes a "best-effort" attempt to conduct an initial assessment of each enrollee's health care needs, including follow up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment.
 - b. Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the MA organization, taking into account professional standards.
 - c. There is appropriate and confidential exchange of information among provider network components.

42 CFR §422.128 Information on Advance Directives

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

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

42 CFR §422.202 Participation Procedures

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

1. Practice guidelines and utilization management guidelines:
 - a. Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.
 - b. Consider the needs of the enrolled population.
 - c. Are developed in consultation with contracting health care professionals.
 - d. Are reviewed and updated periodically.
2. An MA organization that suspends or terminates an agreement under which the physician provides services to the MA plan enrollees must give the affected individual written notice of the following requirements:
 - a. The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the MA organization.
 - b. The affected physician's right to appeal the action and the process and timing for requesting a hearing.
3. The MA organization must ensure that the majority of the hearing panel members are peers of the affected physician.
4. An MA organization that suspends or terminates a contract with a physician because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.
5. An MA organization and a contracting provider must provide at least 60 days written notice to each other before terminating the contract without cause.

42 CFR §422.208 Physician Incentive Plans: Requirement and Limitations

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

Any physician incentive plan operated by an MA organization must meet the following requirements:

1. The MA organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
2. If the physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the MA organization must

assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss and conduct periodic surveys.

3. For all physician incentive plans, the MA organization provides all information requested to CMS.

42 CFR §422.504 Contract Providers

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

1. To provide:
 - a. The basic benefits and, to the extent applicable, supplemental benefits.
 - b. Access to benefits as required.
 - c. In a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.
2. To disclose information to beneficiaries in the manner and the form prescribed by CMS.
 - a. To operate a quality improvement program and have an agreement for external quality review as required.
 - b. To comply with the reporting requirements for submitting encounter data to CMS.
 - I. The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful.
 - II. The CEO, CFO or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the encounter data it submits are accurate, complete, and truthful.
 - III. If such encounter data is generated by a related entity, contractor, or subcontractor of an MA organization, such entity, contractor or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.
3. To submit to CMS all information necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. The information includes, but is not limited to:
 - a. The benefits covered under the MA plan.
 - b. The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the MA monthly MSA premium.
 - c. The service areas and continuation area, if any, of each plan and the enrollment capacity of each plan.
 - d. Plan quality and performance indicators for the benefits under the plan including:
 - I. Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years
 - II. Information on Medicare enrollee satisfaction
 - III. Information on health outcomes
4. To comply with:
 - a. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84

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- b. The Age Discrimination Action of 1975 as implemented by regulations at 45 CFR part 91
- c. The Rehabilitation Act of 1973
- d. The Americans With Disabilities Act
- e. Other laws applicable to recipients of Federal funds
- f. All other applicable laws and rules

42 CFR §422.562 GENERAL PROVISIONS

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

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

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

42 CFR §422.752 Basis for Imposing Sanctions

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

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

REQUIRED SUBMISSIONS

The Healthcare Informatics Department at HPN Inc. contracted Medical Groups/IPAs are responsible for collecting, managing and analyzing all encounter data and paid claims for HPN members submitted by all Physician Groups, IPAs, and providers contracted with HPN Inc. contracted Medical Groups/IPAs. HPN, Inc. requests that the following types of information be submitted timely (i.e., within 45 days of date of service) by all contracted Physician Groups, IPAs and Providers for all HPN, INC. members:

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

MEDICARE REGULATIONS

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

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

Proprietary and Confidential Information - Subject to Non-Disclosure Agreement"

COMMON ERRORS

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

1. UB92
 - a. ICD-10-CM coding not to the highest level of specificity.
 - b. No HCPCS/CPT coding when required by Revenue Code.

2. CMS 1500
 - a. "Unbundling" or fragmentation of services.
 - b. ICD-10-CM coding not to the highest level of specificity.
 - c. Use of outdates or invalid procedure and diagnosis codes.

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

ADDITIONAL INFORMATION

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

www.medicaretraining.com.