

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

- 1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:
- 1.1.1 Obtaining coverage that meets the requirements for a separate child health program **(Section 2103); OR**
 - 1.1.2. Providing expanded benefits under the State's Medicaid plan **(Title XIX); OR**
 - 1.1.3. A combination of both of the above.
- 1.2 Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**
- 1.3 Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**
- 1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:
- Effective date: August 24, 2001
- Implementation date:

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Section 4. Eligibility Standards and Methodology. (Section 2102(b))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

- 4.1.1. Geographic area served by the Plan:
- 4.1.2. Age:
- 4.1.3. Income:
- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources):
- 4.1.5. Residency (so long as residency requirement is not based on length of time in state) :
- 4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility):
- 4.1.7. Access to or coverage under other health coverage:
- 4.1.8. Duration of eligibility:
- 4.1.9. Other standards (identify and describe):

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

- 4.2.1. These standards do not discriminate on the basis of diagnosis.
- 4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102)(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

California's HFP enrollment system is perhaps one of the most conceptually pure enrollment systems in the country. It was built to reflect the State's commitment to providing low-cost medical insurance to a target population and eliminating the obstacles so often associated with seeking public assistance. As such, it boasts an impressive array of nodes through which an applicant can interact with the HFP and Medi-Cal systems; all of these are tied to a single point of entry. The underlying idea is that such a system accommodates the preferences of a variety of users, while maintaining accountability. California's Single Point of Entry (SPE) is run by the HFP administrative vendor. Applicants enter the application process through any of several possible avenues, such as a certified application assistant or HFP's automated system, Health-E-App; all of these feed to one entity – the SPE - which is responsible for screening and routing the applications.

Enrollment Process:

The majority of applicants mail their applications directly to the SPE. Occasionally, applicants mail their applications to their local county of

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residence instead; however, counties have been instructed to forward these applications on to the SPE. The SPE first screens all applications for no-cost Medi-Cal eligibility, and then routes the applications to either the County Welfare Department (CWD) or HFP as appropriate. By creating the SPE, California has eliminated much of the confusion applicants experience when applying for HFP and Medi-Cal. Applicants mail in their applications with some supporting documentation to the SPE, and their information is automatically routed to the appropriate program.

Forwarding of applications to HFP:

If an application sent to Medi-Cal from the SPE or an applicant is determined to be ineligible for no-cost Medi-Cal, the CWD returns the application to the SPE using the SPE, HFP, or county transmittal form to indicate why the person is ineligible for no-cost Medi-Cal. The SPE has on-site liaison staff who are proficient in Medi-Cal eligibility criteria and can evaluate whether the information received or forwarded from the county is sufficient to forward directly to HFP. The SPE liaison staff work directly with county staff on those applications in which the information forwarded to the SPE is not sufficient to support an eligibility determination of HFP eligible. This quality improvement effort has increased the standardization of eligibility determinations and reduced the unnecessary flow of applications between programs.

The State has further expedited the enrollment process by providing an alternative to the standard HFP application. A Medi-Cal application (MC 210) with a Notice of Action (NOA) from the county and supporting documentation, can be forwarded to the SPE and is acceptable for use as an application for the HFP.

If a person is determined to no longer be eligible for no-cost Medi-Cal at the time of his or her Medi-Cal redetermination, the CWD will forward the information form, notice of action, and the supporting documentation to the HFP for a determination. Consistent with this end, DHS has also issued an All County Welfare Directors Letter, which instructs counties to forward the applications of no-cost Medi-Cal ineligible persons to the HFP.

HFP has also developed a new transmittal form which will be used by the county to return or send individual mail-in applications from the county Medi-Cal program to the Healthy Families Program. A summary transmittal will list all applications included so the HFP may verify all applications are received. If the county Medi-Cal staff determines a share-of-cost (SOC) exists or will occur for an individual included on the application, the county staff will forward a copy of the application, a NOA and budget information with the transmittal to the HFP. Healthy Families staff will be alerted that this mail-in application may have already been routed through the SPE process and may be

evaluated for Healthy Families eligibility rather than screened through SPE and potentially returned directly to the county based on former income calculations. Verification that an applicant has given permission for his or her mail-in application to be forwarded to the other program will be done prior to forwarding any applications.

Description of the redetermination process and how the demonstration project will be monitored, tracked, and claimed.

This includes a discussion of how the State will assure that individuals are enrolled in the program for which they are eligible and disenrolled from the program for which they are no longer eligible within the two-month available demonstration coverage period.

Medi-Cal completes annual redetermination reviews for parents as well as children. At the time of a Medi-Cal redetermination, if a person is determined to no longer be eligible for no-cost Medi-Cal because of income, the CWD forwards the new summary and transmittal, notice of action, and the supporting documentation to the HFP for a determination. This process eliminates the need for HFP to do a subsequent determination when the county has made a definitive eligibility determination. Moreover, the SPE, MEDS, and the HFP administrative vendor's internal data systems interface. If a Medi-Cal or HFP enrollee has an income change before his/her redetermination and requests a redetermination to establish eligibility for the other program, each program has the ability to forward (or receive) information and supporting documentation. This information can be used to establish eligibility and maintain seamless health coverage.

Since the HFP's inception, the State has provided a "one-month bridge" for those children living in families with incomes that no longer qualify them for no-cost Medi-Cal. The one-month bridge continues the child's coverage for an additional month while the family applies and the child is enrolled in the HFP. The State will extend the Medi-Cal to HFP bridge from one to two-months and (when the parental coverage waiver is implemented) will include parents who are enrolled in no-cost Medi-Cal, but no longer eligible due to an increase in family income. Each person enrolled in a Medi-Cal health plan will continue his or her enrollment in the same health plan during the two month transition period. Once the determination has been made by the CWD that a person is no longer eligible for no-cost Medi-Cal, the information and supporting documentation, along with the notice of action, will be forwarded to the SPE for processing with the summary and detail transmittals. These children/parents will be coded as 7X on MEDS. Once at SPE, the same process will be followed for determining eligibility for the HFP that is followed for processing new applications. Following this process will help to

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ensure that a determination for eligibility for the HFP is made and the person is enrolled within the two month bridging period. This process includes screening the application/information forwarded from the CWD within three business days of receipt to determine completeness, calls and letters to applicants to obtain any additional information needed for completeness, and completing the process to determine eligibility for the HFP pursuant to the HFP regulations. MRMIB is currently working with DHS to create a standardized redetermination form that will be used by the CWD to forward the necessary information and documentation to the HFP when a person has been determined to be no longer eligible for no-cost Medi-Cal at the time of redetermination or re-evaluation for Medi-Cal.

To further the seamlessness of the process, the State will provide children and parents with two months of continued eligibility in the HFP (via a HFP to Medi-Cal bridge) when the HFP determines at AER that the household income qualifies the child or parent (once parental coverage is implemented) for no-cost Medi-Cal. These additional days provide continued access to care while the CWD completes the Medi-Cal eligibility determination. Individuals given the two month HFP to Medi-Cal-bridge will be given an ending date of HFP coverage at the end of the two month bridge period. These individuals will be coded as 7Y on MEDS. As described above, the HFP will send the AER information and documentation to the CWDs so the CWDs can determine eligibility for Medi-Cal. The HFP also will forward any AER information for applicants who initially did not give permission to have their AER packet sent to the CWD but later return the authorization form to the HFP. HFP sends the summary and detail transmittals for these reevaluations. The HFP will maintain reports of all individuals who are granted the two month bridge to Medi-Cal and will generate reports on which of these individuals are enrolled in Medi-Cal.

The SPE will also have on-site liaison staff who are proficient in Medi-Cal to evaluate whether the information received or forwarded from the county is sufficient to forward directly to HFP. The SPE liaison staff will work directly with county staff on those applications in which the information forwarded to the SPE is not sufficient to support a definitive eligibility determination. This quality improvement effort will increase the standardization of eligibility determinations and reduce the unnecessary flow of applications between programs. As described above, the SPE liaison staff will assist with any information that is returned by the CWD to the HFP if the CWD finds that an individual is not eligible for no-cost Medi-Cal.

- 4.4..4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section**

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2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

- 4.4.4.1. Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.
- 4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.
- 4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.
- 4.4.4.4. If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

- 4.4..5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Section 7. Quality and Appropriateness of Care

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

- 7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
7.1.2. Performance measurement
7.1.3. Information strategies
7.1.4. Quality improvement strategies

- 7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

7.2.2 Access to covered services, including emergency services as defined in 42 CFR, 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b)**

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or**, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

California state law contains specific requirements for health plan utilization review, including prospective, retrospective, and concurrent review. State law also requires independent medical review of health plan decisions concerning medical necessity. These requirements, found at Health and Safety Code Section 1367.01 and 1374.30 et seq., are designed to ensure that the prior

authorization process does not present an undue barrier for continuity and access to care.

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Section 8. Cost Sharing and Payment (Section 2103(e))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

- 8.1.1. YES
8.1.2. NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

- 8.2.1. Premiums:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(B)) (42CFR 457.505(b))

The notification process is disclosed in HFP regulations, evidence of coverage, and the HFP Handbook. The HFP is currently in the process of reviewing its subscriber notification procedures. We anticipate that our review will be completed with necessary changes implemented by January, 2003.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
8.4.3. No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

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- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

The HFP is currently in the process of reviewing its cost-sharing calculation procedures. We anticipate that our review will be completed with necessary changes implemented by January, 2003.

- 8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**
- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

Currently, if a program participant fails to make a payment, the next month's invoice he receives includes a 30 day past due warning. The second month's invoice includes the amount due for the previous month and the current month, the date by which payment must be remitted, and the date the coverage will end if payment is not made. All invoices with past due warnings include a statement that if the subscriber is disenrolled for non-payment, he or she must wait 6 months before he or she can enroll in HFP again.

If the premium is 45 days past due, a warning letter is sent to the applicant, which includes information on payment options and the disenrollment date. If the premium has not been received on the 20th of the second month, a courtesy call is placed to the applicant. The applicant is reminded that a premium payment is due and that his or her child will be disenrolled as of the end of the month. He or she is also questioned regarding whether he or she received the notification. A last billing statement is also mailed to the applicant on the 20th day of month, and if HFP has not received payment by the last day of the second month, a disenrollment with appeal information letter is sent to the applicant.

HFP is in the process of reviewing its disenrollment practices. It is anticipated that revised practices will be implemented in January, 2003.

- 8.7.1 Please provide an assurance that the following disenrollment protections are being applied:
- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR**

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457.570(a))

- The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**
- In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

- 8.8.1. No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**
- 8.8.2. No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)**
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 11. Program Integrity (Section 2101(a))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.
- 11.1 The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**
- 11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*
 - 11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
 - 11.2.2. Section 1124 (relating to disclosure of ownership and related information)
 - 11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)
 - 11.2.4. Section 1128A (relating to civil monetary penalties)
 - 11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)
 - 11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

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Section 12. Applicant and enrollee protections (Sections 2101(a))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

Definition:

MRMIB defines an 'Appeal' as correspondence received from an applicant expressing his or her disagreement with a decision made by the Healthy Families Program. An appeal must be received by the HFP administrative vendor or MRMIB within 60 days of the initial written decision or action notification. HFP will only consider appeals related to decisions pertaining to:

- 1) Program Qualifications (e.g., on no cost Medi-Cal, employer sponsored insurance within 90 days, disenrolled for non-payment within 6 months, etc.)
- 2) Eligibility determinations (e.g., income below guidelines, treatment of step-parent income, income above guidelines, etc.);
- 3) Effective date of coverage (e.g., enrollment delayed, application processing delay, etc.).

Any appeal that does not meet at least one of the three above appeals criteria or is received beyond the specified timeframe (i.e., 60 days), is defined as a Program Review.

HFP Appeal Process:

The Healthy Families Program has a three step appeals process. These processes are referred to as:

- 1) First Level Administrative Reviews.
- 2) Second Level Administrative Reviews.
- 3) State Administrative Hearings.

First Level Administrative Review:

First level administrative reviews are written appeals received by the HFP administrative vendor or MRMIB for the first time. First level administrative reviews must be received within **60 days** of the date on the decision notification. First level administrative reviews will be processed by the HFP within 30 days of receipt.

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Exceptions:

The HFP administrative vendor will forward all first level administrative reviews to MRMIB if:

1. The appeal includes outstanding medical bills or expenses.
2. The appeal is of a sensitive nature and the referral has been approved by an HFP administrative vendor supervisor.

If a first level administrative review is denied, the applicant will be notified of his or her right to request a second level administrative review with the Executive Director at MRMIB.

Second Level Administrative Review:

Second level administrative reviews are appeals to first level administrative review decisions made by HFP. Second level administrative reviews must be received within 30 days of the first level administrative review decision notification.

If a second level administrative review is denied, the applicant will be notified by the Executive Director of MRMIB of their right to request a State administrative hearing.

State Administrative Hearing:

An applicant may request a State administrative hearing only if he/she has complied with both the first and second level administrative review processes. An Administrative Law Judge (ALJ) conducts administrative hearings. The ALJ will only address issues or decisions related to eligibility determinations, disenrollments, and/or effective date of coverage.

Program Reviews:

Program reviews are written appeals received by HFP or MRMIB which do not meet at least one of the three appeal criteria or are not received by HFP or MRMIB within the specified time requirements (i.e., 60 days for first level).

If a program review is denied, the applicant will be notified of the decision, that a Program Review is not an appeal and that there are no appeal rights.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

Participating plans are required by state law to establish and maintain a grievance system approved by the Department of Managed Health Care (DMHC). The DMHC is responsible for licensing and regulating pre-paid plans (health, dental, and vision) in California.

The plan's grievance process must provide reasonable procedures in accordance with

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DMHC regulations to ensure adequate consideration of grievances and provide for rectification when appropriate. Subscribers who are not satisfied with the plan's final determination or who have not received a response to their grievance within 30 calendar days, have the option of appealing to the DMHC.

DMHC will review the appeals as a standard review or as an Independent Medical Review (IMR). (The IMR allows subscribers to obtain an impartial review of any health care service eligible for coverage and payment under a health plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary). The standard review and Independent Medical Review process include a final binding resolution by DMHC staff or DMHC contractor.

The patient protection provision in state law that were established for managed care enrollees in California also apply to HFP subscribers. Thus, members are instructed to use their health plan's grievance process –including the DMHC's IMR process, if the subscriber has a grievance. When subscribers call MRMIB directly MRMIB staff serves as an ombudsman assisting subscribers with the grievance process.

MRMIB requires all HFP participating plans to report benefits related grievances once a year. In addition, MRMIB tracks all complaints directly received from subscribers, and any publicly available information on the number and type of benefit grievances filed by subscribers enrolled in a participating plan. Grievance information is used by MRMIB to identify problem areas and to take appropriate steps towards improvements.

Premium Assistance Programs

- 12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.